Coming Down the High Road:
Doing Residential Drug Rehabilitation

Volume 1:
A Literature Review on Residential Drug Rehabilitation

Hannah Graham & Rob White
School of Sociology & Social Work
University of Tasmania
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Glossary of Terms

**Action Research:** A specific type of research that moves past simply looking at the surface level of whether an initiative, intervention or project is working, and goes further to analyse and appraise if it is working, how it is working, why, and for whom, plus examination of areas for improvement and enhancement. Action research can be used as a part of evaluation research.

**Benzodiazepine:** Benzodiazepines are sedatives prescribed for the treatment of insomnia (tranquilisers/sleeping pills) or also a range of anxiety conditions, and it is possible to become dependent on the drug and also suffer associated harm. There is both a licit and illicit benzodiazepine market that exists, and an increasing level of use in Australia.

**Biopsychosocial model:** this model involves the recognition that the status of a person’s health is influenced by complex interactions between biological, psychological, and sociocultural factors.

**Comorbidity:** the terms comorbidity, dual diagnosis, and co-occurring disorders all describe an individual who is both a substance user and lives with a mental illness.

**Court mandated diversion (CMD):** Court mandated diversion is a new therapeutic jurisprudential programme which allows magistrates to divert defendants whose offending is linked to their drug use into treatment using bail conditions, a drug treatment order, or the sentencing process.

**Crystal Meth – Ice:** Crystal meth or ‘ice’ is one of three forms of methamphetamine (a psychostimulant), given its street name because it takes on the appearance of a crystal or a chunk of ice. It can be imbibed in a number of ways through injecting, swallowing it, snorting it, or smoking it.

**Drug:** The term drug covers a range of substances, legal and illegal, including alcohol, prescription drugs, marijuana and other illicit drugs. The term drug has multiple aspects. It may refer to the medicinal definition of pharmacology in which a natural or artificial substance is prescribed to treat or prevent disease or lessen pain. In this report, drug is used to refer to a licit or illicit substance that (a) may, in some cases, be addictive, (b) which causes changes in behaviour or perception, and (c) is taken for its effects.

**Evaluation:** A specific form of research methodology that involves analytical appraisal and assessment of the capacity and effectiveness of a service, intervention, policy or practice. Evaluation research can be conducted during or after (or both) a process is complete.

**Pharmacotherapy:** this is a term to describe substitution therapy in which an alternative, less harmful substance is taken instead of another substance with the aim of lessening or stopping dependence on that other substance. Use of pharmacotherapy medication is viewed as more
socially acceptable, and is supported widely in Australian society by governments and institutions. Pharmacotherapy medications are usually dispensed through pharmacies, and require prescription from a doctor.

**Rehabilitation:** The process by which an individual with a substance use problem attains an optimal state of health, psychological functioning, and social well-being.

**Shared care:** Shared care advocates a partnership approach between services that are involved in the treatment and support of drug users. The shared care is usually referral based and is parallel – occurring at the same time – i.e. sharing the support of an individual. However, while this is a collaborative approach, it does not involve much integration of care or service delivery.

**Therapeutic jurisprudence:** Therapeutic jurisprudence entails both philosophy and practice that focuses on the capacity of the law as a healing agent and law as one of the original helping professions. Instead of being coercive or sanction focused, therapeutic jurisprudential practice involves treatment and therapeutic interventions enacted by the court to address the underlying problem(s), which should then in turn ameliorate the offending behaviour.

**Uptake:** when a person commences substance use, most commonly used in reference to drugs.

**Wellbeing:** this term refers to the individual having overall health and a positive sense of personal satisfaction or balance in various areas of life – medical, psychological, social, financial. It does not simply denote the absence of negative elements, but involves the individual maintaining a level of optimal functioning and feeling well within themselves.
Abbreviated Terms

AIC    Australian Institute of Criminology
ADCA   Alcohol and Other Drugs Council of Australia
ANCD   Australian National Council on Drugs
AOD    Alcohol and Other Drug
ATDC   Alcohol, Tobacco and Other Drug Council, Tasmania
ATOD   Alcohol, Tobacco and Other Drug
ATS    Amphetamine-type stimulant
BBV    Blood borne virus
CALD   Culturally and linguistically diverse
CBT    Cognitive behavioural therapy
CMD    Court mandated diversion
DHS    Department of human services, Victoria
DHHS   Department of health and human services, Tasmania
DTO    Drug treatment order
DUCO   Drug use careers of offenders
DUMA   Drug use monitoring in Australia (survey of police detainees)
EIU    Effective interventions unit, Scotland
EOC    Episodes of care
HCV    Hepatitis C virus
HIV    Human Immunodeficiency Virus
IAWGD  Inter Agency Working Group on Drugs, Tasmania.
IDU    Injecting drug user
MMT    Methadone maintenance treatment
MOU    Memorandum of understanding
NDRI   National Drug Research Institute
NGO    Non-government organisation
NSP    Needle and syringe programme
TC     Therapeutic community
WHO    World Health Organisation
WHOS   We Help Ourselves, Australia
Introduction

This project reflects The Salvation Army’s desire to provide the ‘best drug and alcohol treatment service in Tasmania’ and develop policy, procedures, and practices that will assist residents. The Salvation Army required a user friendly Final Report to identify and describe best practice models and examples of alcohol and drug residential rehabilitation. The Final Report is meant to inform future Salvation Army planning regarding the provision of residential rehabilitation services in Tasmania.

This project has comprised a literature review with reference to a service delivery context that includes:

1. Court mandated provision of services
2. Involuntary clients and practice
3. Innovative models and examples

The literature review was based on, but not limited to:

1. The continuum of care concept, and existing evaluation practices
2. Relevant international and national comparisons
3. Information on treatment reporting and evaluation systems

In preparation of the report we were aware that residential drug rehabilitation must address issues related to:

- Capacity and approach adopted by service agencies
- Client profile and receptivity to diverse types of rehabilitative services
- Policy context of licit and illicit substance use, such as implementation of drug diversion programs and harm minimisation strategies
- Collaboration and partnerships across agencies and client services
• Concepts of rehabilitation and restorative processes
• Language(s) of communication, professional practice and service mission

The report is provided in two volumes. Volume 1 of the report provides ‘A Literature Review of Residential Drug Rehabilitation’. The information provided in Volume 1 is largely based upon publicly available documents and documentation, as reflected in the reference list and the list of websites at the end of the report. This information was supplemented by participation at a few drug and alcohol forums and workshops ‘National consultation forum on amphetamine-type stimulants’ and the ‘Court mandated diversion drug offenders in Tasmania symposium’, and informal discussions with stakeholders from a variety of different agencies within the Hobart precinct.

Our key task was to provide an overview of existing practices, to discuss prevalent principles and practices within the residential drug rehabilitation sector, and to synthesise ‘the best of the best’ in terms of constructing an ideal type model for the doing of residential drug rehabilitation. This is the substantive content of the second volume of the report. Volume 2 provides ‘A Model of Residential Drug Rehabilitation’. Based upon the literature review in Volume 1, it provides a step-by-step approach towards innovative practice, and gives strategic direction towards organisational change. Volume 2 has been designed to be practitioner-friendly and a manual of service provision.

We wish to acknowledge the commitment of the Salvation Army’s Ronda McIntyre, Peter Fraser and Jed Donoghue to the development of this project.
Part One: Existing Drug Treatment Practice

Part One of the report comprises a detailed descriptive survey of relevant existing practice in the alcohol and other drug sector. A brief examination of the context of drug rehabilitation programmes forms the foundation upon which current programmes have been built and from which they developed. The national and international examples and case studies described in this section highlight current leaders in the field. The systems and approaches utilised at The Bridge Programme are outlined to provide insight into the local service delivery context. The context of the Tasmanian alcohol and other drug sector, and accompanying government initiatives for the future, is described, as are emergent issues pertaining to drug use and drug services.

The Context of Alcohol and Drug Rehabilitation Programmes

Alcohol and drug rehabilitation treatments and programmes have developed extensively over the last few decades. Historically, people with a substance abuse problem may have been encouraged to “go cold turkey” and just stop their problematic use of a specific substance. However, the development of pharmacotherapies such as methadone maintenance treatment showed the recognition that substituting a harmful drug addiction with a carefully monitored less harmful addiction could be much more beneficial in some cases and allow users to lead a functional lifestyle of relative health and well-being.

Within the alcohol and drug sector, there has been a clear paradigm shift from the disease model of understanding addiction to the biopsychosocial model, which emphasises not only biology but also psychological and social factors as well. The disease model basically sees substance use and addiction from a predominantly biological and medical perspective. The biopsychological model incorporates biological, psychological and broader social elements into the contextual understanding of a person and their substance use.

One significant development has been in the area of abstinence and relapse. Abstinence always has, and continues to be, advocated as one of the most effective ways of reducing drug-related harm. However, treatment providers has changed their views from simply mandating abstinence to recognising that it may be a process in which an individual client eventually
reaches abstinence as the goal. Realistic appraisal of relapse as a common occurrence for many has been a part of the embrace of harm minimisation into the principles and practices of rehabilitation programmes. The provision of relapse prevention education and training in rehabilitation programmes is a welcome advancement in the field.

An example of the development of the sector is alcohol dependence. For a long time, it was maintained that, in order to overcome a drinking problem, a person needed to stop drinking altogether. However, over time, this disease concept began to be questioned (Drug Info Clearinghouse 2007). It was acknowledged that people developed alcohol dependence rather than inheriting it at birth, and that alcohol dependence was a series of behavioural patterns or habits that could be unlearned or reduced. A critique offered of the disease concept is that it ‘failed to take into account the effect of societal factors, such as the way alcohol use was promoted within society’ (Drug Info Clearinghouse 2007). It also encouraged passivity and a lack of empowerment or control over personal substance abuse. The changes in thinking resulted in the popularity of the treatment goal of controlled and appropriate drinking – allowing people to drink in moderation, but not in a way that impedes personal functioning or well-being (Drug Info Clearinghouse 2007).

**Interstate and International Examples of Good Practice**

Each of the following case studies utilise different systems and structures, and lessons can be learned from their examples and stories. These case studies exemplify best practice, but realistic reflection is provided to demonstrate how these treatment services and approaches are continually identifying barriers or issues in order to further enhance their quality of service provision.

**Case Study 1: Turning Point and alcohol and other drug services in Victoria**

*Turning Point Alcohol and Drug Centre*

Turning Point Alcohol and Drug Centre is recognised as a leader in the alcohol and other drug [AOD] sector in Australia. They are an excellent example of a comprehensive practice in Victoria. Turning Point’s Alcohol and Drug Centre in Fitzroy offers a variety of programmes and services including: clinical and forensic services, pharmacotherapy research, epidemiology and surveillance, peer based support groups, health services research and evaluation, AOD tertiary education, training and information resources, vocational and technical education, corporate services, and a telephone and online counselling, referral and consultancy service. Treatment and Support services offered include: assessment, counselling, direct response
outreach programme, post withdrawal group, forensic services, home based withdrawal service, needle and syringe exchange program, outpatient withdrawal service, specialist pharmacotherapy services, comorbidity screening, and hepatitis C treatment. Consultancy services are available 24 hours a day for professionals and community service providers in need of advice on the clinical management of drug and alcohol issues. Turning Point employs staff from a range of disciplines and professional backgrounds, and all their staff are recognised as being well trained and each having impressive educational histories (Turning Point 2006b). Collaboration and partnership occurs with organisations across the health, education and community services sectors. The Centre is formally affiliated with St. Vincent’s Hospital Melbourne and the University of Melbourne.

Turning Point’s Healthy Liver Clinic is a part of the Alcohol and Drug Centre, and it is a good example of an integrated multidisciplinary service in that both opiate pharmacotherapy and HCV education and treatment are both offered in the same service (Topp 2007). Due to its location, the Healthy Liver Clinic can utilise other Turning Point resources and services, such as those listed above. According to Topp (2007: 22), ‘recent data collected for an evaluation of the Healthy Liver Clinic suggests that the integrated one-stop-shop model is popular with clients, and that convenient access to a wide range of staff and services under the same roof is perceived as one of its major strengths’. Along with an interdisciplinary team of highly skilled professionals, a peer worker is employed to provide a link between the clients and the health professionals, who can liaise with both groups and act as an advocate for clients (Topp 2007).

Four strategic goals have been articulated for achievement within the next few years:

1. **Services, research and development that matter** – to create thriving service delivery, research, and development cultures, generating knowledge and practice on alcohol and other drugs that promote health and wellbeing for individuals and communities.

2. **Making services, research and development matter** – to apply, use and translate research and development outcomes to promote change, build effective and rational policy, and demonstrate, provide and contribute to world’s best practice in treatment of alcohol and other drug problems.

3. **Strong and healthy communities** – to build our own and our communities’ capacity through strategic relationships, partnerships and collaborations with individuals and organisations.

4. **Strong and healthy organisation** – to build organisational capacity that provides the best environment for quality staff to achieve their potential, and to achieve financial stability and long-term security.

(Turning Point 2006a: 7).
Specific strategies are articulated in the Plan for each of these goals, providing a clear direction for how to achieve them. Turning Point adopts a ‘shared care’ model which is similar to the integrated care approach outlined later.

**The Victorian alcohol and other drug sector**

The Department of Human Services (2007a) in Victoria have developed a blueprint for enhancing alcohol and other drug treatment state-wide. Consumer representatives and practitioners were consulted in order to reflect on the strengths and achievements of the Victorian sector, as well as highlight areas for improvement and strategies to ensure good practice. The Victorian model is a *client-centred system* that sees individuals as “people first… not just drug users.” The mandate is for a service that is ‘accessible, evidence-based, effective, safe, efficient and flexible, providing integrated service delivery and coordination through holistic and professional case management’ (DHS 2007a: 29). Client participation in service design, planning, and delivery is encouraged. Currently, a charter of Client Rights is being developed in association with the Association of Participating Service Users (APSU) as a part of the quality framework.

**Service strengths and achievements in Victoria**

These include (Department of Human Services 2007a: 27):

- Specialist alcohol and other drug treatment agencies now help more than 26,000 people every year.
- Specialist treatment beds have increased by more than 80% since 1999.
- Waiting times for treatment services are significantly shorter since 2000.
- Access to treatment in rural and regional Victoria has improved through new facilities.
- The Dual Diagnosis Initiative leads Australia in offering specialist support and treatment for people with mental health and alcohol and other drug problems.
- A mobile overdose response service and mobile drug safety workers operate across Melbourne linking overdose survivors with treatment, and providing crisis support and early intervention, as well as advice and information for harm minimisation.
- People with brain injuries linked to their alcohol and other drug use can access specialist services.
- Homeless people have access to specialist support, advice, and treatment through the Homelessness and Drug Dependency Program and associated service partnerships.
• The Needle and Syringe Program in Victoria is internationally acclaimed and has been extended to help prevent the spread of HIV / hepatitis C. It has been instrumental in maintaining one of the lowest drug-related HIV infection rates in the world.

• Five primary health services for injecting drug users operate in five cities (“drug hot spots”) across Victoria.

• A specialist 15-bed family residential rehabilitation program provides treatment and help to families and a parenting support service operates through the facilities.

• A specialist antenatal and post-natal support service based at the Royal Women’s Hospital provides treatment and support to pregnant women with a drug or alcohol problem.

• A parenting support toolkit helps workers consider parenting issues and provide support to people with children.

• Outreach to local General Practitioners to deliver shared care models of treatment that support the delivery of pharmacotherapy in a range of community settings.

• 24 hour hotlines are in place to ensure timely advice for substance users.

• The Juvenile Justice Alcohol and Drug Strategy has underpinned the development and implementation of initiatives to address substance use among juvenile justice clients.

• Custodial Health and Alcohol and Drug Nurses is a joint initiative between DHS and Police providing assessment, treatment and referral of prisoners held in police custody.

The Department of Human Services has a significant focus on quality assurance and accreditation, and core standards and specifications are in place across the state to provide benchmarks for success. In the new blueprint released in 2007, there are a few priority areas for action which form lists of the next steps to take and strategies on how to achieve change. Opportunities for further progress are highlighted, and some of the areas of focus currently include:

• Increasing flexibility – services that fit clients
• Building further capacity into a skilled workforce
• Engaging in more research – finding what works best
• Retention in treatment – the hallmark of success
• Recognising the importance of case management in complex cases
• Enhanced measurement of client success and treatment outcomes
• Improving information sharing
• Better waiting list management
• Building harm reduction linkages
• Building further partnership and collaboration
• Emphasising holistic and integrated treatment responses
• Better support of indigenous and culturally and linguistically diverse (CALD) clients
• Tackling emerging drug types
• Intervening earlier – brief interventions
• Using new technology to promote self-help
• Increased support for families and improving information in this area

Source: Department of Human Services (2007a).

This list of opportunities for progress is relevant in its application across the board in the alcohol and other drug sector. Evidence-based research is advocated as a strong foundation on which to build organisational change, and evaluation and monitoring are promoted as ways to assess the effectiveness of a service and how it matches up to objectives for progress and innovation.

| This brief summary has provided an indication of the extent of services, not quality; principles, not actual practices; and things to do, not what is being done. Nevertheless, it provides a useful roadmap to best practice. |

**Summary: What have we learned from this case example?**

• Multiple and accessible services
• Client centred service with clients having an active role in case planning
• Strategic goals
• Quality assurance and future improvements
Case Study 2: The Integrated Care approach to drug treatment in Scotland

The ‘integrated care’ approach to treatment of drug users is a good example for discussion because it is clearly established and well researched. It does not refer to a single residential treatment centre, but to a framework for practice that has been streamlined across Scotland and is utilised by a variety of agencies and organisations.

From shared care to integrated care

The approach to drug treatment in Scotland has, until recent years, been underpinned by the shared care approach. During the 1990’s, there was an expansion of shared care arrangements across Scotland, mainly involving GP’s and primary care staff, pharmacists and specialist drug services (Rome, Morrison, Duff, Martin & Russell 2002). However, the establishment of the Effective Interventions Unit (EIU) by the Scottish Executive in 2000, and subsequent inquiry and consultation by the EIU uncovered difficulties with the shared care approach. Faced by barriers of the fragmentation of initiatives, the EIU was commissioned to ensure enhanced effectiveness, the efficient and appropriate use of resources, and the best outcomes for services and users. The consultations highlighted that agencies themselves did not properly understand the term ‘shared care’, that there were different interpreted meanings, and that the term was ‘potentially a barrier to providing a coordinated or integrated approach to the care of the individual with complex needs’ (Rome et al. 2002). Agencies instead spoke of the need to broaden the number and range of agencies involved in providing treatment, care and support to drug users (Rome et al. 2002). In other words, in the minds of some agencies and practitioners in the field, the term ‘shared care’ did not appear to extend beyond primary care partnerships, and was thus inhibiting progress in collaboration because of misunderstanding and ambiguity. This narrow view of shared care was, arguably, somewhat indicative of the limitations of the approach to partnership – it was not enough to only meet the primary care and specialist drug-related needs of an individual. The move from shared care to integrated care was driven by the aim of achieving true person-centred service with the streamlining of service access to more efficiently, effectively, and holistically meet all treatment needs as much as possible, thus resulting in better recovery outcomes.

The guidance of the EIU is utilised in a variety of organisations in the alcohol and drug sector as well as other community service organisations in Scotland, and is strongly linked to broader drug strategies in the United Kingdom. The influence of the EIU on policy and practice is guided by extensive consultation with and feedback from service providers, practitioners, and substance users. Also, the integrated care approach comprises agencies providing court mandated diversion by working in partnership with local drug courts with individuals under drug treatment and testing orders. Ensuring good practice is a core driving factor of the way in
which the strategies are implemented and regulated, and relevance and reflexivity are evident in the way it is applied in different agencies and treatment centres in Scotland.

**Goals and objectives of the integrated care approach**

The integrated care approach can be described as encapsulating ‘a proactive approach to treatment, care and support; enables the participation of a range of services; and involves the individual and their family in the assessment and planning of care’ (Rome *et al.* 2002). It is a holistic person-centred service that requires:

- treatment, care and support to be person-centred, inclusive and holistic to address the wide ranging needs of substance users
- the service response to be needs-led and not limited to organisational or administrative practices
- collaborative working between agencies and service providers at each stage in the progress of the individual in treatment, care and support, through to rehabilitation and reintegration into the community

**Source:** Rome *et al.* (2002)

This approach recognises that substance users have complex needs that can be effectively addressed during their rehabilitation. It is innovative, and this is mainly because of the extent to which collaboration and partnership are utilised in the best interests of the individual. For example, an individual may transition in spending time at a detoxification centre to a drug rehabilitation centre, but it is recognised the person may need to engage at different times with a variety of services. These may include: treatment from other agencies (for example, those mandated by the drug court as part of a treatment plan), medical and health services (including mental health/psychiatric), pharmacies, legal advice, correctional and probation services, financial planning and debt reduction, employment services, housing support, social work and personal development services, indigenous or immigration services, religious support, youth workers, and family, parenting and child custody support. An individual may simply require the service of a single agency, or if they have more complex needs, they may require the services of several agencies. A ‘care coordinator’ (like a case manager) from the main agency of use (often a rehabilitation centre) may coordinate and help the individual liaise with different services.
The overarching aim of integrated care is to help users overcome problems associated with their drug use and potential accompanying health and social difficulties by providing effective, co-ordinated and timely treatment, care and support (Rome et al. 2002). Thus, the goals of integrated care are to:

- reduce illicit drug use through promoting harm minimisation, stabilisation, recovery and (if desired) becoming drug free,
- reduce the risk of the spread of blood-borne viruses,
- improve all aspects of health and well-being,
- reduce offending/criminal behaviour,
- improve personal, social and family functioning,
- improve education and employment prospects, and
- improve stability of housing and accommodation

Source: Rome et al. (2002)

It should be noted that all of the above goals may not apply to every individual because of different personal needs. As an overall framework, this is important in that it has multiple goals rather than being limited by a specific agency mandate (e.g., courts and recidivism reduction objective may be too narrow to address the problem).

*Planning and delivery of integrated care*

The planning of care is the ‘process of making decisions about the treatment, care and support that the individual will receive and about who will be involved in providing the appropriate services’ (Rome et al. 2002). It follows from the outcome of the assessment process and results in the production of an integrated care plan for the individual. The delivery of care is the ‘process of co-ordinating, managing and providing the care so that the individual receives the right services at the right time, and in the right way to match their assessed needs and in accordance with the agreed integrated care plan’ (Rome et al. 2002). They assert that the key requirements for effective planning and delivery of integrated care are:

- communication between agencies and service providers and the individual,
- co-operation and consistency between agencies and service providers,
- co-ordination of services and interventions;
- involvement of drug users and their families, partners, and friends
The benefit of integrating the planning and delivery of care is to reduce duplication, overlap, and maximise the benefits of the efforts of all service providers involved and achieve better treatment outcomes, especially in responding to individuals with complex needs (Rome et al. 2002). Engaging the individual and their support network results in a sense of satisfaction and empowerment in helping direct the care process and a sense of responsibility when working towards recovery.

A significant point made in this approach is that ‘it is important to match the level of management and intervention with the level of need’ (Rome et al. 2002). Matching the amount of intervention (and accompanying resources) to the level of priority of a case ensures best use of existing resources. Thus, there is a distinction made between ‘care management’ and ‘care coordination’. Care management is described as an intensive approach for individuals with complex, frequent or changing needs requiring complex packages of active, ongoing support (Rome et al. 2002). Care co-ordination is described as relating more to individuals with straightforward needs and may revolve around “simple” or single services (Rome et al. 2002).

In some parts of the country, new initiatives have been undertaken to ensure optimum integration of services and benefits for the individual clients who use them. One example is the establishment of a Community Rehabilitation Service that contains a multi-disciplinary team of community service sector partners who specialise in drugs, accommodation, employment, and government benefits advice (Rome et al. 2002). This initiative helps clients reduce their drug use and reduce their service dependency, encouraging recovery and independence. Another example of a new initiative is the establishment of an Integrated Care Planning Service comprising a multi-disciplinary team of nurses, specialist GP’s, care/case managers, and other community services staff (Rome et al. 2002). The key objective is to have strategic planning that maximises the treatment process and stabilises the client’s lifestyle throughout their engagement with medical and social rehabilitation interventions.

**Goal-setting**

The integrated care approach contains a well developed set of principles and philosophy underlying practice; however, there is also practical guidance that can be applied to each individual client. The discussion of goal-setting is illustrative of this; it has been identified as an integral part of the care planning process. Specificity and definition of goals is encouraged, and must align with the client’s current state and motivation. Examples of defined goals of treatment may include: reductions in drug use or stabilisation, reductions in offending, improvements in physical health, increased self-confidence, motivation and relationships (Rome et al. 2002). According to Rome and colleagues (2002), goals should be negotiated and should be:
• SMART – specific, measurable, achievable, realistic, and timebound
• Service-user directed
• Respectful of service user’s stage of change
• Overall treatment goals to be broken down into their smallest components

Goals should reflect the philosophy of care:
• To reduce the harm associated with the individual’s drug use
• To provide alternatives to drug use which are appropriate to the individual’s interests and attributes
• To empower the individual to maintain positive changes that are made (Rome et al. 2002).

Clear articulation of goals is encouraged from the outset. The integrated care approach also recognises the developmental nature of rehabilitation goals as the individual transitions through the treatment and recovery process. Change can be made in accordance with progress.

Transparency of identifying and overcoming barriers to good practice

Extensive research and monitoring and evaluation are core components of the integrated care approach. Both service level evaluations and strategic level evaluations are conducted on an ongoing basis, and the development of an ‘evaluation culture’ is encouraged to ensure transparency and best practice (Rome et al. 2002).

There are clearly articulated guidelines surrounding the more complex issues that arise from service integration. Processes of communication and how to achieve effective partnership are discussed, along with problems associated with information sharing, protecting individual rights and confidentiality, lack of client satisfaction with specific interventions, staff burnout and lack of retention, misuse or lack of advocacy, and specific issues relating to the treatment of female substance users. Strategies to significantly reduce waiting times are available for implementation by any agency that requires guidance, with the main aim of achieving more efficient and effective service provision and treatment for individuals. Leaders in the alcohol and other drug field in Scotland, such as the Aberdeen City Drug Action Team Integrated Care Model, provide information as to how they have achieved organisational and structural change, horizontal and vertical integration, and lists of things that have helped or that have hindered.
Summary: What have we learned from this case example?

- Importance of integrated care
- Devising a care plan
- Care management involves an intensive approach for individuals with complex, frequent or changing needs requiring complex packages of active, ongoing support.
- Establishing specific goals
- The importance of transparency and specificity in identifying and overcoming barriers to organisational change

Case Study 3: We Help Ourselves therapeutic communities, Australia

Services and activities

We Help Ourselves (WHOS) is an drug and alcohol treatment service that operates therapeutic communities (TC) for people wanting to overcome their addiction. The WHOS therapeutic communities are abstinence-based; however, their approach to drug treatment is somewhat radical and controversial (as will be discussed later). There are currently five therapeutic communities across Australia. Some of these are designed for specific populations. For example, two are gender specific: ‘New beginnings therapeutic community for women’ and ‘Metro Men’s therapeutic community’. The other three therapeutic communities are for both genders. The ‘Methadone to Abstinence residential therapeutic community’ helps clients to reduce their dependency and use of methadone while engaging them in life skills training to encourage recovery (WHOS 2007). This specific therapeutic community is funded by the Commonwealth Department of Health and Ageing under the National Illicit Drug Strategy. WHOS is a professional member of: International Congress of Alcohol and Addictions; Network of Alcohol and Other Drug Agencies; World Federation of Therapeutic Communities; and the Australasian Therapeutic Communities Association (WHOS 2007). Monitoring and evaluation are part of the programme structure to ensure quality service provision and outcomes.

The services and activities at different We Help Ourselves therapeutic communities include:

- A voluntary three to six months residential programme
- Separate living accommodation for men and women in cottages, providing a safe and secure environment
- Staff available 24 hours a day
• Access to legal, welfare, housing and employment services
• Free transport to and from the dosing clinic for people on MMT
• Group work and individual counselling
• Living, social and communication skills development
• Relapse prevention support
• Stress management program
• Assertiveness training and self-esteem building
• Parenting skills training and support
• HIV, hepatitis C, and other BBV education and support
• Registered needle exchange
• Women’s health support
• Access to outside activities such as TAFE, self help meetings etc
• Leisure activities and exercise programmes
• Outreach and aftercare
• Half-way houses for clients who have completed the programme, but are not yet ready to live outside a supportive environment
• An ex-residents support group

Source: We Help Ourselves (2007)

Innovative harm reduction in WHOS abstinence-based therapeutic communities

The World Health Organisation (WHO) has recognised We Help Ourselves as a best practice example of the integration of harm reduction into abstinence-based therapeutic communities. A common barrier to achieving this integration is the perception that the goal of being drug-free is an approach that is not conducive with harm reduction. However, WHOS is a proponent of the argument that ‘harm reduction complements abstinence based drug treatment approaches by providing IDUs with the knowledge and tools to stay healthy and alive until they are willing to achieve abstinence’ (WHO 2006: 7). In more recent times, this position has been adopted and implemented by therapeutic communities in Europe. WHOS is a leader in the field because of its early uptake and implementation of harm minimisation into everyday practice, and a key
area of achievement is the reduction of HIV and HCV related harm. They are recognised as being realistic and practical in responding to relapses into addiction.

It is useful to describe the process of change the service provider went through to achieve the success it enjoys today. The changes that took place in the 1980s were radical for that time, and are still considered as innovative in the alcohol and other drug sector. The key shift can be described as a move from the goal of ‘abstinence only’ to one of ‘abstinence eventually’ (WHO 2006: 9). Between 1985 and 1990, a somewhat revolutionary change occurred in the philosophy and practice of the WHOS therapeutic communities. This started by an identification by core staff that the current approach was not working well (as demonstrated by low retention rates and extensive relapse), and that something needed to be done about this. Extensive consultation was conducted with stakeholders, sponsors, and, most importantly, current and former clients. The Executive Director of the organisation set about implementing a ‘common sense approach of risk prevention by integrating HIV prevention services like education, condoms, needle and syringe programs into the abstinence based therapeutic communities’ (WHO 2006: 11). The question was raised ‘are we here to help the drug-dependent or only those who do it our way?’ (WHO 2006: 11). Initially, some staff were concerned about sending mixed messages, perceiving a conflict between (a) the preference for abstinence, and (b) the provision of services and items for use in injecting drug use and sexual activity (WHO 2006). However, extensive consensus building and discussion, accompanied by a SWOT [Strengths, Weaknesses, Opportunities, Threats] analysis and reviewing the evidence base for such a change, helped ensure that all parties were on board – so much so that there were no resignations in relation to the changes and no sponsorship withdrawal (WHO 2006).

One of the new initiatives included “Safe kits” being designed containing drug and treatment information leaflets, three full injecting equipment packs, condoms, lubricant, and a “fitpack” syringe disposal container (WHO 2006). These safe kits were available from all toilets in WHOS therapeutic communities, provided to all clients leaving the programme, and accompanied with an attitude “only take it if you need it”, but no monitoring of who used them took place (WHO 2006). A HIV/infectious disease coordinator was employed through a funding grant, and all clients were extensively briefed on why the new harm reduction education and items were being made available to them (WHO 2006). Overcoming temptation and relapse prevention were important points raised: ‘abstaining from sex and injecting drug use despite the availability of condoms and syringes became a lesson for clients in coping with risky relapse situations’ (WHO 2006: 16). Therefore, both in and out of the therapeutic communities, abstinence is maintained as an important goal for clients to achieve as a part of full recovery from addiction. However, a realistic recognition of the potential for relapse and a prevailing concern for the health and well-being of clients contributed to the integration of harm reduction measures to complement the goal of abstinence.
We Help Ourselves built both internal and external monitoring and evaluation into their programme structures to gain insight and feedback about the outcomes of harm reduction integration. The results speak for themselves:

- Programme completion and client retention rates increased
- The median length of stay increased
- There was a significant decrease in the amount of clients leaving against staff advice
- There was not an increase in the amount of sexual activity within the therapeutic communities
- There was not an increase in the amount of injecting drug use within the therapeutic communities
- There was a reduction in rates of risk-taking behaviours amongst clients
- There was an increase in the number of clients achieving abstinence


*Steps towards organisational change in integrating harm reduction*

We Help Ourselves (2007) use the ‘stages of change’ from the trans-theoretical model to conceptualise the different stages of organisational change and integrating harm reduction into the policy and practice of abstinence-based therapeutic communities. It is useful to replicate these in detail because they are beneficial for other organisations in assessing where they are at in relation to accomplishing risk management and the minimisation of harm to clients.

1. **Pre-contemplation** – ‘Organisations in the pre-contemplation stage are yet to consider the possibility of integrating harm reduction into their therapeutic community.’

2. **Contemplation** – ‘Organisations are aware of HIV among their clients and are concerned about preventing its further spread. Organisations in the contemplation stage may wish to consider if they have a role to play in helping their clients avoid HIV until they are willing or able to achieve abstinence. Staff should familiarise themselves with the concept of harm reduction and evidence supporting this approach… The option of HIV education is widely acceptable; condom and needle and syringe provision is more controversial, but also very important. Organisations that review the evidence and decide to incorporate harm reduction into their current services should then move into the preparation stage.’
3. **Preparation** – ‘Organisations that make a commitment to harm reduction have reached the preparation stage. Strong leadership from a harm reduction advocate within the organisation is vital at this stage. This person will be needed to prepare staff, key stakeholders, other service providers, and clients for the changes that are to be implemented. This may require reassessing the aims and priorities of the service… Meetings with staff, official bodies that oversee the treatment service, other drug treatment service providers, and current and potential clients are recommended… It may be helpful to talk about shifting the organisation from the aim of “abstinence only” to the aim of “abstinence eventually”. This stage may take some time… Before moving on to the action stage, organisations must ensure that implementation strategies are in place. These define what is going to be done, how it is going to be done, and who is going to do it. An evaluation strategy should also be drafted.’

4. **Action** – ‘In the action stage, organisations act on decisions made in earlier changes. The organisation implements the harm reduction measures deemed appropriate. Where several changes are being made, it may be easier to introduce one harm reduction strategy at a time… If funds are available, it may be useful to hire a dedicated harm reduction worker to oversee the implementation and everyday operation of harm reduction activities.’

5. **Maintenance** – ‘Organisations in the maintenance phase have implemented harm reduction and should now undertake evaluation projects. Both harm reduction and abstinence aspects of the organisation’s treatment programme should be evaluated. Evaluating the effectiveness of the programme ensures that scarce resources are being used appropriately. Regular programme evaluations also ensure that high standards are maintained, and can provide feedback for further improving programmes. Outcomes to measure might include reductions in risk behaviours and drug use, increases in client retention and treatment completion, and improved physical and mental health of clients… Finally, organisations in the maintenance stage should ensure that all of their staff members engage in regular training and professional development activities.’


Examining each of these five stages can shed light on an organisation’s progress in achieving enhanced harm minimisation and organisational change from tradition to innovation and ground-breaking strategies and activities.

A significant observation that can be made is that the primary focus of WHOS harm reduction appears to be HIV/AIDS, as demonstrated by the consistent mention of it in the above quotations. The reduction of HIV/AIDS is important amongst populations of injecting drug users in Australia. However, it should be noted that hepatitis C is much more infectious and
prevalent in Australia – thus posing a more significant threat. In 2006 it was found that hepatitis C affected one in every 77 people across Australia, and 99% of people with hepatitis C do not access treatment (see Graham & Chapman 2006). Also, 90% of new infections result from the sharing or reuse of drug injecting equipment contaminated with infected blood (Department of Health & Ageing 2001). Hepatitis C rates are much higher amongst populations of offenders, especially those in prison, with an estimated 60% of prisoners having the virus (Graham & Chapman 2006). Thus, for residential rehabilitation centres that are increasingly taking in offenders with a history of injecting drug use, hepatitis C is a major area for consideration in regards to harm reduction. The philosophy and harm reduction strategies of We Help Ourselves are cutting edge, but it is important to acknowledge that things such as safe kits not only prevent HIV/AIDS but hepatitis C as well. Harm minimisation that focuses on universal prevention of all infectious diseases is the most effective and exemplifies best practice in the community services.

In conclusion, it is acknowledged that other organisations may have much to learn from the We Help Ourselves approach to drug treatment. As advocated by the World Health Organisation (2006), important lessons can be learned in order to enhance the integration of harm minimisation policy and practice in residential rehabilitation centres.

<table>
<thead>
<tr>
<th>Summary: What have we learned from this case example?</th>
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<tbody>
<tr>
<td>• The importance of therapeutic communities</td>
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<tr>
<td>• Harm minimisation in everyday practice</td>
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<td>• ‘Abstinence eventually’</td>
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<tr>
<td>• Stages of organisational change – the ongoing process to implementing true harm minimisation that is thoroughly embedded in practice</td>
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**Local Systems and Approaches: The Bridge Rehabilitation Programme**

The following observations and discussions are based solely on information directly from the report about the Bridge Programme ‘Model of Practice: towards recovery, wellness and independence’ by Denise Leonard (2006). Located in New Town, the centre and accompanying programme can be described as being like an abstinence-based therapeutic community.
Recent developments and transition

One development in recent years has been the transition from viewing alcohol and other drug addiction from the perspective of the disease model to viewing it from the perspective of the biopsychosocial model. This change in perspective has been accompanied by subtle changes to practice in working with the client towards recovery. For example, while the goal of abstinence is advocated, the original method of discharge from the programme in the occurrence of relapse was recognised as lacking in relevance to client needs and pathways.

A second development that occurred in 2000 has been staff observation and acknowledgement of a changing consumer profile – resulting in increased demand for the service from a heterogeneous client group (Leonard 2006). The report notes increases in the following client groups: women, young people (18-24), clients with dual diagnoses, amphetamine users, polydrug users, and clients who list cannabis as a principal drug of concern.

Principles guiding practice and programme objectives

The following principles are influential in the day-to-day provision of service:

1. No single treatment is appropriate for all individuals.
2. Treatment needs to be readily available.
3. Effective treatment attends to multiple needs of the individual, not just his or her drug use.
4. An individual’s treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person’s needs.
5. Counselling (individual and/or group) and other behavioural therapies are critical components.
6. Medication/pharmacotherapy is an important component of treatment for many clients.
7. Clients with coexisting mental health and substance use disorders should have both conditions treated in an integrated way.
8. Developing a ‘treatment team’ or ‘shared care’ approach with other professionals and or stakeholders is important.
9. Understanding that relapse is more the rule than the exception.
10. Increased social and family functioning assists self-efficacy.

Source: Leonard (2006: 5)
Therefore, the above principles cover elements such as recognition of the need for flexibility and individualised service, meeting the treatment needs clients with complex needs, and the desire to develop working relationships amongst practitioners and partnerships across organisations. Specific treatment interventions are also listed as important components of rehabilitation.

At The Bridge, the specific programme objectives are:

- To deliver evidence based services as well as innovative and responsive programmes.
- To provide education and skills based training focused on physical, emotional, social and spiritual development.
- To coordinate casework, group work, and residential activities in order that they complement and or consolidate the vast learning opportunities.
- To tailor treatment plans to individual need.
- To provide a graded transition towards independence, tapering support and promoting self-reliance.
- To expose residents to a range of alternative coping styles.

Source: Leonard (2006: 7)

The objectives listed above embody the therapeutic aim of helping them to achieve good health and well-being outcomes and personal development. There are three main stages of rehabilitative treatment: stabilisation, personal development, and transition to independence in the community (Leonard 2006).

The model utilised at the Bridge outlines partnerships that could be described as exemplifying a shared care approach to treatment. Treatment partnerships exist in the areas of a medical centre, pharmacy, alcohol and other drug outreach support, recreation and wilderness therapy, infectious disease and harm minimisation education, and the government alcohol and drug service (Leonard 2006). Existing partnerships are positive and beneficial in trying to meet the needs of clients living at the Bridge centre. As with any evaluation, questions can be asked about what the evaluation actually did evaluate. Specifically, what criteria or measures were used to gauge performance in relation to (1) clients; (2) service/agency; and (3) staff (including turn over)?
Issues for the Tasmanian Alcohol and Other Drug Services Sector

During mid-late 2007, the state government Department of Health and Human Services conducted a Review of the Tasmanian Alcohol and Other Drug sector. The Discussion Paper preceding the Review (DHHS 2007) comprises initial analysis of the existing capacity of the sector and highlights priority areas for improvement and development.

Key issues and barriers to good practice in Tasmania

The Discussion Paper is insightful and realistic in outlining existing issues and barriers to good practice in Tasmania affecting both the government and non-government sectors. For each area that is highlighted, there are accompanying ‘Actions’ and ‘Future strategic directions’. The areas where key issues and barriers are most acute and salient and that require urgent action include:

- **Staffing and Sector Capacity** – ‘A recurrent theme has been the very limited capacity of both the government and non-government sectors to deliver effective and quality ATOD services. Two major factors impact on this capacity: staffing levels (critical mass) and recruitment and retention issues’ (DHHS 2007: 14).

- **Opioid Pharmacotherapy Programme** – ‘There is an urgent need to address the problems that are arising in relation to prescription opioids and benzodiazepines… The Alcohol and Drug Service does not at present have sufficient medical and nursing resources to provide the Opioid pharmacotherapy Programme for the projected numbers in a manner that would meet national and State standards for clinical safety and efficacy’ (DHHS 2007: 15).

- **Youth Specific Interventions or Services** – ‘At present, there is no withdrawal management or rehabilitation facility to treat young people (less than 18 years) presenting with alcohol and drug problems… This area has become increasingly challenging with the higher prevalence of trans-generational drug use and the growing incidence of drug induced psychoses and depression. There are also specific challenges in working with young people
at risk and for those ‘coerced clients’ referred through the youth justice system or through child protection’ (DHHS 2007: 16).

- **Improved Support for GPs, Primary Health Service Providers, and Acute Health Services** – ‘A key issue identified through the primary and acute health sector has been the lack of support, advice and liaison available through specialist alcohol and drug services... The Review has identified a clear deficit in a number of health professional training programmes in how to deal with ATOD issues. This has left health professionals with skill deficits and considerable challenges when faced with patients who have addiction issues’ (DHHS 2007: 17).

- **Support for the Non-Government Sector** – ‘Like the government, the non-government sector has faced challenges with its existing resource base struggling to meet the demand for services’ (see paragraph below) (DHHS 2007: 17).

- **Review of Alcohol and Drug Dependency Act 1968** – ‘This is an old Act and is in need of review as some of the provisions are not in keeping with current practice and service delivery’ (DHHS 2007: 18).

Some of the issues listed above are specific to Tasmania, while others are not unique but are also faced by alcohol and other drug sectors in other states and on a national level. The issues of resources, funding and sustainability while trying to achieve best practice are barriers to overcome, and are especially difficult in the context of a small population base, extensive geographical area to cover across the state, and high demand and waiting lists for alcohol and other drug services from a relatively small sector/community of service providers.

Of specific relevance to the Non-Government alcohol and other drug service sector in Tasmania are the following issues:

- The small number of staff operating some services
- Problems attracting and retaining skilled staff
- Limited pool of expertise to recruit staff from and issues related to career path and status of staff within the sector
- Education, training and professional development for staff is challenging due to small staff size and the fact that a number of services provide a range of services not just alcohol, tobacco, and other drug services.
- The lack of clarity between what NGOs and State Government services should offer.
- Problems with long-term funding and the capacity to bid for services and funding from State, Commonwealth and other philanthropic sources.
Source: Department of Health and Human Services (2007: 17)

As evident from the issues listed above, staff and human resources is a salient issue requiring sustained development. To help towards the process of improving the sector, more long-term funding was secured for the peak body for non-government alcohol and drug sector, the Alcohol Tobacco and Other Drug Council [ATDC], to aid capacity development in this area.

We might also note that success through innovation is likely to breed pride in one’s work and better retention of staff. That is, to work in a field that is exciting, that has a good reputation and that provides one with a sense of achievement is the best way to recruit and retain the best staff available.

It is evident from the Review Discussion Paper that sweeping changes and new projects and interventions are needed to achieve good practice in the alcohol and other drug sector in Tasmania. Measures are already being taken to address some of the urgent issues that have been outlined. The Department of Health and Human Services (2007: 19-20) have compiled a table (reproduced below) that summarises changes and new initiatives that will be happening over a 12 month period to further develop the Tasmanian alcohol and other drug sector.
<table>
<thead>
<tr>
<th>Initiative</th>
<th>Outcomes</th>
<th>Time frame</th>
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<tbody>
<tr>
<td>Recruit medical and other key staff to the Alcohol &amp; Drug Service</td>
<td>• Increased capacity of the opioid pharmacotherapy program.</td>
<td>By November 2007</td>
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<td></td>
<td>• Improved clinical leadership for Tasmanian ATOD sector.</td>
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<td></td>
<td>• Improved backup, support, clinical advice and consultation and liaison to acute and primary health sectors, other health services and general practice.</td>
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<tr>
<td>Recruit a clinical expert to support the professional development and education of staff.</td>
<td>• Increase the knowledge and skill of staff working within the alcohol and drug services in both the government and non-government sectors.</td>
<td>By December 2007</td>
</tr>
<tr>
<td></td>
<td>• Delivery of contemporary models of service provision for people with alcohol and/or drug problems.</td>
<td></td>
</tr>
<tr>
<td>Provision of training and professional development for clinical staff in acute and primary health sectors, other health services, general practice settings.</td>
<td>• Improved service delivery to clients in a range of settings.</td>
<td>By March 2008</td>
</tr>
<tr>
<td></td>
<td>• Greater support to enable other services to more effectively manage clients who present with alcohol and/or drug problems.</td>
<td></td>
</tr>
<tr>
<td>5 year funding of Alcohol, Tobacco &amp; Other Drugs Council</td>
<td>• Increased support for non-government services.</td>
<td>By July 2007</td>
</tr>
<tr>
<td>Recruit staff with clinical expertise in working with youth with alcohol and/or drug problems.</td>
<td>• Increased capacity to meet the needs of youth with alcohol and drug issues.</td>
<td>By November 2007</td>
</tr>
<tr>
<td>Review the Alcohol and Drug Dependency Act 1968</td>
<td>• Establish legislation which better supports contemporary models of service provision.</td>
<td>Starting in 2008</td>
</tr>
<tr>
<td>Establish a quality improvement framework for the Alcohol and Other Drug service sector</td>
<td>• Clear clinical governance framework established.</td>
<td>Started in 2007</td>
</tr>
<tr>
<td></td>
<td>• Improved clinical leadership for the alcohol, tobacco and other drug sector in Tasmania.</td>
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<tr>
<td></td>
<td>• Establishment of clear models of service provision that are based on contemporary best practice.</td>
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<td></td>
<td>• Establishment of standards of best practice for both government and non-government services.</td>
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<td></td>
<td>• Development and implementation of an ongoing quality monitoring and review process for all services in the ATOD sector.</td>
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Development and implementation of the strategic directions and initiatives listed above will require ongoing governance from the State government and commitment and collaboration from all service providers involved in the sector.

In the Tasmanian ATOD Discussion Paper, a state-wide tiered approach to alcohol, tobacco and other drug services was outlined. There are four tiers of services (DHHS 2007: 22-24):

1. **Tier One** services include: General Practitioners, generic primary health services, community based services, and population health promotion information and strategies. Tier one services are usually the first point of contact for those in the community seeking generic health and community based services. These services would also include the broader population based health promotion and harm reduction strategies.

2. **Tier Two** services include: Needle and syringe programmes, supported accommodation services, peer support, community-based self-help groups, and ATOD information services. Tier two services are generally for people seeking support, assistance, and information. Clients falling under this category would have access to the provision of community based services that target people with alcohol and drug issues as well as generic alcohol and drug information to both clients and other services providers.

3. **Tier Three** services include: consultation liaison services, specialist assessment and referral, case management, relapse prevention, community pharmacotherapy, youth specific interventions, counselling, sobering up, outreach, family support, and group work. Tier three services are provide support and interventions which are targeted at people with alcohol, tobacco and other drug problems. The range of services in tier three is designed to assist clients requiring specialist alcohol and other drug interventions and support.

4. **Tier Four** services include: specialist withdrawal management services (youth and adult), specialist pharmacotherapy (including opioid pharmacotherapy programmes), residential rehabilitation, specialist community based interventions, specialist consultation liaison services, clinical advisory service, withdrawal management services provided through acute care services. Tier four service provision is expected to address the needs of clients with complex and high risk issues requiring specialist medical treatment services. Services provided include highly specialised medical and clinical interventions that are aimed at improving the function and reducing the risks for clients with complex alcohol and drug issues.

This new re-structuring provides clarity of categories for service provision and the likely population of service users for each tier. Parenthetically, however, we might mention that tiers seem to imply levels of ‘priority’. As an alternative conceptualisation of services, the notion of ‘spheres’ might be utilised, since it connotes ‘networks’.

**Emergent Issues**

There are a few emerging issues at a national level, however, the occurrence of new alcohol and drug use patterns are evident in Tasmania as well. In addition to the phenomenon of polysubstance use and dependence, there are relatively new substances that are also emerging as serious threats to the health and wellbeing of those who take them.

*‘Ice’ and treating amphetamine-type stimulant users*

Crystal methamphetamine, or ‘ice’ as it is more commonly known, and use of a range of amphetamine-type stimulants is emerging as a significant issue. This is especially salient amongst populations of young people who may take so called ‘party drugs.’ After cannabis, amphetamine-type stimulants are the second most commonly used illicit drug in Australia (National Drug Research Institute [NDRI] 2007).

The term amphetamine-type stimulant covers the group of psychostimulant drugs that contain the compound amphetamine, which include: MDMA (ecstasy), MDA, and methamphetamine which take one of three forms, powder (speed), paste (base) or crystalline form (ice or crystal). Crystal methamphetamine can be imbibed in a number of ways through injecting, swallowing, snorting, or smoking. According to the 2004 National Drug Strategy Household Survey (cited in NDRI 2007: 3), ‘9.1% of the general population aged 14 years and older has tried amphetamine-type stimulants, and 3.2% had used it in the previous 12 months.’ Ecstasy is regarded as particularly easy to obtain, with a perceived purity amongst users as being ‘medium’ or of ‘fluctuating quality’ (Mundy 2008: 21). A national survey of ecstasy and related drugs, the EDRS, shows that the most common place in which ecstasy is used is nightclubs – 76% of all participants – with an average price of $30 to $50 per pill, depending on jurisdiction (National Drug and Alcohol Research Centre 2008a).

In a recent study in Sydney, different categories of regular methamphetamine users were identified:

1. Primary methamphetamine injectors who used once to several times a week, and also had high levels of alcohol and cannabis use.
2. Long-standing heroin injectors who used methamphetamine as part of their polydrug use and many commenced due to the heroin shortage.

3. Non-injectors who were a younger group that used ecstasy in addition to snorting amphetamine powder and/or smoking crystal methamphetamine.

4. Those who use amphetamine-type stimulants in occupational settings. This is most notable amongst those employed in the forestry, transport, hospitality and construction industries.

Source: National Drug Research Institute (2007: 3)

The populations of users delineated above highlight the difference of the context in which they use the drug, and the different demographic groups that use it. However, the most alarming statistics relate to amphetamine-type stimulant use amongst offender populations. According to the NDRI (2007: 7), a study of regular methamphetamine users found that ‘45% had committed an offence in the past month, and the most common types of crime committed were drug supply and property crime.’

Psychosocial interventions are currently considered the most appropriate treatment choice for amphetamine-type stimulant users (NDRI 2007). Turning Point Drug and Alcohol Centre have released a report containing clinical treatment guidelines for methamphetamine dependence and treatment (which can be accessed for free via the web). First, there are a number of barriers to accessing treatment for methamphetamine users, which include:

- Negative attitudes towards treatment
- Not believing treatment will help
- Concerns about not receiving appropriate treatment
- A belief that available treatment options are inappropriate
- Low levels of confidence in treatment services and staff
- A perception that treatment will be ineffective
- A perception that it will make the addiction worse
- Concerns about confidentiality, especially for those seeking treatment for the first time
- Concerns that attending a treatment service and spending time with other users might act as cues for relapse to drug use
- Organisational barriers such as opening times, waiting times, location and lack of a timely response

The barriers listed above represent a significant challenge for service providers to overcome. Other research shows that there is an increasing amount of stigma surrounding the use of methamphetamine (especially ice) because both expert professionals and other drug using peers perceive people who use it to experience more negative experiences (Mundy 2008). Stigma is a powerful social element that can prevent some users from being open about their substance use, even with close peers or professionals who know them.

Second, there are a number of principles outlined for good practice in working with clients who use methamphetamine:

- Assessment should be considered integral to the engagement and treatment process rather than an independent process.
- Early engagement is vital for methamphetamine users and working with consideration of the stages of change or other engagement model is important.
- Intervention specific to methamphetamine should be negotiated with the client, as with other drug use intervention, and incorporated into a comprehensive treatment plan.
- Each individual is different and requires a tailored response.
- The pattern and extent of use should be considered when deciding on intervention or management strategies.
- Methamphetamine use should be addressed in the context of other drug use, given the high prevalence of polydrug use amongst methamphetamine users.
- Methamphetamine use should be addressed in the context of mental health and other psychosocial factors.
- Drug use, including methamphetamine, is a cyclical and relapsing condition. Interventions may need to be applied repeatedly, before significant change is achieved.

Source: Lee et al. (2007: 13)

Amphetamine-type stimulant users, especially methamphetamine users, are a complex sub-group of substance users who require specific interventions based on understanding and reflexiveness regarding the context in which their use takes place and their individual requirements.
Increasing benzodiazepine use (licit and illicit)

Benzodiazepine use, with its associated harms, is increasing in Tasmania and across Australia. Both illicit and licit (through prescription) forms of the drug form a part of this emerging trend. Benzodiazepines are prescribed for the treatment of insomnia (tranquilisers/sleeping pills) or also a range of anxiety conditions, and it is possible to become dependent on the drug and also suffer associated harm (Loxley 2007). Specific types of benzodiazepines most commonly prescribed include diazepam, flunitrazepam, temazepam and alprazolam (Loxley 2007).

There is a number of concerning statistics and research findings that provide an evidence base for citing benzodiazepine use as an emerging issue. The 2007 Illicit Drug Reporting Survey, which uses information from people who regularly use drugs, key experts and routine data sources, found that 66% of respondents reporting using benzodiazepines (including both licit and illicit) in 2007 (National Drug and Alcohol Research Centre 2008b). A survey of those who used benzodiazepines for non-medical purposes found that the majority of users were aged between 20-29 years old (Australian Institute of Health and Welfare 2005 cited in Loxley 2007). Benzodiazepine use has relatively significant rates amongst offending populations. Australian Institute of Criminology DUMA data was used in a study of police detainees, and found that 20% had used it legally and 12% had used it illegally in previous months. Also, in the general population, benzodiazepines are also present in ‘half to two-thirds of drug deaths, either in motor vehicle accidents where they are the most prevalent prescription drug, or in combination with other depressants such as opiates and/or alcohol (VDCPC 2006 cited in Loxley 2007: 1). Common ways of accessing benzodiazepines is through doctor shopping, theft, fraud and/or forgery of prescriptions (VDCPC 2006 cited in Loxley 2007: 2). Reasons for the misuse of benzodiazepines include ‘dependence, self-medication, dealing with withdrawal from other drugs, drug substitution, enhancement of other drug use, and use as a street currency’ (Loxley 2007: 2).

In Tasmania, benzodiazepine use is an emerging problem of concern. Deficits and a critical lack of resources associated with the opioid pharmacotherapy programme have been linked to this phenomenon. According to the State Government’s alcohol and drug review,

There is an urgent need to address the problems that are arising in relation to prescription opioids and benzodiazepines. There have been an unusually high number of avoidable deaths among the subpopulation that abuses legally prescribed drugs. Recent Australian data shows that Tasmania has a higher rate of death in this population than other states (DHHS 2007: 15).

Morbidity and mortality are significant imperatives for further research and initiatives to ameliorate both legal and illegal benzodiazepine use in Tasmania and on a national level.
An expansive body of research and understanding of both of the drugs methamphetamines and benzodiazepines and their impact on the lives of those who take them is not yet available because of their relatively new emergence. However, it is critical for service providers to maintain a heightened awareness of emergent issues in alcohol and drugs in Australia to inform their ability to meet the needs of those seeking rehabilitation in a relevant and effective way.
Part Two: Principles and Practices

In this section, philosophy as a driver of practice is examined in relation to both drugs and service. Principles of good practice are then outlined in relation to the client and service provision. Part Two has an analytical focus on any tensions, issues or conflicting roles that may arise from practice, as well as emphasising positive opportunities for progress and development.

Best practice has been defined as ‘a comprehensive, integrated approach to the continuous improvement of all facets of an organisation’s operations. It is the way that leading edge companies manage their organisations to deliver world class performance’ (Department of Industrial relations cited in National Crime Prevention 1999: 59). The principles and practice outlined in the following sections highlight and synthesise elements of achieving strategic and successful service provision.

Philosophy as a Driver of Practice: Drugs

There are different philosophies that are evident in policy on drugs. Two major (and arguably dichotomous) philosophical perspectives are zero tolerance and harm minimisation. Zero tolerance is much like its name suggests – having no tolerance for drug use, and enacting strong punishment for those that choose to break the law. The zero tolerance perspective can often be found in political rhetoric surrounding law-and-order campaigns and moral panics about drug use and social harm, and is particularly evident in the United States. An example of zero tolerance in the criminal justice system is where harsh sentences are enacted (often with no judicial discretion), with the sentencing motive of the punishment being to deter drug use on the part of both the offender and the wider population. This kind of approach results in major negative social consequences. Examples of these include: increasing criminalisation, burgeoning prison populations, prison stays that result in increased personal damage to the offender (and hence greater likelihood of future substance use), higher recidivism rates, and failure to address the causes of substance abuse (whether based on illicit or licit drugs).

By contrast, Australia’s philosophical and policy approach to drugs is underpinned by harm minimisation, and Australia is recognised as being a leader in this area. The National Drug Strategy encompasses several specific strategies relating to specific types of substances and is
designed to give strategic direction in reducing drug-related harm across the country. The three main goals are supply reduction, demand reduction, and harm reduction (National Drug Research Centre 2004). Supply reduction simply means efforts to limit the available supply of illicit drugs. Demand reduction involves reducing demand ‘through the promotion of opportunities, settings, and values that foster resilience and reduce the uptake and use of drugs and the risks of drug use’ (White & Habbibis 2005: 114). Harm reduction aims to ‘reduce the harm for individuals who use drugs, their families, and the community’ (White & Habbibis 2005: 115). The practical implementation of this strategy ensures that philosophy and practice aimed at prevention are balanced with philosophy and practice aimed at reducing harm to those who do choose to use drugs. Harm minimisation does not encourage substance use, instead it is recognised as potentially harmful behaviour; however, everything possible is done to ensure the safety, health and well-being of users until they are ready to reduce or stop their substance use. In addition to the three main goals of reduction, there are two key areas in which the National Strategy is promoting improvement and development (White & Habbibis 2005: 114):

**Treatment Options**

‘Through providing treatment, the aims are to:

- Increase capacity to provide the full range of evidence-based treatment options for users
- Increase capacity to provide support to the families of drug users and to include them in treatment where appropriate
- Provide an integrated treatment system able to provide continuity of care across relapse episodes, and across the criminal justice and the health sectors
- Maintain an illicit-drug-treatment system with strong links to mainstream health and welfare systems
- Increase capacity in the treatment system to undertake systematic needs analysis, including the capacity to respond to emerging drug problems and institute new services
- Provide a comprehensive, relevant treatment system that is culturally appropriate and integrated with other services (including mental health), and attracts and retains drug users early in the course of harmful use

**Workforce Development**

‘Through workforce development, the aims are to:

- Further develop the capacity to attract and retain an effective workforce in health, welfare, education, and law enforcement sectors, with emphasis on:
  - A generalist health and welfare workforce with increased capacity to identify drug problems and related harm and apply evidence-based interventions
A health, education, and law enforcement workforce educated in the principles that support the reduction of harm caused by illicit drug use

Highly skilled law enforcement investigators who can be deployed flexibly

A skilled and supported health promotion workforce familiar with evidence-based health promotion and the antecedents of drug use

Increase capacity to attract and retain a highly skilled and specialist drug and alcohol workforce in the wider health system’


Enhancing treatment options across the country, as well as developing the workforce in the alcohol and other drug sector, presents an ongoing challenge for both federal and state governments. However, the National Illicit Drug Strategy provides beneficial guidance with specificity and coordination as positive outcomes.

The other interrelated strategy of note is the Tasmanian Drug Strategy (2005-2009) (Interagency Working Group on Drugs [IAWGD] 2005). It lists six principles that are important in implementing action and change in the Tasmanian alcohol and other drug sector:

1. Partnerships and collaborative effort are essential to shaping our responses to drug use across the community.

2. Building capacity in the community and the alcohol and other drugs sector is fundamental to addressing drug use.

3. The concept of harm minimisation underpins practice and philosophy.


5. Equity of access to evidence-based service delivery is fundamental.

6. Research, data collection and evaluation are critical elements for increasing understanding of and improving responsiveness to emerging trends.

Source: IAWGD (2005: 8-9).

In addition to these principles, three priority areas are put forward which dovetail with the National Drug Strategy, the Tasmania Together goals, and the Tasmanian Drug Strategy: (1) community safety, (2) prevention and reduction, and (3) improved access to quality treatment (IAWGD 2005: 10). Both government and community service providers operating in the Tasmanian context can enhance relevant strategic planning and service delivery by utilising the directions and guidance of the state and national plans for the alcohol and other drug sector.

Collaborative strategies occur in practice between different parts of the criminal justice system in Tasmania, similar to other jurisdictions. Legislation and policies are in place in Tasmania to
ensure that people with substance use issues are most likely to enter a diversion scheme for minor drug-related offending – thus keeping them out of the formal criminal justice system and diverting them to mechanisms that can assist them to change. For example, there is the cannabis cautioning scheme by Tasmania Police, and also court mandated diversion and court ordered drug treatment by magistrates and the judiciary. These demonstrate the proactive role of criminal justice officials in pursuing therapeutic options for drug users through diversion. The Tasmania Together goals, as represented in the Tasmanian Drug Strategy, of prevention and reduction, community wellbeing, and improved access to good treatment are more likely to be achieved using these mechanisms – benefiting the individual as well as the community.

**Philosophy as a Driver of Practice: Service**

There can be multiple philosophies driving the practice of residential rehabilitation centres, and these can have an effect on service provision.

*The differences in approach between treatment and rehabilitation*

A distinction can be made between treatment and rehabilitation because both entail different models. The word ‘treatment’ in the alcohol and other drug sector has connotations of relating to physical addiction, medical intervention, primary health care, and pharmacotherapy. A clinical perspective of rehabilitation focuses on changing the specific behaviour – substance abuse – but may not take into account contributing factors because these are not targeted specifically by chosen modes of treatment. The client adopts a relatively passive role as recipient of treatment, relying on the clinical expertise and judgment of the professionals administering or facilitating the treatment.

The term ‘rehabilitation’ refers more to therapeutic interventions and holistic health and social care – to restoring the person as a whole. Therefore, a residential rehabilitation centre may facilitate both treatment for the biological bases of the addiction and substance misuse problems, as well as be instrumental in rehabilitating a person to ensure they are not only able to recover physically from their drug problem but also psychologically and socially, and achieve overall well-being.

*Restoration and rehabilitation*

Restorative Justice refers to an emphasis on dealing with offenders by repairing harm, and in so doing involving victims and communities as well as offenders in the reparation process. Restorative justice thus emphasises re-integrative and developmental principles and offers the
hope that opportunities will be enhanced for victims, offenders and their immediate communities, with the direct participation of all concerned in this process.

Of particular interest here, with respect to what can be learned from restorative justice in regards to drug rehabilitation, is the emphasis on active agency. This refers to the idea that people are to be held directly accountable in some way, and that they are meant to do things, themselves, rather than simply being passive actors in the criminal justice (or drug rehabilitation) system. Importantly, when they engage in doing something (e.g., painting a fence), this is generally constructed as being to the benefit of somebody else (e.g., a victim of graffiti). Restorative justice thus involves acts of giving, as well as acts of forgiving.

There are a range of practical approaches under the restorative justice umbrella, and different approaches emphasise different objectives in order to suit the chosen focus of the programme or intervention (White, 2004). Nonetheless, restorative justice is relevant to both drug-related offending and residential drug rehabilitation. Many substance users may engage in crime, and this offending behaviour may be linked to their substance addiction or misuse. Restorative justice is more commonly known and used in the criminal justice system (especially juvenile justice), yet it can be argued that it is relevant to the health and welfare system, especially if dealing with court mandated offenders. In fact, it can perhaps hybridise the goals and interventions of both systems, while adding its own flavour to the blend.

Restorative justice is complementary to and fits within the rehabilitation model, especially because it encourages active client engagement and competency development. This does not negate the use of individual treatment; instead it demonstrates how individual treatment can take place in tandem to complement broader competency development practices. The differences between individual treatment and restorative competency development are demonstrated in the table below, which is specifically from the juvenile justice field but which nevertheless has relevance here.
### Table 2.1:
**Differences between Individual Treatment and Competency Development Practices**

<table>
<thead>
<tr>
<th>Individual Treatment</th>
<th>Competency Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group and family counselling</td>
<td>Peer counselling, leadership development, service projects, and family living skills</td>
</tr>
<tr>
<td>Drug therapy and drug education</td>
<td>Youth as drug educators and drug researchers</td>
</tr>
<tr>
<td>Remedial education</td>
<td>Cross-age tutoring (juvenile offenders teach younger children) and educational action teams</td>
</tr>
<tr>
<td>Job readiness and job counselling</td>
<td>Work experience, service crews, employment, job preparation, and career exploration</td>
</tr>
<tr>
<td>Recreational activities</td>
<td>Youth as recreation aids and recreation planners</td>
</tr>
<tr>
<td>Outdoor challenge programs</td>
<td>Conservation projects, community development projects, recycling and community beautification projects</td>
</tr>
<tr>
<td>Cultural sensitivity training</td>
<td>Youth-developed cultural education projects</td>
</tr>
<tr>
<td>Youth and family mediation</td>
<td>Conflict resolution training and youth as school conflict mediators</td>
</tr>
<tr>
<td>Mentoring and &quot;big brother&quot; programs</td>
<td>Work with adult mentors on community projects and intergenerational projects with the elderly</td>
</tr>
</tbody>
</table>

Source: Bilchick, 1998 (Adapted from G. Bazemore and P. Cruise. 1995)

One relevant argument of proponents of restorative justice is that ‘through understanding the human impact of their behaviour, accepting responsibility, expressing remorse, taking action to repair damage, and developing their own capacities, offenders become fully integrated, respected members of the community’ (Bilchick 1998: 5). It is an approach that treats all people with dignity and worth, and this is balanced with the obligation of the offender to put things right (Bilchick 1998). It can be argued that residential rehabilitation, likewise, provides a positive intervention point and opportunity for working on things such as capacity building.
and integration. Residential rehabilitation centres involved in court mandated diversion are presented with the opportunity to consider their role in being a community of support that could promote the above goals and tasks.

In a restorative justice context, competency is defined as ‘the capacity to do something well that others value’ (Bilchick 1998: 19). Restoration is a communal exercise, one which encapsulates principles and processes relevant to drug rehabilitation.

**Characteristics of Restorative Competency Development:**

- Strategies build on the strengths of offenders, families and communities.
- Clients are given a role in work, family and community that instils a sense of belonging, usefulness and control. Clients have active roles that allow them to practice productive behaviour.
- Cognitive learning and decision-making are integrated into active, experiential, and productive pursuits.
- Treatment and services (e.g. counselling) are used as supports for the overall restorative process rather than in isolation.
- Clients work and interact with law-abiding people within the community.
- Delinquent and non-delinquent people are mixed whenever possible to avoid the image of programmes for problematic or “bad” people.
- Activities are designed with input from the community.
- Opportunities are provided for clients to help their peers, children, and the less fortunate.
- Group experiences and teamwork are emphasised frequently.

**Roles for Professionals**

- Assess client and community strengths, resources and interests.
- Develop community partnerships with employers, religious institutions, clubs, and civic groups to provide work and service roles for clients on supervision, and recruit supervisors.
- Find creative, active roles for offenders in treatment programmes as helpers to others.
- Develop projects in which clients can be trained in areas such as mediation, conflict management, and drug prevention and then educate others.
- Involve clients in programme-planning groups and committees with staff and other adults in the community.

These strategies are accompanied by the expectation of any or all of the following possible positive outcomes. Offenders benefit from (a) ‘the increased capacity to contribute to their community,’ (b) increased bonding to positive role models and conventional adults, (c) improvements in self-image and public image, and (d) ‘measurable increases in educational, occupational, social and decision-making abilities’ (Bilchick 1998: 22). The community has an increased capacity to accept and integrate people who have previously been problematic, and increased positive involvement in the criminal justice system (Bilchick 1998). Building the competencies and capacity of offenders, as well as the community’s capacity to help them, are both advantageous undertakings. Positive reinforcement and constructive development results in better outcomes than those that do not include rehabilitation, reintegration, or capacity building as part of their mandate.

**Principles of Good Practice: The Client**

*Key values*

The articulation of key values in the service delivery context is essential. The organisation and all practitioners within it need to be aware of the principles that influence practice. In Scotland, the National Care Standards for residential accommodation are based on seven key values:

1. Dignity
2. Privacy
3. Choice
4. Safety
5. Realising Potential
6. Equality
7. Diversity

Source: Rome *et al.* (2002)

An organisation may adopt key values such as those outlined above, or may go further and add other values. Examples of these may include respect and esteem, sensitivity of care, compassion and empathy, trust, hope, accountability, positive change and empowerment, and transparent communication. Once an agency has chosen their key values, it is important that these are made public and simply explained, and are written down so that all members of the
residential community are able to view them at any time. The rationale for the existence and influence of key values is the importance of maintaining a truly client centred service.

Profile of clients

There are a few key aspects of the profile of clients that need to be carefully considered, and these are accompanied by specific or individual needs. As outlined in Part One, workers at the Bridge Programme have noted a changing client profile in the past five years, and it is likely that many other agencies would have noted similar changes and trends.

Gender: Gender is an important factor in residential rehabilitation because the experience and needs of men and women can be different. In the past, this type of intervention has mainly been used by men. However, it has been noted that there are an increasing number of women entering the Bridge programme (Leonard 2006). Research raises a number of additional difficulties to accessing treatment that women may face: they are likely to have a substance using partner; experience domestic violence; a history of sexual abuse; low self-esteem and reduced emotional health; and the more salient stigma attached to drug use among women (see Rome et al. 2002). The first difficulty is significant because it highlights that drug use may potentially be an important common experience in the relationship with their partner. For example, most female injectors were given their first injection by their male partner (Powis 1996 cited in Rome et al. 2002), and ‘having a partner who uses drugs decreases readiness to enter treatment’ (Riehman 2000 cited in Rome et al. 2002). Thus, the context of a woman’s relationship with their partner is important in examining barriers to access and problematic experiences of drug treatment for women.

Parental Status: Being a parent and the responsibilities of motherhood are significant factors to consider. Problematic substance use may be the reason why some women do not currently have custody of their children, and the personal support component of rehabilitation offers the opportunity of support for any issues or distress arising from this. Women who are raising their children may have fears or misunderstandings about entering residential rehabilitation. The provision of parenting and child care support in concordance with the provision of drug rehabilitation is a positive opportunity to overcome barriers to access which mothers may face. Research shows that ‘allowing women to live with their children during residential drug treatment enhances retention in care, potentially improving the mother/child relationship and post-discharge treatment outcomes’ (Hughes 1995 cited in Rome et al. 2002). To promote the best recovery outcomes, it is important that women can be offered a service that incorporates ‘holistic programmes which are women-sensitive and pay attention to the full range of health and other needs’ (Hinton 2005: 6). Parenting and family support should form an important component of rehabilitation. Professional guidance on fertility and women’s health are also an
important area of service provision in holistically supporting female substance users towards the best possible outcomes. For pregnant women in residential rehabilitation, specialist antenatal care and support is needed and, once born, the baby may require specialist primary health care if it has been affected by the mother’s substance use in utero. Also, rehabilitation support workers have the opportunity of detection, or even early intervention, if post-natal issues arise.

Hinton (2005) has researched and explored the issues surrounding mothers engaging in alcohol and drug rehabilitation, the lack of services for this client group, and the key characteristics required for best practice in residential rehabilitation for women with children in the Tasmanian context (outlined in Box 2.a below). It is important to recognise the context in which female drug use is likely to take place; each of the following elements can lead to substance abuse by women: ‘physical, emotional, and sexual abuse, health issues, domestic violence, offending and mental illness including depression, eating disorders, and attempted suicide. High levels of guilt, shame and low self-esteem are also recorded’ (Hinton 2005: 6). Residential drug rehabilitation that is women-sensitive needs to address the complexity of issues and factors contributing to personal substance use. The opportunity arises also to therapeutically assist the children of the female drug user if one or more of the above elements has affected them too.
Box 2.a: Snapshot: Best practice model for residential drug rehabilitation for women with children

The following key characteristics have been derived from consultations with service providers, interstate services, and women/parents with drug issues:

- A minimum of 6-8 adults in order to facilitate therapeutic community dynamics and a workable ratio of adults to children.
- Priority given to the safety and security of women and children.
- Programme duration of a minimum of four but preferably six months.
- Retaining the flexibility to respond to individual needs including accommodating couples and single fathers if required.
- A physical design which incorporates a balance between private and communal spaces, and which replicates real life as far as possible (e.g. a comfortable relaxed family home like setting).
- A location close to a range of services including health services, transport and schools.
- 24 hour staffing by well trained valued staff – including ex users and men as positive role models.
- Funding which covers the costs of accommodating children, aftercare, and long-term evaluation.

Key services and programmes: The services offered should involve a strengths-based approach within a holistic programme which can comprehensively address all women’s needs and include individual and group counselling, life skills and parenting education, and especially an aftercare programme. There is also a need for high quality childcare and proactive interventions for children including counselling, recreational activities and outings. The service should work in partnership with other agencies to provide a comprehensive service including health services and child protection, possibly framed by guidelines and memorandums of understanding.

Source: Hinton (2005: 9-10)

If an approach that is sensitive to the needs of women and families can be developed, then this will help to ameliorate the low levels of engagement with treatment and rehabilitation amongst women with children in Tasmania. A parent and child inclusive approach is helpful in meeting the needs of each of the family members that stay there (e.g. mother and each child), as well as building individual capacity, and strengthening positive family ties to aid recovery and wellbeing.

Age: Age is another important factor for consideration within the context of residential rehabilitation. According to the Drug Info Clearinghouse (2007), young people may find it difficult to stay in a therapeutic community for the full course of their treatment because they may struggle with the high amount of rules and regulations. Therefore, residential
rehabilitation centres need to consider how to improve client retention and treatment outcomes for this age group, and have strategies in place to help those who have barriers to continuing at the centre. It can be argued that, for some mature people who have previously engaged in a healthy and functional lifestyle, rehabilitation may be about returning to that positive way of life. However, in the case of some young adults, who may have engaged in substance use from a young age, they may not know what it is like to conduct their adult life in a healthy and functional way. Their perceptions of adult life may be complicated by the problematic effects of their substance use, and new life skills and coping behaviours may need to be taught to realign their perspective. The rehabilitational goals of achieving positive independence may be a first for some. This is illustrative of the fact that the life stage of an 18 year old is quite different to that of a 65 year old, and highlights the necessity to explore the developmental needs of each individual.

Pertinent questions for consideration in regards to offering youth-sensitive or youth-specific services to juveniles with offending and/or substance use issues include (White, 2003: 32):

- What principles and practices do current services embody from the point of view of special needs and interests of young people? e.g. how are the ‘best interests of the child’ interpreted in service terms?

- What is the actual and/or preferred policy framework for different types of service provision? e.g. based upon notions such as mutual obligation or pre-emptive intervention.

- What is the relationship between coercion and consent in the provision of specific youth services? e.g. what justifications are there for suppression of choice on the part of the young people, and under what circumstances?

The discussion of coercion, consent, and partially or fully having the status of involuntary client is relevant to young drug users who may be referred to a service by the criminal justice system or relevant government agency which is requiring them to address their substance use. Service providers need to give special consideration to individual agency, responsibility, and self-determination in light of the circumstances or conditions in which a young person is using their service.

Bell (2005), a Tasmanian researcher, has conducted insightful research into youth drug and alcohol rehabilitation for 12-18 year olds and has designed an evidence-based model for a residential service. There is a critical lack of drug and alcohol rehabilitation options for young people in Tasmania, and the acute implications of not meeting the service requirements of individual needs of this client group are concerning. The preferred model for youth drug and alcohol rehabilitation is outlined in Box 2.b (Bell 2005: 10-11), and is based on a Learning Model of Rehabilitation (see below Key Practitioner Terms Table). While it is specifically
designed for 12-18 year olds, there are principles and practices contained in the model that are applicable to both young adults (19-24) and adults more generally.

**Box 2.b: Snapshot: Best practice model for residential drug rehabilitation for young people**

The evidence gathered suggests that the service should be a multidisciplinary service, with strong community ownership and links, offering a holistic service that caters for a wide range of clients aged 12-18. Learning should be central to its ethos and service culture, particularly experiential learning. The service should provide a rich learning environment that targets the underlying causes of alcohol and other drug issues. The other central part of its ethos is an engagement with the lived experiences of youth, in all its services and programmes. This engagement should involve diverse approaches that include, but are not limited to, solution-based and cognitive behavioural therapies, family-based approaches, formal and informal education programmes and opportunities, and recreational activities. The service should offer abstinence-based recovery goals as only one of a range of options, but have a ‘no drugs’ policy while clients are in residence. Long-term mentoring of clients should take place.

**Key services and programmes:** Services should be integrated as part of a continuum of care approach, and include outreach, as well as flexible admission carefully managed to maximise the therapeutic value of the client milieu. Client services should include mental health services, clinical medical services, counselling, and alternative health services. Programmes should be individualised and tailor made, focusing on long-term development of the client using client-centred approaches. Client timetables should be both structured and individualised, in line with client goals and planning. Aftercare programmes will continue at least 12 months after exit from the service.

Source: Bell (2005: 10-11)

There is a strong link that can be developed between service provision, and theories that encourage individual agency and a strengths-based approach. Self-empowerment, equipping individuals with skills, the prioritisation of holistic well being, an emphasis on service engagement, and personal and community capacity development are key features of these kinds of models of rehabilitation. Bell’s (2005) report provides much greater detail in specifying the way in which residential rehabilitation for young people should be designed, and this research is valuable for consideration of residential rehabilitation service design more generally.
Other individual differences between clients: Other individual characteristics that need to be taken into consideration are things such as socio-economic status, ethnicity, sexuality and gender issues, and religion. For example, holding certain religious beliefs may result in an individual experiencing additional guilt and stigma relating to their substance use because it is not socially acceptable within their belief system. This individual may feel pressure from external sources such as family or friends who hold the same beliefs, as well as internal emotions about letting themselves down. Spiritual support is highlighted as an important personal support component of rehabilitation for clients (Bell 2005). A second example is that there may be a need for careful consideration of the needs of clients who are trans-gender or who have a non-heterosexual sexual orientation. In a residential setting where the same gender types are housed together, both the needs and preferences of the individual as well as the perspectives and preferences of other residents need to be taken into account. It can be concluded that any of the above individual characteristics listed need to be thoughtfully contemplated and each person needs to be supported in a warm and non-judgmental environment that promotes diversity. The theme of this section is that specific clients have needs that require specific types of service response.

Involuntary and voluntary clients

Although clients are often referred to as a homogenous group, there is a distinction that needs to be made between voluntary and involuntary clients. Clear examples of involuntary clients involve offenders on probation or parole, or psychiatric clients who have been mandated into custody and therapeutic care. However, it can be asserted that:

The distinction between voluntary and involuntary clients is … not always clear. It is perhaps best viewed on a continuum, with court-ordered clients towards one end, partially voluntary clients in the middle, and clients who seek services on a voluntary basis towards the other end (Trotter 2006: 3).

This is reflected in alcohol and drug residential rehabilitation centres. Some clients may enter the programme entirely of their own volition and accord because they have come to a point where they recognise their need for rehabilitation. Some clients may enter the programme because a partner has indicated they are no longer willing to continue in the relationship if the substance use is not addressed. Some clients may choose to enter the programme because it may serve other purposes – such as reaching a state of recovery and well-being to prove to a social worker they can regain custody of children who have been taken due to the parent’s problematic substance use. Other clients may be court mandated and enter the programme as a part of their sentencing or bail conditions from the court. Therefore, there is a variety of reasons for entering rehabilitation, and these are accompanied by different sorts of compulsion.
A significant issue for practitioners is how to achieve excellent practice in both of their roles: a legalistic, guardianship, or surveillance role, and a therapeutic, helping, or problem-solving role (Trotter 2006). The goals and motivations of the two roles are quite different, and managing a balance can be a complicated task. Being authoritative in one instance and supportive in another instance, and knowing when to wear which hat, requires professional judgment and intuition as well as thoughtfully developed protocols and guidelines. In fact, it can be asserted that coming to terms with this dual role ‘is one of the greatest challenges in work with involuntary clients’, and ‘workers and organisations often find it easier to focus on one of the roles to the exclusion of the other’ (Trotter 2006: 4).

Achieving a successful balance requires a close examination of practice at the operational level to help workers clarify ways in which they operate that are effective in helping involuntary clients. Trotter (2006) reviews the literature on the direct practice approach to dealing with involuntary clients, and lists interventions and their varying levels of effectiveness and appropriateness. The section that discusses ‘approaches that sometimes work’ refers to research which suggests that some of these are better suited to some client groups, and may not work with others.
Table 2.2: Effectiveness of Approaches for Working with Involuntary Clients

<table>
<thead>
<tr>
<th>Approaches that work</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Role clarification – outcomes are improved for involuntary clients when workers focus on helping them understand the role of the worker and the role of the client in the direct practice process.</td>
</tr>
<tr>
<td>• Reinforcing and modelling pro-social values – this involves the worker affirming and exemplifying ‘pro-social’ actions and values which are tolerant, non-criminal, and which support and care for others.</td>
</tr>
<tr>
<td>• Collaborative problem-solving – this approach involves working with the client’s definition of the problem, developing achievable goals which are the client’s but are collaboratively developed, and identifying strategies with the client to achieve those goals. CBT can help this.</td>
</tr>
<tr>
<td>• An integrated approach – integrating all of the above approaches to holistically promote improved personal development and outcomes.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Approaches that sometimes work</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Empathy and reflective listening – these are popular counselling techniques; however, the research support for the use of empathy with involuntary clients is somewhat vague.</td>
</tr>
<tr>
<td>• Humour – this can be an appropriate tool to use in the helping professions, and can be used to humanise situations or ease tension. However, it is imperative that humour be used in a way that is appropriate to the situation, the style of the worker, and the client’s ability to see the humorous side. Misguided or fake humour may damage the worker-client relationship.</td>
</tr>
<tr>
<td>• Optimism – optimism can promote hope, expectation and self-efficacy. However, in the case of involuntary clients, it must be used appropriately and not in a way that invalidates the client’s emotions by always trying to make everything positive and upbeat.</td>
</tr>
<tr>
<td>• Self-disclosure – there are varying perspectives amongst workers on self-disclosure and the extent or context in which it is appropriate or inappropriate is uncertain. Clinicians must use their judgment and have the sole motivation of the disclosure helping the client.</td>
</tr>
<tr>
<td>• Case management – this approach is widely used. However, it has been criticised as being symptom focused instead of person-focused, and needs to be more holistic. Consistency of approach to a client who has complex needs and multiple service case managers is another issue. However, individualised case management that is responsive and informative may be effective.</td>
</tr>
<tr>
<td>• Short-term versus long-term intervention – time-limited specific interventions are more appropriate for some client groups, whereas others (e.g. drug addicts) may benefit from longer-term intensive and holistic interventions.</td>
</tr>
</tbody>
</table>
Approaches that don’t work

- Approaches which blame, punish or judge clients with the hope of change are likely to fail.
- Interventions which just focus on insight and the relationship, without including pro-social or problem-solving dimensions, have limited support.
- Interventions that are not person-centred but instead focus on worker goals for the client do not seem to work.
- Pessimism about the client’s capacity for change and a lack of encouragement for positive behaviours is inhibitive of progress.
- Situations where there is uncertainty about roles with the client or the worker, or the purpose of the intervention, have poor outcomes.
- Where there is a lack of clarity about what is negotiable and what is not negotiable is linked with poor outcomes with involuntary clients.
- Poor modelling by the worker is related to poor outcomes, especially with behaviours such as lateness, unreliability, and lack of follow-up.


Consulting the evidence base and research into the effectiveness can yield surprising results, especially in the section on ‘approaches that sometimes work’. The above guide to clinical practice is not intended as way of telling practitioners what to do; it is included to stimulate practitioners to examine the context within which they utilise certain interventions. When working with this specific population of clients, a one-size-fits-all raft of interventions will not yield the most effective outcomes. Therefore, the contextual use of specific interventions needs to be reconsidered in preparation for the influx of court mandated offenders and the aim of achieving better practice and outcomes. The theme of this section is the importance of flexibility and the situational context for what works in given circumstances. The question of the effectiveness of different approaches also raises issues of accountability and competency of staff in relation to clients.

Clarity of client rights and responsibilities: equity and advocacy

It is important that good practice and models of service delivery be informed by the perspective of those it affects – the clients. Ongoing consultation with clients can provide insight into the effectiveness of interventions in the progress of their treatment outcomes. Good practice ensures that client input occurs in the planning, delivery, and evaluation of services and approaches. It is important that clients are aware of their rights and responsibilities to ensure
equity, as well as clarity that can help avoid ambiguity and misinterpretation that may be a component of problematic conflicts in residential rehabilitation centres. Within the residential context, effective advocacy may require some independence; some clients may feel daunted about speaking openly with a person who may be perceived as part of the establishment of which they speak about. Equity cannot be assured unless all parties have a voice and are comfortable in expressing their perspective. An example of an advocacy group in Victoria is the Association of Participating Service Users. The Victorian government is currently developing a charter of client rights in partnership with this group – a charter which will be built into the quality framework.

Unlike other states, it seems that Tasmania has no formal substance user advocacy or consumer group. Thus, advocacy is an area that clearly needs development in the alcohol and other drug sector locally. Research by Rome et al. (2002) shows misconceptions amongst both practitioners and clients about advocacy. The table below sets out the integrated care perspective of the aims and purposes of advocacy.

<table>
<thead>
<tr>
<th>Advocacy is about:</th>
<th>Advocacy is not about:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• protecting people who are vulnerable, discriminated against, or difficult to provide services to</td>
<td>• creating a substitute for making services more accessible or to bypass user involvement in the planning and delivery of services</td>
</tr>
<tr>
<td>• empowering people who need a stronger voice by enabling them to express their own needs and make their own decisions</td>
<td>• avoiding the need to provide person-centred services</td>
</tr>
<tr>
<td>• the right of the service user to be heard, and the promotion of a person’s rights in an assertive but gracious manner</td>
<td>• primarily about making complaints, although advocacy may involve supporting people who want to make a complaint and helping them to do so effectively</td>
</tr>
<tr>
<td>• developing partnership between providers and users of services</td>
<td>• subtly putting the pressure on practitioners to comply with client demands due to the presence of an advocate</td>
</tr>
<tr>
<td>• empowering individuals to be active in the provision of their care</td>
<td>• being informative and supportive</td>
</tr>
</tbody>
</table>

Source: Rome et al. (2002).

Feedback and consultation is vital. It can be argued that there is little point in achieving well integrated service provision and excellent partnership if there is insufficient communication and collaboration between service providers and service users. Advocacy is about informing
and empowering the individual client to actively engage in this process of communication and collaboration. The theme of this section is the importance of participation, dialogue and advocacy.

**Principles of Good Practice: Service Provision**

*Mission objectives and guidelines for good practice*

The mission objectives of a residential rehabilitation centre are fundamental in directing the principles used in policy, and the subsequent effect on practice. Clear articulation of an organisation’s mission objectives, and strategies and steps to achieve those objectives, is necessary. These objectives and strategies should be revisited and reassessed on an ongoing basis, in recognition of the developmental and flexible process of organisational change and achievement.

A set of ‘Service Standards for Addiction Therapeutic Communities’ has been developed in the UK by Community of Communities, The Royal College of Psychiatrists, the European Federation of Therapeutic Communities, and the College Centre for Quality Improvement. It comprises a set of criterion that can act as benchmarks for best practice in alcohol and drug rehabilitation therapeutic communities, and was developed after extensive consultation. According to the editors, Shah and Paget (2006: iv), the standards ‘represent ideal practice and it would be unusual if services met every standard.’ While there is not enough room to outline all criteria, some of the most pertinent are listed below.

The ‘Core Standards’ outline 16 basic requirements and specifications:

1. The whole community meets regularly.
2. All community members work alongside each other on day to day tasks.
3. All community members share social time together.
4. Members of the community share meals together.
5. Community members take a variety of roles and levels of responsibility.
6. Informal aspects of everyday living are integral to the work of the community.
7. All community members can discuss any aspects of life within the community.
8. All community members regularly examine their attitudes and feelings towards each other.
9. All community members share responsibility for each other.
10. All community members create an emotionally safe environment for the work of the community.

11. Community members are involved in the selection of new staff members.

12. All community members participate in the process of a new client member joining the community.

13. Community members are involved in making plans with a client member for when he or she completes the programme.

14. There is an understanding and tolerance of disturbed behaviour and emotional expression.

15. Positive risk taking is seen as an essential part of the process of change.

16. The therapeutic community has a set of clear boundaries, limits or rules which are understood by all members.


These core standards can be utilised as basic standards for the operation of a good therapeutic community. As such they pertain to working as a living community. They cover a variety of facets of a therapeutic community, and promote collaborative participation, communication, and transparency. As the sixteenth criterion denotes, it is important for there for be a working structure in place to ensure each member of the community knows where they stand, what the protocols are, and how things should be done. This negates any possibly ambiguity or conflicts that might arise.

In addition to this, it is suggested that certain things are put into place to ensure an excellent therapeutic environment. Some of the following exemplify basic principles and values, and others contain depth of understanding and direction regarding how the community should be run:

- Community members treat one another with respect at all times.
- The therapeutic community promotes a culture of openness. It promotes an environment of open and honest feedback.
- Confidentiality and its limits are understood and respected by all members.
- Problems and solutions are discussed in the community before action is taken. The discussion is regarded as a learning opportunity. Potentially difficult topics can be openly discussed.
- Managerial information and issues that affect the community are shared with the whole therapeutic community.
• The therapeutic community has a written complaints procedure known and understood by all members.

• Community members are involved in the day-to-day running of the community. They are involved in the process of allocating members to community roles and jobs, as well as involved in the decision-making process.

• Community members are involved in reviewing each others care and treatment. Individual client members are involved in all decisions about their own care and treatment.

• Community members can offer each other advice on constructive ways of coping with conflict and frustration. Members give each other feedback about their behaviour and the way it affects others.

• The tension between risk and therapeutic opportunity is safely managed by the whole community, and is used as a learning process.

• The community maintains a drug-free environment, with the exception of prescribed drugs. Staff members do not use or support the use of recreational drugs.

• There is a well documented system (e.g. sign in/out logs) that keeps track of the whereabouts of residents.

• There is a regular process for the community to review the quality and effectiveness of the therapeutic community process. The review is to take into account the views of external people or agencies (e.g. families, multidisciplinary teams, commissioners).

• The review has written information about the community (e.g. accident and incident records, key performance data such as drop-out rates, waiting times, referral information, occupancy, non-attendance, and the findings of key audits).

Source: Shah and Paget (2006: 15-18)

The criteria listed above implicate the following facets of good practice: transparency and openness, good communication, client involvement and empowerment, collective decision-making, and the implementation of structures that serve specific purposes in the therapeutic community.

Desistance and strengths-based offender rehabilitation – innovations in practice

It is useful to describe and compare the ‘Risk, Need and Responsivity Model’ with a positive strengths kind of intervention approach (as exemplified in the Good Lives Model and also by the Social Recognition Model). Key differences in philosophy and practice have strong implications for outcomes and the way in which offenders are perceived. It should be noted
that the Risk, Need and Responsivity model is the predominant model within correctional, justice and rehabilitative settings in assessing and dealing with offenders. The other models are newer and still undergoing development, but are increasingly being referred to as well in different applications and settings.

The Risk, Needs and Responsivity [RNR] Model: This model is driven by the imperative of risk management and highlighting and dealing with the negative issues and criminogenic needs of the person, and trying to change those things. The focus is on the identification of empirically derived risk factors associated with offending. This approach exemplifies the ‘what works’ perspective, and commonly used methods are cognitive behavioural therapy. In relation to each individual offender, attention is fixed on criminogenic needs (dynamic risk factors empirically associated with offending) and other non-criminogenic discretionary targets (e.g. self esteem, personal distress). Thus, the model is based on assessment and action around risk, need and responsivity.

- The need principle: the assumption is that the most effective and ethical approach to the treatment of offenders is to target dynamic risk factors.
- The risk principle: the assumption that the treatment of offenders ought to be organised according to the level of risk they pose to society – the higher the level of risk the greater the dosage or intensity of treatment should be.
- The responsivity principle: the assumption that we match the delivery of correctional interventions to certain characteristics of participations, such as motivation, learning style and ethnic identity.

The Risk, Needs and Responsivity Model has attracted criticism because it is largely a deficit based approach focused on risk reduction and management (things to remove or control) and community safety, rather than the wellbeing of the offender and desistance due to living a good life (Ward & Maruna 2007). Initial critique of the RNR model is that concentrating on reducing dynamic risk factors (criminogenic needs) is a necessary but not sufficient condition for effective correctional interventions. In practice, there are also a range of interlinked issues:

- Eliminating or modifying various dynamic risk factors is extremely difficult. Individuals want to know how they can live a better life, and what the positive rewards in desisting from crime are.
- RNR model tends to neglect role of self-identity and personal agency, that is, self-directed, intentional actions designed to achieve valued goals [a ‘whole person’ perspective].
- RNR model is associated with a rather restricted and passive view of human nature.
• RNR model does not appreciate the relevance and crucial role of treatment alliance in the therapeutic process [trust and personal relationships].

• RNR model tends to be preoccupied with offenders’ risk profiles or traits and downplays relevance of contextual or ecological factors in offender rehabilitation.

• RNR model is often implemented in practice in a ‘one size fits all’ manner, which is at variance with the ‘responsivity’ principle [heavily manualised and prescriptive].

The Good Lives Model [GLM]: By focusing on self-empowerment and self-determination through capacity development, this model is forward thinking and operates on the assumption that increases in the positives will naturally result in decreases in the negatives, e.g. desistance from offending (Ward and Brown 2004; Ward and Maruna 2007). The approach has systematically been articulated in a recent book on rehabilitation (Ward & Maruna, 2007). The GLM starts from the assumption that offenders are essentially human beings with similar needs and aspirations to non-offending members of the community.

One of the key assumptions of positive psychological theories is that all human beings are naturally inclined to seek certain types of experience or human good, and that they experience high levels of well-being if these goods are obtained. Criminal actions are thought to arise when individuals lack the internal and external resources to attain their goals in a pro-social way. …From the perspective of positive psychology, in order for individuals to desist from offending they should be given the knowledge, skills, opportunities and resources to live a ‘good’ life, which takes into account their particular preferences, interests and values. In short, treatment should provide them with a chance to be better people with better lives.


We all, as human beings, are naturally predisposed to seek certain primary human goods. These include:

• Life (including healthy living and physical functioning)
• Knowledge
• Excellence in play and work (including mastery experiences)
• Agency (i.e. autonomy and self-directness)
• Inner peace (i.e. freedom from emotional turmoil and stress)
• Friendship (including intimate, romantic and family relationships)
• Community
• Spirituality (in the broad sense of finding meaning and purpose in life)
• Happiness
• Creativity

(Ward & Maruna, 2007:113)

Instrumental or secondary goods provide particular ways and means of achieving primary goods, for example, certain types of work or relationship. For instance, it is possible to secure the primary good of relatedness via romantic, parental or personal relationships among other means (Ward & Maruna, 2007:114).

The term ‘Good Lives’ refers to ‘ways of living that are beneficial and fulfilling to the individual in that they meet the basic human needs of body, social and self’ (Ward 2002 cited in Birgden 2002: 181). In addition to this, it is agued that any new rehabilitation initiative or intervention should incorporate or consider the strengths and good facets of each offenders’ ‘abilities, interests, opportunities and basic value systems’ (Birgden 2002: 181). The goal of this model is to display the talents and abilities of the offender in a useful and visible role, giving the person individual agency and a role in which to demonstrate personal community contribution to others. It is an enhancement approach focusing on providing offenders with the necessary conditions (e.g. skills, values, opportunities, social supports etc) for meeting their needs in more adaptive ways (Ward & Maruna 2007). The aim is to support the person and facilitate the discovery and development of necessary strengths and new talents that promote living a prosocial life and healthy balanced lifestyle.

Birgden (2002: 183) outlines seven key principles inherent in a positive strengths based rehabilitation framework that focuses on therapeutic jurisprudence and attaining ‘good lives’:

1. The law has an impact on rehabilitation. Therapeutic effects of the law should be maximised and anti-therapeutic effects minimised. Opportunities and motivation to make informed decisions and to change offending behaviour should be enhanced.

2. Rehabilitation should meet psychological needs. Low levels of psychological wellbeing are less likely to result in prosocial identities. Rehabilitation should rely upon an enhancement rather than a harm avoidance model and so programmes that are holistic rather than driven by risk management are more therapeutic.
3. **Autonomous decision-making is necessary in rehabilitation.** There is therapeutic value in choice and rehabilitation is more likely to be effective if offenders can weigh the costs and benefits of participation, provide consent and are motivated.

4. **Rehabilitation is a multi-disciplinary and multi-agency endeavour.** Rehabilitation should employ a coordinated approach as equal partners.

5. **Rehabilitation needs to be individualised.** Individualised assessments and interventions should be provided with a balance between individual need (for responsivity) and a standardised approach (for programme integrity). A greater focus on offender learning styles and attention to Aboriginal offenders, culturally diverse groups, female offenders, young offenders, and those with special learning needs is required.

6. **Rehabilitation is normative.** Rehabilitation is not value-free; judgments are made regarding risk, need and responsivity. Value conflicts that are inevitable and necessary should be articulated. For example, offenders have a choice about whether to participate in rehabilitation programmes.

7. **Rehabilitation requires an individual-community balance.** A therapeutic jurisprudence framework is required to weigh prudential values (best interest of offenders) with ethical values (best interest of the community).


While the above rehabilitation model is one used in correctional services, it has relevance and application to court mandated drug offenders and drug and alcohol rehabilitation more generally.

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**Social Recognition Model:** In addition to the strengths-based rehabilitation approach, Barry (2006) proposes a desistance theory that is complementary to such an approach because it promotes the expenditure of personal capital to achieve wellbeing and thus desistance from offending. Desistance theories include both psychological and sociological emphases, and are concerned with those processes (and outcomes) whereby young people desist or stop from offending. The concept of desistance as *outcome* is measured predominantly by reconviction data (e.g., repeat offending, recidivism). The concept of desistance as *process* is gauged predominantly by narrative data (e.g., what individuals feel and perceive, how they make meaning of their lives). The desire and propensity to desist or to engage in offending is linked to both structural and personal influences.
Barry (2006) examines youth offending from the point of view of diverse forms of social, cultural, economic and symbolic capital. She argues that it is not just the accumulation of capital that preoccupies young people, but also its expenditure.

Forms of capital include:

- **Social capital** – valued relations with significant others and which is generated through relationships which in turn bring resources from networks and group membership (e.g., peer groups).

- **Economic capital** – the financial means to not only the necessities but also the luxuries of everyday living, including inheritance, income and assets.

- **Cultural capital** – legitimate competence or status, and which comes from knowledge of one’s cultural identity in the form of art and education and language

- **Symbolic capital** – an overarching resource that brings prestige and honour gained from the collective, legitimate and recognised culmination of the other three forms of capital (i.e., social, economic, cultural). It is, in effect, the ‘recognition’ received from a group.

In discussing why young people persist or desist in offending behaviour and activities, Barry (2006) argues that achieving *social recognition* is vital for young people to gain a sense of achievement and social belonging as they move through the childhood and teenage years. This concept refers to the attainment of a combination of accumulation and expenditure of capital that is both durable and legitimate.

Social recognition suggests that people both recognize the need of others (generativity) and are concurrently recognized in addressing those needs (responsibility). It is this ‘duality’ of recognition that is crucial in ensuring durability and legitimation. (Barry, 2006: 159).

The family of origin and one’s local community provides the platform upon which capital accumulation grows and develops. In other words, resources and recognition of varying kinds stem in the first instance from what the family and friends can provide. Issues of poverty, unemployment, lack of income, homelessness and so on are relevant here.
But it is the expenditure of accumulated capital that brings the rewards of individual
gratification and social stability. Examples of this include such things as buying your own
clothes, engaging in volunteer work, and generally encouraging and helping others. Social
recognition and self esteem, generally, are built through expenditure of capital (doing
something for oneself and for someone else). If this is so, then it also ought to be an important
component in the development of juvenile justice intervention strategy. This means addressing
the constraints as well as acknowledging the importance of spending what the young person
has accumulated in their life.

Thus, for present purposes, it can be observed that through the process of rehabilitation and
transition into the community, the individual must be assisted and encouraged to garner and
accumulate personal capital in various areas of their life (which goes beyond the narrow focus
on the problem of drug use), and then exert the ability to use or spend their capital in the course
of a newfound healthy and balanced lifestyle of wellbeing. The natural consequence or result
of this desistance is that the person no longer engages in criminal offending. Overall, the good
lives rehabilitation approach and the social recognition theory approach have distinct
differences. However, they are complementary and have wider application to rehabilitation
than just in the field of corrections (Siegert, Ward, Levack, & McPherson 2007). Both
approaches represent clear innovations in practice compared to old or customary approaches
involving a primary focus on risk and deficit.

The treatment programme and effectiveness of interventions for different substance users

The treatment programme, its flexibility and relevance, and its application to different
individuals form eminent areas of analysis. The majority of residential rehabilitation centres
utilise similar tools and interventions, yet each treatment programme between centres and
therapeutic communities can differ. Therefore, it is important to reconsider the tools and
interventions that are used, and the context within which they are used with each client. Best
practice therapeutic treatment outcomes are more likely to be achieved using a carefully
tailored treatment programme and associated “tool box” of effective interventions, all built
upon a foundation of research and evidence.

Building on the criteria and standards described earlier, it is useful to consider some of the
standards outlined for achieving a best practice treatment programme:

- The community has a planned therapeutic programme.
- Each stage of the programme has clearly defined written goals, activities and expectations.
- There is a structured and consistent daily schedule of group activities.
• There is a provision for crisis meetings, with a recognised procedure for calling one that can be used by all community members.

• All client members have a written care plan, which as been agreed with the client member and is subject to regular reviews.

• The community prepares members for independent living in the wider community.

• The community offers appropriate educational and vocational training.

• The community offers relapse prevention training.

• The community offers appropriate health education training in both the prevention and control of threatening diseases.

• The community has an explicitly structured hierarchy. Senior client members should take a responsible role in relation to junior members.

• There are clearly defined privileges with a rationale and process for allocating them e.g. status advancement, more desirable living space. Actual choices of privileges are supportive of recovery, self-enhancement, and positive social behaviour.

• There are clearly defined sanctions with a rationale and process for allocating them. Client members are able to give input regarding behavioural sanctions imposed by staff.

• Sanctions for violations of rules are well defined, and known by all community members; including learning experiences. The community protects members from public humiliation or physical punishment.

• The community takes responsibility for improving and maintaining client members’ physical health. Client members should have a medical examination. Client members’ dietary needs should be met. Community members are provided with training in nutrition.

• Where client members are offered a methadone treatment programme, there is a written policy. The policy includes details of who supplies and administers the methadone, and recognises the medical protocols involved.

Source: Shah and Paget (2006: 19-22)

The above measures are useful because they ensure that all members of the community know where they stand and the appropriate protocols by which they should do things. Effectively implementing the overall treatment programme is beneficial because it provides the framework within which rehabilitation and clinical interventions can be built.

Two separate national reports, ‘Evidence supporting treatment: the effectiveness of interventions for illicit drug use’ and ‘Treating Alcohol Problems: Guidelines for Alcohol and Drug Professionals’, have examined the research and evidence base regarding the appropriate
use of certain interventions for specific types of clients. There is a raft of options that can be used in therapeutic practice, but it is important to prioritise and specify which should be used and which interventions should be avoided in certain contexts.

Over the next few pages we provide tables that list the effectiveness of specific psychosocial therapeutic interventions for different types of substance use.

**Table 2.4:**

**Effectiveness of Psychosocial Therapeutic Interventions for Opioid Users**

<table>
<thead>
<tr>
<th>Substance</th>
<th>What works</th>
<th>What doesn’t work</th>
</tr>
</thead>
</table>
| Opioid Users    | • Psychosocial therapy adds to the effectiveness of methadone maintenance treatment.  
• Contingency management interventions in conjunction with methadone maintenance treatment are effective in reducing illicit drug use.  
• Therapists with high-level skills – the competency and approach of the therapist are important factors in the context of methadone maintenance treatment.  
• Available evidence suggests that, in the years following treatment, ex-residents of therapeutic communities show lower levels of heroin use and criminal behaviour, and higher levels of legal employment than in the years prior to treatment.  
• Psychotherapy may be useful for treatment of heroin addicts on methadone maintenance who have comorbid psychiatric disorders, but otherwise cannot be justified on present evidence. | • Abstinence-based treatment without pharmacotherapy - psychosocial therapy as a stand-alone treatment only works with 5-30% of long-term heroin addicts.  
• Intensive day program treatment is not necessary with opiate users because it is no more effective than weekly counselling as an adjunct to methadone maintenance treatment, and thus is taxing on time and resources.  
• There is no evidence that specific techniques such as relaxation training impact on client outcomes.  
• There is no evidence that ex-addicts are more effective than other therapists or educators.  
• Coercively mandated counselling may be counterproductive for some. |


Table 2.4 highlights the importance of pharmacotherapy with opioid users, emphasising that psychosocial interventions are designed to be supportive and complementary not stand-alone as
a treatment for opioid addiction. Also, it contains a warning by suggesting that the coercion of involuntary clients into counselling may be counterproductive for some.

Table 2.5:
Effectiveness of Psychosocial Therapeutic Interventions for Alcohol Users

<table>
<thead>
<tr>
<th>Substance</th>
<th>What works</th>
<th>What doesn’t work</th>
</tr>
</thead>
</table>
| Alcohol Users  | • Counselling using psychological interventions such as those listed below is helpful. Clinicians should have a warm and supportive client relationship.  
• Cognitive behavioural therapy is more effective than just general counselling alone. It gives the client a set of thinking and behaving strategies that can be used to assist change. Cognitive restructuring and skills training are both useful.  
• Behavioural self-management training is helpful to clients who wish to cut down rather than abstain from drinking. This procedure is especially useful for drinkers whose lives are enmeshed in a drinking culture, where non-drinking is unlikely.  
• Couples therapy involves the partner of the drinker. It can produce better drinking and relationship outcomes compared to approaches that do not include the partner. However, this therapy should only be used if all three agree about it.  
• Cue exposure is effective in changing a person’s associations to do with drinking and the context in which they do so.  
• Residential treatments are better for clients with a history of chronic drinking and relapse, clients who are homeless, clients who live within an enmeshed drinking culture, and clients with comorbid disorders. | • Except for those types of drinkers listed in the previous column, most clients do as well in a non-residential treatment as they do in residential programmes.  
• Unstructured counselling alone is not usually sufficient to change drinking behaviours and should be supported by more specific techniques.  
• Clinicians who use confrontational methods will do more harm than good. Confrontation is associated with increased client resistance and higher levels of drinking. |

Source: Shand & Gates (2003: 17-19)
Table 2.5 makes the point of non-residential treatment options being as effective as residential treatment options for alcohol users. This raises interesting considerations in relation to efficacy and use of resources, leading to the conclusion that residential treatments are best suited to those in the categories outlined in the ‘what works’ column.

Table 2.6:

**Effectiveness of Psychosocial Therapeutic Interventions for Psycho-stimulant Users**

<table>
<thead>
<tr>
<th>Substance</th>
<th>What works</th>
<th>What doesn’t work</th>
</tr>
</thead>
</table>
| Psycho-stimulant Users | • Best outcomes are associated with treatment duration of three months of more, psychological treatment and monitoring at least once a week.  
• Individual counselling in addition to group drug counselling has significantly better outcomes in comparison to just group drug counselling.  
• Attendance of and participation in self-help groups (generally based on 12-step model) may improve long-term outcomes.  
• Cognitive behavioural therapy (CBT) is more effective at moderating cocaine use than equivalent time spent in non-therapeutic activities.  
• The effects of cognitive behavioural interventions may be more durable than other psychotherapies, and hence be more protective against relapse.  
• Positive reinforcement for abstinence, in combination with a community reinforcement approach, can reduce cocaine use.  
• For cocaine users, participation in long-term residential programmes (with at least 3 months in treatment) is associated lower relapse to weekly cocaine use one year following discharge. | • Group drug counselling alone (without other counselling) is not very effective with this type of user. |

Table 2.6, and the associated research it was developed from, does not demonstrate extensive knowledge of interventions that do not work. It is possible that further research into the effectiveness of psychosocial interventions with psycho-stimulant users may be warranted in order to establish or seek out any treatments that may not work.

**Table 2.7:**

**Effectiveness of Psychosocial Therapeutic Interventions for Cannabis Users**

<table>
<thead>
<tr>
<th>Substance</th>
<th>What works</th>
<th>What doesn’t work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis Users</td>
<td>• Adult cannabis users (not polydrug users) are interested in treatment and respond well to several types of intervention.</td>
<td>• Non-behavioural supportive treatment was found to be significantly less effective than treatment involving behavioural components.</td>
</tr>
<tr>
<td></td>
<td>• Comprehensive relapse prevention or brief intervention is more effective than no treatment in reducing cannabis use.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• A community reinforcement approach, relapse prevention, cannabis-focused supportive social interaction groups, and brief motivational interventions, or combinations of these, are likely to be effective in clinical treatment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Long-term residential and outpatient drug-free treatment may reduce cannabis use by polydrug users, with the degree of reduction dependent on length of stay in treatment.</td>
<td></td>
</tr>
</tbody>
</table>


Table 2.7 highlights considerations of use of a single substance, and polysubstance use and cannabis as a principal drug of concern. The evidence is supportive of long-term residential drug-free treatment of cannabis use for polysubstance users.

The above variations of what works and what doesn’t demonstrate the need for the clinician to consider therapeutic interventions in light of a client’s principal drug of concern. Also, polysubstance use needs to be considered in relation to any interactions or clashes that might potentially occur between the appropriateness of different therapeutic interventions. Clinical judgment and insight is needed in addition to the evidence base presented in the tables above.
Dual diagnosis and comorbidity: overcoming challenges to helping the whole person

Comorbidity refers to the co-existence of two disorders – mental health and substance use. Dual diagnosis is a commonly used term; however, it should be noted that some people with highly complex needs may have multiple diagnoses. The amount of people who have issues in both the area of mental health and the area of substance use is significant – and it is increasing. In a census of registered mental health clients in Victoria in 2002, 45% of clients were reported to have a dual diagnosis (Department of Human Services 2007b: 4); this figure is consistent with both national and international statistics.

However, actual rates of comorbidity are difficult to assess due to segregation of the mental health sector and the alcohol and other drug sector. The ‘recognition and reporting of dual diagnosis by staff in mental health and alcohol and other drug services is variable and currently appears to be more related to individual worker knowledge and interest rather than systemic identification as part of core service assessment practices’ (Department of Human Services 2007b: 6). Generally, the assessment tools of alcohol and other drug services and mental health services focus on assessing the person from the perspective of their primary presenting disorder – which risks ignoring the complex inter-relationship between co-occurring disorders.

However, to achieve holistic practice and overall recovery, it is important that assessment tools used in both sectors are redesigned to include understanding and awareness of each problem area to facilitate a better treatment plan (Steele & Rechberger 2002: 815). In Australia, findings in a report by the National Comorbidity Project show that there is ‘little consistency in assessment processes by specialist treatment services’ for clients with a dual diagnosis (Department of Health & Ageing 2003: 125). Subsequent to assessment, case management and cognitive behavioural therapy have been found to be a successful methods or models of intervention for people with a dual diagnosis, however, it should be noted that there are no specific case management models that have been found to be more successful than others (Department of Health & Ageing 2003).

Achieving change in the area of comorbidity and dual diagnosis service responses is an ongoing challenge for what is a notoriously difficult group of people:

Dual diagnosis can bring with it exacerbation in challenging behaviours, including self-harm and aggression, avoidance of services, and resistance to and non-compliance with treatment and recovery programmes. Those experiencing dual diagnosis can have long-lasting difficulties experiencing stigma, relapse and ongoing disability requiring services to invest in long-term care (Department of Human Services 2007b: 7).

Perceptions of this client group as difficult are common amongst practitioners. A study of 338 mental health staff in Sydney found that 82% reported that working with consumers with a dual diagnosis as ‘moderately’ or ‘very difficult’ (Kavanagh et al. 2000 cited in Allen & Davis 2007).
Practitioners feel that there is a strong need for more information and training to acquire skills to work effectively with this group of people (Graham 2004 cited in Allen & Davis 2007).

There is significant need to overcome the ‘either/or’ dichotomy between mental health and alcohol and drug services because it results in the client going to and fro – and possibly falling through cracks in the middle. Often clients with a dual diagnosis do not meet the eligibility criteria for service engagement. Opposing philosophies and perspective of the problems, as well as either sector requiring the person to deal with the other problem before receiving treatment creates conflict and barriers between treatment providers and disadvantages the individual client (Steele & Rechberger 2002). Thus, bridging the gap through mutual understanding, collaboration and integration of care is imperative. Integration of care has been found to work better than parallel models, and parallel models have been found to work better than sequential models (Department of Health & Ageing 2003). The Department of Human Services in Victoria has designed a policy directive that outlines the best practice guidance for the development of coordination and partnership between services:

- ‘Partnerships between specialist mental health and alcohol and other drug services, that deliver operationally useful relationships at the local level, underpin continuity of care and integrated treatment and recovery. This requires the development of mechanisms for clear communication between sectors and to address issues that may hinder agreement on collaborative action.

- Shared understandings about the needs of the target group, how to best address them and the roles that services in each sector will play, are essential requirements to underpinning effective collaboration and protocol development.

- Partnerships will need to agree on common intake and assessment arrangements, joint management plans, and case management work.

- Mental health and alcohol and other drug services are not alone in working towards improved dual diagnosis outcomes. Carers, non-government support agencies, community and acute health services and other services provided outside the mental health and drug and alcohol sectors play key roles and are key partners if needs are to be effectively responded to.

- The behaviours of some people with a dual diagnosis can be confronting and challenging. Individuals displaying such behaviour risk rejection or exclusion from services that can feel ill-equipped to respond effectively to both their mental health and alcohol and other drug services. Effective service planning requires these partner agencies to define collaborative approaches prior to developing and implementing programmes.

- Although tensions may exist between the differing professional, consumer and carer conceptions of mental health and wellbeing, if effectively managed these differences can result in services being made more responsive to need and provided in ways that engage and retain consumers in treatment.
• The participation of consumers and carers in service development and design is now recognised as good practice and a key to the success of programmes. Service design and development must take account of how mental health and drug and alcohol use varies across ages and impacts on both consumers and carers. Issues of engagement and retention in services are particularly challenging around marginalised young people with dual diagnosis.

• The inclusion of consumers and carers in the education and training of staff will assist in the ongoing development of respectful approaches through better understanding of their experiences.’

Source: Department of Human Services (2007b: 19-20)

The points cited above are supported by literature examining the integrated care approach in the United Kingdom for clients with a dual diagnosis – finding that integration care pathways including support from both sectors and the mainstreaming of service delivery produces best practice results (Sims, Iphoffen, & Payne 2003: 112). However, there is still a long way to go in achieving best practice, and a concerted effort is urgent. Research in the US shows that ‘the increased costs of care and poor outcomes associated with co-occurring substance use disorders and mental illness demand the ongoing focus of the public, consumers, researchers, clinicians, funders and other stakeholders’ (Rachbeisel, Scott, & Dixon 1999: 1433). Further research is needed to better understand treatment opportunities and approaches to care.

To achieve organisational change towards integrated care for clients with a dual diagnosis, the following strategies have been proposed to identify barriers to integration:

• ‘Consciousness raising through regular interest groups and seminars which incorporate case discussions and practice based role plays.

• Identify and engage clinical leaders.

• Encourage participation in the change process from all parties.

• Create an ongoing training programme in order to increase competencies, training should be dynamic in order to allow for different learning styles.

• Provide training funds (management, government).

• Ongoing clinical supervision focused on dual diagnosis issues and skills development.

• Induct new clinicians to be ‘integrated treatment’ focused.

• Engage consumers and carers to assist in advocating for and initiating the shift to integrated treatment.’

Source: Allen and Davis (2007)
A high level of integration of care across both the alcohol and other drug and mental health sectors requires intra-sectoral and inter-sectoral development over time with high levels of commitment and coordination. Thus, improving responses to people with dual diagnoses is imperative to ensuring that this vulnerable population has their complexity of need addressed in a holistic, humane, and timely manner.

Case management

There is a wide body of literature stemming from a number of disciplines on the theory and practice of case management. As noted in the ‘Key Practitioner Terms’ (see below), there are also a number of ways of referring to case management, with small nuances reflecting different philosophies of practice. In fact, the use of the terms ‘case management’ and ‘case manager’ has been criticised for emphasising the locus of power with the case manager, ‘who is then seen to manage an amorphous group of cases’ and thus it is argued taking away power and personal identity from the individual client (Dowling, Fossey, Meadows, Minas & Purcell 2007: 343). On the other hand, the term case may be used to describe a ‘case’ of service provision, rather than the individual person receiving this service (Dowling et al. 2007). Regardless of the debates surrounding terminology, case management is a core component of a practitioner’s work that needs ongoing reflection and enhancement.

Some of the most useful discussion of case management comes from the field of social work and mental health practice, and is easily adaptable to a variety of settings with different practitioners and client groups. Even within this, there are various models of case management. To add context to these different perspectives, the different case management models have been conceptualised by Bachrach (1993) on a continuum that polarises a negotiator/service approach at one end, and a therapeutic treatment case management approach at the other end:

However, while there are various models, all case management approaches are seen to share the same overall goal and accompanying phases:

- The overall goal is the coordination of service provision to ensure the consumer outcome of access to appropriate services. The four phases are assessment, planning, implementation, monitoring, and then review which reflects both a cyclical process and emphasis on continuity of coordinated care. (Dowling et al. 2007: 343)

The cyclical approach demonstrates the ongoing relationship between the case manager and the client, whether the case manager is involved in the provision of therapeutic interventions or whether this is accessed by the client from other service providers. In other words, the case manager serves the function of liaison and coordination, but also serves as provider of care and rapport themselves – not simply a referral manager.

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A final point of significance to note in relation to case management and service provision is the need for prioritisation. The integrated care service delivery model in Scotland utilised prioritisation of individual cases, which simply involves matching the level of intervention and the level of resources to the level of need. The highest need (and often most complex) require high levels of collaboration and integrated referral across services, as well as time and resources to help ameliorate the personal issues they are encountering.

**Staffing Resources**

Staff and human resources form a critical component of the alcohol and other drug sector and provision of services. Specific limitations or deficits in this area, both in Tasmania and across Australia, are an urgent area for action (Department of Health and Human Services 2007). Staff retention rates, stress levels, workload, level of clinical support, and burn-out are key areas of crisis across the alcohol and other drugs sector nationally. Sectoral development and changes in organisational culture are required to make progress in ameliorating these key issues. Recruitment and retention of well qualified staff are two of the most salient areas of need.

Shah and Paget (2006: 5-10) distinguish 12 principles with detailed suggestions for recruiting, developing and maintaining human resources of a high calibre:

1. **There are enough staff members for the community to operate effectively.**
   a. During informal therapeutic activity there is at least one senior community member available and others available if needed.
   b. During the formal therapeutic programme there is at least one senior community member in each group and others available if needed.
   c. At night, in a residential therapeutic community, there is one staff member available.

2. **Vacant posts are filled as quickly as possible, ideally with suitably qualified and experienced candidates.**
   a. There are clear criteria for staff selection based on therapeutic community principles.
   b. The staff team includes a proportion of graduates from a therapeutic community.

3. **New community members are monitored by more experienced senior community members for the first six months.**
   a. Induction training is provided for all temporary and permanent community members, including students and volunteers, before they have unsupervised contact with client members.
4. Community members, who are involved in directing the therapeutic process, receive regular clinical supervision from a suitably trained person.
   a. Community members who are involved in directing the therapeutic process attend regular group supervision.
   b. Community members who are involved in directing the therapeutic process attend regular individual supervision.
   c. Supervision involves discussion of client material in which theory, practice and experiential learning are integrated.

5. There are regular forums for all staff to reflect on their experience and work.
   a. There are regular meetings to examine how the community is dealing with events/issues.
   b. There are regular staff business meetings.
   c. There is a daily handover process.
   d. There is a forum for a staff only reflective space.
   e. There are staff debriefing sessions following all therapeutic, community or group meetings to discuss the issues that have arisen.
   f. There are staff debriefings following any critical incidents.

6. Therapeutic community staff work effectively as a team.
   a. The staff team explore the relationships that exist between them and the impact these have on their work.
   b. Staff members, as a group, tolerate the expression of conflict among themselves.
   c. Staff challenge each other’s perceptions of events in the therapeutic community and work to understand the difference between them.
   d. The staff team examine their relationships to their organisation and external professionals.

7. Staff function in a manner that is consistent with the philosophy and practice of the therapeutic community.
   a. Staff members conduct themselves as mature positive role models at all times.

8. Staff members are adequately trained.
   a. There is an adequate budget for training relating to working in a therapeutic community.
   b. The training needs of all staff members are assessed in supervision and appraisals.
   c. A skills audit of the staff group is conducted and reviewed regularly.
   d. All staff participate in continuing professional development.
   e. There is suitable therapeutic community training for support and administrative staff.
   f. Staff have access to material to support their professional development (e.g. internet, books, journals, videos and DVDs).

9. Staff receive theoretical training appropriate to their role in the therapeutic community.

10. Staff receive clinical training appropriate to their role in the therapeutic community.
a. Training is provided in a range of appropriate therapeutic interventions.
b. Staff know the evidence and theory underpinning the therapeutic intervention.
c. Training is provided in group facilitation skills.
d. Training is provided about the effects of medication.
e. Training is provided in risk assessment and management.
f. Training is provided in the management of imminent and actual violence.
g. Training is provided in identifying and understanding the symptoms of substance induced behaviour and its effects.

11. Staff receive experiential training appropriate to their role in the therapeutic community.

12. Appropriate methods are used to ensure the quality and effectiveness of staff training.


It is significant to note that several of the principles go beyond commonly discussed issues of recruitment and retention and focus on quality and quantity of different forms of training and professional supervision. Services in the alcohol and drug sector may encounter difficulty in the area of training and development because of the time-intensive and highly resource-intensive nature of undertaking it for each member of staff in an organisation. Nonetheless, it remains an important area for consideration and implementation. Overall, achieving all the principles established above is a difficult task; however, they provide a benchmark or ideal for drug rehabilitation therapeutic communities to work towards within the constraints of their local service delivery context and specific human resources needs.

Within the Model (Volume 2), the following areas are further developed:

- The staff team – multi-disciplinary
- Staff differences and diversity: gender, age and culture of the workforce
- Enhancing human resources: use of volunteers and students to build capacity
- Staff self-care and avoidance of staff stress, burnout and turnover
- Professional development, training and education
- Staff recruitment
Court Mandated Diversion

Drug court participation and court mandated diversion

Drug courts and court mandated diversion programmes have become a part of the criminal justice landscape in recent years in Australia. According to Freiberg (2000), this type of court has developed to better meet the needs of offenders with a drug addiction who have previously not been dealt with adequately in the criminal justice system. The needs of these people have not been met due to ‘a lack of understanding as to the nature of addiction, inadequate treatment resources, a failure to recognise relapse as a part of the healing process, a lack of proper supervision and a failure to intervene early and quickly enough’ (Freiberg 2000 cited in King 2006). The basic premise underlying the drug court model is to not solely focus on the symptoms (crimes) but consider these in light of the root causes (substance addiction, criminogenic needs etc) and treat those root causes, subsequently ameliorating the symptoms. In order to overcome the ‘revolving door’ and the failure of traditional methods to reduce drug related re-offending, the drug court emphasises the offender’s rehabilitation and places the judicial officer as a member of the treatment team/problem solving court team (Winick 2003). Therefore, court innovation has been a necessary response in order to overcome the issues at hand in the criminal justice system such as recidivism rates and increasing prison populations.

Drug courts and court mandated diversion are rather conducive with restorative justice principles and practice. King (2006) asserts that they are a better alternative to law and order campaigns, and yet they are not ‘soft’ on crime but are instead ‘smarter’ on crime. Offenders are made to take responsibility and accountability for their actions – and they are answerable directly to the court (King 2006). Offenders do not escape consequences of their actions; the subsequent interventions are simply more targeted towards addressing their health, welfare, and criminogenic needs. It can be argued that this approach is more forward thinking than traditional courts because it does not involve one-off retrospective punishments, but goes further to reduce future offending and be a catalyst for change. In the US, drug courts have been operating for years (there are now over 1,160 drug courts in all 50 states), and exciting evidence-based results are emerging. According to the Centre for Court Innovation (2007), there has been a 32% reduction in recidivism amongst drug court participants in New York, which is quite significant in light of the fact that recidivism rates are usually quite high. Thus, one positive element is that drug courts ‘reduce the number of future victims of crime by promoting offender rehabilitation’ (King 2006: 9). A second positive element is that:

Drug courts and court diversion programmes can also generate powerfully moving stories – stories of healing, overcoming adversity, reconciliation with family and friends, and the gaining of a productive and happy life that contributes to community well-being. Bringing these stories of hope to the community should be an essential part of raising community awareness about the value of these programs (King 2006: 10).
Drug-related offending is an area that is perceived to be a perennial problem containing a cyclic chicken-and-egg type of nexus. Thus, stopping this destructive cycle presents a good news story long overdue in the criminal justice and health and welfare sectors, and an incredible benefit for the local community.

To illustrate differences between the traditional approach and the approach used by problem oriented courts, Warren (1998 cited in Rottman & Casey 1999) utilises a comparative summary of differences between general lists of the traditional court and specialist lists of a drug diversion court, which is reproduced below:

**Table 2.8:**

<table>
<thead>
<tr>
<th>Traditional Court Process</th>
<th>Transformed Court Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dispute resolution</td>
<td>Problem solving dispute avoidance</td>
</tr>
<tr>
<td>Legal outcome</td>
<td>Therapeutic outcome</td>
</tr>
<tr>
<td>Adversarial process</td>
<td>Collaborative process</td>
</tr>
<tr>
<td>Claim or case oriented</td>
<td>People oriented</td>
</tr>
<tr>
<td>Rights based</td>
<td>Interest or needs based</td>
</tr>
<tr>
<td>Emphasis based on adjudication</td>
<td>Emphasis placed on non-adjudication and alternative dispute resolution</td>
</tr>
<tr>
<td>Judge as arbiter</td>
<td>Judge as coach</td>
</tr>
<tr>
<td>Backward looking</td>
<td>Forward looking</td>
</tr>
<tr>
<td>Precedent based</td>
<td>Planning based</td>
</tr>
<tr>
<td>Few participants and stakeholders</td>
<td>Wide range of participants and stakeholders</td>
</tr>
<tr>
<td>Individualistic</td>
<td>Interdependent</td>
</tr>
<tr>
<td>Legalistic</td>
<td>Common-sensical</td>
</tr>
<tr>
<td>Formal</td>
<td>Informal</td>
</tr>
<tr>
<td>Efficient</td>
<td>Effective</td>
</tr>
</tbody>
</table>


However, it is recognised that these ‘transformative’ or new therapeutic court perspectives and processes operate within the traditional court legal framework and environment. Cases from specialist courts or lists can be referred back to the general criminal court lists as well. This highlights the significance of court process – a key and somewhat contentious issue between supporters and skeptics of therapeutic jurisprudence. Nonetheless, safeguards are put into place
to protect due process and the principles of natural justice and open justice, so that the interventions of new ‘transformative’ court processes are not a divergence from foundational principles of law and the criminal justice system. To put it simply, law and justice are still attained, but the methods and the means to the end have developed and are different.

With the establishment and implementation of a drug court in Tasmania, court mandated diversion (CMD) presents some interesting challenges and opportunities for collaboration and partnerships. This new form of problem-oriented court utilises therapeutic jurisprudence and diversion into treatment to achieve better justice outcomes for offenders with a drug problem. McGlone (2003: 136) notes new methods are used that depart from traditions of adversarial justice, and the accompanying ‘perceived failure of current custodial sanctions to adequately address drug use and related offending while retaining the structure and authority of the court.’ On a pragmatic level, drug courts make sense on a fiscal level because, while they may be resource intensive and require funding, they are ‘accepted as cheaper than gaol’ which ‘in turn has freed up resources, which can then be directed towards other offenders who present a greater public safety risk’ (McGlone 2003: 138). Thus, not only are they therapeutic for the offender in addressing personal criminogenic needs, they are also beneficial for the court and the community, and in the bigger picture may even save government money through reductions in recidivism and correction costs.

Therapeutic jurisprudence can also be referred to sometimes as ‘collaborative justice’, which recognises the important role of therapeutic treatment providers and their partnership and active involvement in the criminal justice system. Collaboration is required across disciplines and service types in the administration of justice to achieve lasting outcomes for the offender, victim(s), and the community. However, those participating in the drug court should be mindful of any ethical issues that may arise. One of these, according to King (2006: 8), is the dual roles of workers whereby they ‘support their clients and yet need to provide information potentially adverse to their clients’ interests to the drug court team as a part of the case management processes.’ This highlights the fine balance between therapy and punishment in this hybrid type of court process. Thus, the collaborative healing process entails issues for consideration for all involved.

The impetus and need for the drug court has been outlined in research by the Tasmanian Law Reform Institute, especially in work conducted by Stojcevsiki (2006a, 2006b). He cites the following Tasmanian drug trends in 2004 as ample reason for this new court:

- Cannabis remains the most widely used illicit drug.
- Tasmania is experiencing increased availability of methamphetamine and increased prevalence of use (like other jurisdictions).
- There is a significant market for the illicit use of methadone.

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The widespread injection of benzodiazepines is a stable feature of Tasmania’s illicit drug market with use amongst local injecting drug user consumers at a relatively high level in comparison to other Australian jurisdictions.

Source: see Stojcevski (2006a).

The link between drug use and crime is further supported by evidence from the Drug Use Monitoring in Australia (DUMA) annual report by the Australian Institute of Criminology. The results of the study found that, of the 77% of offenders who agreed to do a urine test, 55% tested positive to cannabis, 23% to methylamphetamine, and 20% to benzodiazepines (Mouzos, Hind, Smith & Adams 2007). Thus, there is ample evidence supporting the need for specialist sentencing and treatment people who engage in both substance use and crime.

Some aspects of the implementation and operation of the drug court pilot project are yet to be articulated in the public domain. Sentencing legislation and provisions are in the process of being enacted. However, a recent symposium on court mandated diversion of drug offenders provided a good picture of what court mandated diversion practice will entail. CMD treatment services include individual counselling, group counselling (cognitive behavioural therapy), medically supervised withdrawal (pharmacotherapies and detoxification), residential rehabilitation, and drug testing. Common assessment tools for crimonogenic needs and substance abuse will be used across the whole court mandated diversion programme (Department of Justice 2007). Treatment providers will need to consider the effectiveness and practical implications of using such assessment tools in light of their existing assessment structures and protocols. Separate sections within this report will discuss issues relating to the dual roles of practitioners in light of the drug court, as well as working with involuntary clients comparative to voluntary clients.

Under Category 2 diversion and with the use of Drug Treatment Orders in Category 3 diversion, a coordinated response will be required to meet the offender’s potentially complex crimonogenic, health and welfare needs. Multiple government departments and community service agencies and professionals will be involved in the diversion and treatment of each offender. Court diversion officers will be appointed to develop and support a coordinated service response at the regional level (Department of Justice 2007). However, with only one diversion officer for each region, it is clear that agencies themselves will need to actively engage in the coordination of cases throughout the continuum of care and treatment. Another area of consideration for community service agencies is the rights and responsibilities of clients and agencies in the context of court mandated diversion. Sentencing and bail conditions and stipulations in individual management plans become increasingly salient, and will impact on the service providers who participate in diversionary treatment provision.
Therefore, it is evident that therapeutic jurisprudence is increasingly being utilised to develop more appropriate approaches, interventions and outcomes for specific types of offenders – and the commencement of court mandated diversion in Tasmania is an excellent example of this.

**Collaboration and Coordination**

*Barriers to effective collaboration and partnership*

Before good practice can be discussed, it is important to recognise certain barriers that can restrain effective working relationships. The following are examples of barriers and difficulties that can arise:

**Doing things together: difficulty in deciding who, what and how**

Multi-agency collaboration and interventions are ‘inevitably difficult to organise and administer’, and raise questions about the precise nature of the partnership, who is to do what, and how they are to do it (White 2003: 57; White & Coventry 2000). Disagreement and lack of clarification are barriers to building an effective partnership, and the key decisions need to be made through a process of communication, reciprocated respect and mutual agreement.

**Power-sharing, accountability and coordinating the coordination**

Multi-agency collaboration often begs the question of ‘who is to co-ordinate the process, and what criteria is to be used for evaluating the purposes and performance indicators of such co-operation’ (Hughes 1996 cited in White 2003: 56). In support of this, the title of Homel’s (2000) article raises a pertinent metaphor and question: ‘When worlds collide – or who’s in charge of this partnership anyway?’ Collaborative programme management is about power sharing – the sharing of responsibility for success and failure – and sharing authority and decision-making (Homel 2000). This power sharing is something that needs to be clearly articulated and agreed upon during the planning process. Difficulties arise when it is left ambiguous or lacking in clarity because of diplomatic rhetoric that does not contain specificity. The worst case scenario is that the partnership encounters extensive difficulties, there is failure in individual cases or specific areas, and the end result is finger-pointing and regretful circumspect. Even though it is unlikely such disintegration would occur commonly, it does raise the significant topic of accountability, and protocols and processes need to be put in place from the start to ensure it is a part of the programme and partnership design (White 2003).

**‘Culture clashes’ and conflicting interests stemming from different perspectives**

Different institutional sectors in a collaborative relationship may have different core imperatives, and this may entail differences in perspective and intervention preferences (White
2003). Because drug courts and court mandated diversion involve interventions with individuals on multiple levels and with a set of mixed goals, conflicts of interest can arise stemming from the different perspectives of the partnering agencies (Homel 2000). These goals typically include reduced offending and improved health and social functioning. There can also be competing agency goals, which can be characterised as a ‘form of competition’ between a focus on community protection – a goal of the criminal justice system – and a focus on individual protection and development – goals of the health/welfare sector (Homel 2000: 2). Thus, for health/welfare practitioners, the framework they work within is seeking to promote individual autonomy, well being, engagement and motivation. For practitioners in the criminal justice system, the framework is one in which their powers are externally imposed on the individual, and they have to consider the community (Homel 2000: 6).

Homel (2000) suggests that within drug court diversion, the above barriers bring the system to a stage where it may develop in one of two ways: on the one hand it could collapse into conflict and competition. On the other hand, a genuinely collaborative partnership could evolve – one that sees new relationships and new ways of operating producing genuine benefits for individuals and the community (Homel 2000: 6). It is evident that this is the way forward, and there are some strategic directions that can be outlined to guide this.

**Building collaboration and partnership: principles and good practice**

An impetus and rationale for taking steps to build partnership is summed up in the comment by a client: “We want to be treated for all our needs, not just our addiction” (Department of Human Services 2007a) – in other words, treating the whole person. Using terms such as ‘holistic’ and ‘integrated treatment response’ become well-meaning but empty rhetoric if not backed up with working relationships that embody healthy partnership and collaboration.

Homel (2000: 2) argues that, in order to achieve an effective collaborative relationship, the first thing that has to happen is the development of a philosophy of partnering – not just partnership agreements. He discusses good partnering practice at in the following way:

Partnering has been described as a working relationship with a high level of trust and close cooperation between two parties that contract with each other to achieve mutually beneficial outcomes. Partnering is a form of implicit contract that, although not legally binding, is self-enforcing because it is in the interests of both parties to honour the agreement (2000: 2).

A perspective that balances the interests of both parties, as well as the interests of the collaborative effort is encouraged and will lead to successful outcomes lauded by both sides.
To successfully put this into practice, the integrated care model suggests the following strategic ingredients need to exist (Rome et al. 2002):

- clear identity and role for the partnership
- clear identity and role for each partner agency in the planning, design and delivery of services
- shared short and long term aims and objectives
- sufficient time and resources dedicated to partnership building
- adequate training for all members, including community and user representatives
- a supportive atmosphere where discussion and new ideas are welcome
- clear and supportive leadership
- an atmosphere where organisational and cultural barriers can be explored

Each of the above strategic ingredients highlights the need for extensive planning and development in the service delivery context to promote a successful connection between the two partnering agencies.

Once the basic foundations of partnership are established, it is possible to engage specificity and strategic direction. For example, it is possible to delineate between partnership at the strategic level and partnership at the operational level. According to Rome et al. (2002), at the strategic level partners should agree upon:

- the aims and objectives of an integrated service
- the range of services that could or should be engaged
- the commissioning and management arrangements, including joint resourcing
- the arrangements for sharing information
- the arrangements for multi-agency training to promote mutual understanding of roles
- monitoring and evaluation arrangements

Rome et al. (2002) go on to assert that, at the operational level, partners should agree upon:

- common or core assessment procedures and datasets
- systems and protocols for sharing information
- systems and protocols for referral and joint working
There needs to be effective mechanisms for communication and exchanging ideas between the strategic and operational levels (Rome *et al.* 2002). What both of these levels of partnership strategy highlight is the importance of clearly articulating and agreeing upon the philosophy of care and partnership (principles), and that the methods by which it will be achieved be well developed too (practice). This can be done on a number of levels. The most basic level is the individual level where professionals from different agencies have a well defined and effective working relationship and liaison between each other, working together on shared cases or issues. The next level is the organisational and inter-organisational level, where specific agencies have partnership agreements in place. The final level relates to the bigger picture – working relationships and collaboration amongst a variety of agencies in a specific geographical location such as a big city or state-wide. Successfully achieving the final level of coordination and collaboration takes integrated management, needs to involve the government or a specified regulatory leader, and should be informed by rigorous and ongoing consultation from all involved. Doing this is difficult and requires careful negotiation to avoid the barriers outlined earlier, however, the difficulty of implementation needs to be weighed against the ensuing results and outcomes.

In order to see strategies and state-wide coordination in practice, it is useful to describe the list of steps articulated to take to ensure better practice in this area in the AOD sector in Victoria (Department of Human Services 2007a: 42):

- Improved pathways for clients of harm reduction services such as needle and syringe services to facilitate access to alcohol and other drug treatment programmes and other health and welfare services.
- Better engagement of GPs, GP divisions, and GP practice staff to support improved responses to alcohol and other drug issues, including pharmacotherapy prescribing.
- Improved hospital setting responses to clients with alcohol and other drug issues and enhanced linkages with alcohol and other drug services.
- Continued access to alcohol and other drug treatments for clients who commit alcohol and drug-related offences and an improved range of treatment options.
- Stronger linkages with family and parenting support services to raise awareness of substance use issues and improve preventative and early intervention approaches.
- Better coordination and referral through Primary Care Partnerships.
- Integrated planning and delivery of health services through the ‘Care in Your Community’ initiative.
• Stronger links with employment, education and training programmes and initiatives to assist people recovering from substance use issues to re-engage in the labour market and/or training.

• Stronger links with Housing Programs to address clients’ accommodation needs and intervene earlier for those at risk of homelessness.

• Investigation of resources required to sustain effective linkages for clients before, during and after treatment.

Each of these points gives specific and strategic direction of areas for improvement in the future, and has relevance of application beyond the Victorian alcohol and other drug sector. A clear aim of such strategies is to avoid ineffective fragmentation and the associated possibility of “losing people through the cracks” so to speak. Examination of the above list highlights a strong intention not only to build and enhance shared-care type partnerships, but to ensure more wide ranging integration that goes beyond just primary health care to integrative incorporation of services from the broader welfare sector. Moving beyond what could be seen as clusters of collaboration (joined by referrals) to service provision that entails integrated networks of care and eventually one large collaborative cluster is a positive advancement in the field. Holistic capacity building across sectors to ensure more holistic service delivery is a vital innovation. Clients will benefit from simply passing them between connected parts of the sector to simply streamlining their progress through clear pathways of recovery that holistically address any and all of their needs.

The ‘Service Standards for Addiction Therapeutic Communities’ has a section on ‘External Relations’ which outlines specific criterion that can be enacted that are relevant to and supportive of the above discussions on collaboration and partnership. These standards also cover topics such as research and development, which suggests positive working relationships with educational and research institutions. Therefore, in achieving best practice, a rehabilitational community should engage in the following:

• The therapeutic community contributes to effective multi-disciplinary and multi-agency working, between health, education, probation services, social services and voluntary organisations.

• The community liaises with other relevant services and has a good working relationship between disciplines and departments to ensure continuity of client member care.

• Community members are involved in the promotion of the work of the TC.

• The community provides training placements for students and post-qualifying professional development opportunities for qualified practitioners.

• The therapeutic community proactively engages with the wider community.
• Community members regularly meet with the senior members of the parent organisation.

• The community is currently participating in a research project or evaluation concerning effectiveness as a therapeutic community (e.g. outcome and process research).

• The community is part of a research network.


If each of the above is put into place, this will result in positive collaboration and working relationships between clients, staff, the parent organisation, other community service providers, government agencies, research and educational institutions, and the wider community. This collaboration is vital to ensure that connectedness is maintained between the rehabilitation centre and external people, groups, and services. Thus, to support client reintegration, it is imperative that the therapeutic residential experience is not segregated in nature. A stronger support network and stronger throughcare will exist if the individual client feels not only supported in the therapeutic environment, but adequately equipped to transition back to the community and receive ongoing support there. Isolation and ineffective levels of collaboration and partnership are barriers to success and impinge upon connectedness.

Agency collaboration and integrated service provision in Tasmania

The Department of Health and Human Services has put out an Agency Collaboration Strategy for improvement to services for people with complex and exceptional needs (DHHS 2004). It is a detailed policy with three tiers of intervention, and it is relevant to a number of sectors: mental health, disabilities, alcohol and other drug, children and families, correctional health, housing services, primary health care and hospitals. Many clients using one service may have complex needs and engage in multiple service use. Unfortunately, the consequence of this for some is lack of coordination and fragmentation – resulting in a need for more services to be well equipped to holistically address or provide case management the individual with a variety of complex needs in different areas.

Specific challenges or barriers to effective collaboration in Tasmania have been identified:

• Lack of collaboration between some programme and service areas.

• Difficulty in addressing the needs of some individuals and in providing sustained responses within existing service frameworks.

• Barriers of access to services including inconsistently applied eligibility criteria.

• Needs not being identified as a priority for a programme area to address.
• Concerns by some service providers about the resource and time intensive nature of addressing the complex/exceptional issues for some individuals.
• Problems with coordination and integration of services.
• Differing legal and policy frameworks.
• Service solutions resulting in unnecessarily high costs.
• Divisional accountability for resource allocation.

Source: Department of Health and Human Services (2004: 3).

A common theme in the points listed above is the extent of the time and resource intensiveness involved in handling caseloads of individuals with complex needs and having fluid communication and integration with the other services involved. It is a challenge that is difficult to overcome, and requires strategic planning and partnership agreements and protocols between those involved.

To ameliorate lack of collaboration and coordination of service provision in Tasmania, five principles are outlined that underpin the suggested framework:

1. **Self-determination and empowerment**: People with complex or exceptional needs will be involved in self-determination of personal need and participation in decision making. It is highly desirable that they should assume the greatest responsibility and personal control into decisions affecting their life. This will require services to provide information that allows for a realistic appreciation of what is possible and for the individual to have an understanding of the available service options.

2. **Liaison with families**: Where possible, families will be assisted to contribute to their maximum capacity for the care of the individual with complex needs. However, for some people ongoing dependence on the service system is inevitable. There must be recognition of the need to individualise responses for most people with complex and exceptional circumstances. Where possible, services must work with families and their carers to establish their capacity to assist in the ongoing care of people with complex needs.

3. **Appropriate service models are required**: Service models will ensure that an empathetic response to needs being reasonably met and quality factors are considered in meeting both the duty of care to the client and to the community. Where possible, smooth transitions and continuity of care of a key service provider between service environments will be provided.

4. **Collaboration is the cornerstone for the management of clients with complex needs**: Collaboration and communication across the service system and a partnership approach to resolution of problems for people with complex and exceptional needs is integral. Service
linkages need to be fully developed and an understanding of the different service areas across the Agency is required. Service areas have a duty of care to work efficiently to address issues and find responsive and reflexive issues. The contributions and responsibilities of agencies involved are to be planned, agreed, and documented in a plan. Comprehensive and specialised assessment of need will inform the development of integrated plans, enhance decision-making and resolution of problems. Collaborative assessment may need to be ongoing to ensure planning is targeted and proactive.

5. **Early intervention is the key to good service provision.** Early development of strategies and resolutions with a proactive focus are required. This principle incorporates the concept that the individual will benefit most when needs are addressed at critical points on the continuum. Early collaboration can assist with capacity building and achieve improved service integration. Early access to appropriate rehabilitation and/or other community support services is also required.


These principles provide priority areas and strategic direction in coordinating service providers to work together towards the best outcomes for all involved. Local service providers may be able to enhance the small-scale nature of Hobart and Tasmania, in that most professionals and organisations are aware of each other and often informally liaise with each other anyway. The important thing is for effective processes of collaboration to be built in to service delivery in order to provide the most holistic and integrated service possible, resulting in good practice and outcomes for the individual and the organisation.

*Information sharing, confidentiality, and informed consent*

In situations of failure, a common criticism is that the right information was not given to the right people at the right time (Rome et al. 2002). According to Rome et al. (2002), the purpose of sharing personal information on individuals between partner agencies is ‘to ensure access to the appropriate treatment, care and support services for those individuals.’ The authors then assert that this requires:

- a culture of openness and trust between agencies
- agreement on the core elements of information to be transferred
- agreement on the circumstances where additional, possibly sensitive, information should be shared
- agreed inter-agency protocols governing information sharing
• respect for the client’s right to privacy, confidentiality, and consent to the sharing of their personal information

Source: Rome et al. (2002)

As illustrated by the above requirements, collaboration and partnership in service delivery and provision of care raise some significant opportunities and barriers in regard to information sharing. On the one hand, information sharing can be beneficial because it reduces the amount of overlap that can occur at multiple assessment stages, e.g. the repeated asking of the same questions can be avoided. Information sharing can result in enhanced treatment outcomes because it assists the service providers to give the individual the best possible service (Rome et al. 2002). On the other hand, there can be confusion about amounts of appropriate discretion, gaining consent, possible mistrust between different parties, and handling confidentiality requirements when dealing with sensitive information. Any form of partnership requires each agency involved to be aware of each other’s protocols, and have similar policies on confidentiality and information sharing that are compatible across agencies dealing with the same individual. In some cases, it may be appropriate to verbally inform a person and ask for their verbal consent, however, more sensitive or serious information sharing may require written consent and strict adherence to procedural guidelines governing confidentiality and care. The following precautions need to take place for any information sharing exchanges:

• Staff need to be fully aware of legal, professional and organisational requirements and procedures.

• Most clients do not have a full understanding of the ways in which their information is used. They have a right to know more.

• When clients come into contact with services, the uses to which the information gleaned from that episode might be put should be explained.

Source: Rome et al. (2002)

Promoting individual agency and decision-making is an important element of empowering individual clients in their engagement with multiple services. They should not be treated as a passive and unknowing element of the partnership.

Another helpful guide is to constantly assess possible actions against the criterion of the client’s best interests. If the sharing of information is beneficial to the provision of service to the client and does not contravene their rights, it is likely they will consent to information being shared – making it easier on them and the various services involved. However, any conflicts that arise from a perceived inappropriateness of information sharing on behalf of the client may harm the worker-client and agency-client relationships. Therefore, specific and careful articulation and clarification of how information will be used, how confidentiality and
rights will be protected, and the benefits of sharing certain information with other services will ensure increased professional conduct.

Clear communication – speaking the same language

The move to develop partnership and collaboration needs to be considered in light of the different perspectives involved. Even at the most basic level, there are important disparities that need to be bridged. One of these is the issue of language. Clear communication cannot occur if different collaborative agencies do not even seem to speak the same language. The table below illustrates how different terms can be used to describe the same thing, and yet, at the same time, there can be important distinctions between the meaning and practice of similar terms. These differences are significant at the strategic level, but they are also important at the operational service level because they can translate into differences in practice. Subtle nuances in phrasing and philosophy can be indicative of different attitudes and perspectives that can affect how the same task is done by different agencies.

Homel (2000: 7) argues that it appears this is starting to happen in the area of drug diversion, and encourages further progress in this:

There is clear evidence of the emergence of one of the most important indicators of a developing long-term partnering agreement. That is an increasing willingness to develop a shared language – a commitment to understanding that the narrow definitions associated with some terms have to be dispensed with… To work together there needs to be both an understanding of the value of each definition as well as a shared meaning.

Duality or multiplicity of meaning can result in ambiguity and confusion, and may impede the operation of the drug court partnerships. Table 2.9 below contains terminology that has both similarities and a diversity of meanings for different groups and contexts – thus highlighting a significant need for further development of shared language.
Table 2.9:

**Key Practitioner Terms**

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential rehabilitation</td>
<td>Residential rehabilitation is based on the principle that ‘a structured drug-free residential setting provides an appropriate context to address the underlying causes of addictive behaviour. These programmes assist the client to develop appropriate skills and attitudes to make positive changes towards a dependence-free lifestyle’ (Gowing et al. 2001: 68).</td>
</tr>
<tr>
<td>Therapeutic communities</td>
<td>Therapeutic communities ‘represent a subset of residential rehabilitation defined by the emphasis placed on accepting personal responsibility for decision and actions, and assigning residents tasks of “everyday living” as part of their treatment’ (Gowing et al. 2001: 68). They are also seen to provide a combination of therapeutic involvements between residents and staff and among residents and living in a caring and challenging community as the principal mediums to encourage change and personal development (Leonard 2006).</td>
</tr>
<tr>
<td>Shared care</td>
<td>Shared care advocates a partnership approach between services that are involved in the treatment, care and support of drug users to ensure an enhanced continuum of care (Rome et al. 2002). It is usually applied to partnership between GP’s and specialist central services working together, and an example of this are the Primary Care Partnerships used in Victoria (DHS 2007a).</td>
</tr>
<tr>
<td>Integrated care</td>
<td>The integrated care approach is an extension or progressive development of the shared care approach. Integrated care is a proactive term indicating action and enabling the participation of a range of services (not just primary health) and the individual drug user and their family in the overall delivery and planning of care (Rome et al. 2002). It comprises holistic and person-centred service, and is especially relevant to clients with complex needs requiring support from a variety of services. The continuum of care is not considered as a chain reaction of referrals, but involves integrated service delivery and collaboration to ensure the best treatment outcomes for the client.</td>
</tr>
<tr>
<td>Planning of care (therapeutic planning)</td>
<td>The planning of care is the process of making decisions about the treatment, care and support that the individual will receive and about who will be involved in providing the appropriate services (Rome et al. 2002).</td>
</tr>
<tr>
<td>Delivery of care</td>
<td>The delivery of care is the process of co-ordinating, managing and providing the care so that the individual receives the right services and interventions as the right time, and in the right way to match their assessed needs and in accordance with their therapeutic plan (Rome et al. 2002).</td>
</tr>
<tr>
<td>Care management</td>
<td>Care management is described as an intensive approach for individuals with complex, frequent or changing needs requiring complex packages of active, ongoing support and interventions (Rome et al. 2002).</td>
</tr>
<tr>
<td>Care co-ordination</td>
<td>Care co-ordination is described as relating more to individuals with more straightforward needs and may revolve around “simple” interventions or single services (Rome et al. 2002).</td>
</tr>
</tbody>
</table>
The case management service component of court mandated diversion from the Tasmanian drug court will involve: ongoing case review, referral to appropriate services for family support, mental health issues, living skills, vocational and housing support, and relapse prevention (Dept of Justice 2007).

As a part of assessment and case planning process within court mandated diversion of drug offenders in Tasmania, individual management plans will be developed in relation to each offenders’ criminogenic, health and welfare needs (Dept of Justice 2007).

The terms ‘treatment plan’ and ‘forward plan’ are used at The Bridge programme (Leonard 2006). Treatment plan is used to describe a written document detailing an individual’s goals and the plan for meeting them in relation to treatment. ‘Forward plan’ is the preferred term by staff because it entails similar things, but is seen to be a more empowering and solution-focused term.

Episodes of care (EOC) are the measurement of client outcomes in treatment, and relate to benchmarks for successful treatment outcomes (DHS 2007a).

In Victoria, these are used to ensure that a client entering an AOD service type in one locality should expect that the service they receive at that agency will address their individual needs and be of the same quality with the same core standards of service that they could expect at an agency elsewhere in the state, notwithstanding variations in service philosophy (DHS 2007a). They are a form of quality assurance and benchmarking utilised in the AOD sector.

The term ‘perilegal’ is used in the drug court context to refer to the community and health resources and infrastructure around or near the court system that support the operation of the drug court (Stojcevski 2006a).

This term refers to a model that emphasises active learning and is commonly used in reference to young people and their rehabilitation. It involves ‘a holistic process of engagement with the individual passion for life, ambitions, character, talents, and growth needs of a young person, in their preferred learning mode, including experiential learning’ (Bell 2005: 15).

The area of language can be a barrier if effective communication is not taking place, but it also presents an opportunity for enhanced collaboration, hybridisation, and new ways of achieving good practice together.

There is a salient need for increased continuity of service provision – as denoted by the term continuum of care. Collaboration and coordination are complex and require a lot of effort and resources, but it can be argued that the benefits outweigh the costs. Initiating the development of connections and capacity building in the sector will foster growth and successful partnerships. Links across sectors and amongst referring agencies need to be developed to
ensure best practice service provision which will benefit the organisations involved and, most importantly, the clients who use them.

**Planning and Facility Design**

The architecture, design and layout form key elements of the physical setting and overall atmosphere of the therapeutic community. The benchmark of good practice in relation to the physical setting is the balance between functionality and purpose and aesthetic and visually pleasing design. Atmosphere and feeling arising from the layout of the campus (internally and externally) is an important consideration. The campus should avoid looking like a hospital or prison and, where possible, should aim for the appearance of a normal living space. Obviously resources and finances are a consideration in achieving optimal design and aesthetic.

There is a complex balance to be maintained between the security imperative of protecting the safety of all on campus and having a therapeutic imperative of having a warm embracing community with space and freedom (i.e. not feeling like a prison). However, the two goals are not mutually exclusive. The establishment and communication of strict security and safety procedures need to be in place, and tested or practiced with regularity. Occupational health and safety considerations should be part of the induction of all clients and staff. Specific strategies should be in place to deal with crimes on campus, e.g. theft or assault. Duress buttons and security measures may be required for situations or areas on campus with moderate to high risk clients. However, violent and property crimes are not the only form of behaviour that need to be deflected. Things such as self-harm, suicide, use of contraband, and substance use on campus need to be focused on as well.

Situational crime prevention measures are specifically designed to alter the physical environment to deter security breaches and anti-social or criminal behaviour. In situations or areas where there is a moderate to high risk of inappropriate behaviour, it may be necessary to employ prevention strategies. Some sanctions may be more severe and coercive, and only used in response to crisis situations, and other sanctions may be naturalised and integrated into routine campus life. Wortley (2002) has devised four key strategies to reduce or eliminate the opportunity for anti-social and offending behaviour in residential institutions:

**Increasing perceived effort**

- **Target hardening** – this involves the physical installation of materials to act as deterrents or barriers to inappropriate behaviour taking place.

- **Access control** – this can involve the restriction of people to certain areas or closing off certain parts of a building or area to general access at specific times, for example, closing off areas like bedrooms during certain times to avoid the opportunity for theft.
Increasing perceived risks

- Entry-exit screening – this involves carrying out checking procedures to prevent contraband being brought in.
- Formal surveillance – this can involve drug testing, room checks, and staff doing rounds during high-risk times in areas that are prone to inappropriate behaviour taking place.
- Supervision by employees – this takes place during natural day-to-day staff interactions with clients across the campus.
- Natural surveillance – this includes open-plan designs and the defensible space principle in which clients are encouraged to take care of their territory. The placement of a person that is prone to self-harm in a shared room will reduce the likelihood of that behaviour, however, there are important considerations for the other clients involved regarding how this natural surveillance role affects them.

Reducing anticipated rewards

- Property identification – it is beneficial to identify property that has a probability of being stolen.
- Reducing temptation – this relates to avoiding situations of where a person with high levels of impulsivity may be presented with obvious opportunity.
- Denying benefits – this is designed to avoid giving in to overtly manipulation that seeks to gain from inappropriate behaviour, for example, a client that misbehaves and causes grief to other clients with the aim of getting their own room. However, this measure should be used with caution and in contexts where it is appropriate.

Increasing anticipated punishments

- Increasing costs – this can involve the use of warnings and sanctions for specific prohibited behaviour. It may also be done informally.
- Removing privileges – this is a basic behaviour control strategy of direct sanctions.
- Increasing social sanctions – if positive community values are shared and lived by the client and staff community, then social control can be a powerful way of ensuring that all people adhere to positive norms. Clients may discourage peers who are engaging in inappropriate behaviour because it is disrupting the positive balance of the community.

Source: Adapted from Wortley (2002: 66-72)
The strategies above are designed for offender populations, so it is necessary for the appropriateness and relevance of application to be judged by residential rehabilitation staff depending on the context of what is happening on campus. While the strategies seem rather strict and imposing for a residential community, they can be adapted and integrated in a way that is both functional and comfortable in response to a need for situational crime prevention.

**Post Release and the Continuum of Care**

The Post Release Options Project (PROP) provides an excellent assessment of issues including throughcare, the continuum of care, referral, outreach, reintegration and transitional support. This project is a collaborative effort of practitioners and academics at Bethlehem House and the University of Tasmania that aims to identify and overcome issues surrounding prisoner post-release needs and gaps in service coordination (Criminology Research Unit 2007). However, there are some important points that are of benefit and wider application to people with complex needs in a variety of situations. In the context of residential rehabilitation, upon release, the client will be no longer living or engaging in treatment intervention at the residential campus, thus there is a hand-over to an outreach worker and other community service agencies dependent on individual needs. According to the PROP model, clients with complex needs require a ‘collaborative, inter-agency, multi-disciplinary model of practice to produce optimal and sustainable client outcomes’ upon leaving an institution (Van Aaken & Burton cited in Criminology Research Unit 2007: 14). To ensure the post-release continuum of care for clients requiring support from multiple services, the model proposes the following steps in the transition into the community and rehabilitation process:

- **Identification by an agency/worker of an exceptional needs case** – this involves the identification of people that will require more than just the support of one outreach worker from one agency in the community.

- **Informed consent by the client** – this may have already been gathered if multi-agency collaborative partnerships were already established earlier in their residential rehabilitation. However, it is important that the client be informed of the ongoing information flow between participating agencies upon their transition to the community.

- **Assessment of needs and issues** – as part of the continuum of assessment (see Volume 2 of the present Report), client needs and issues need to be assessed at various times throughout their transition through rehabilitation.

- **Identification of current and past agencies engaged** – this forms the basis for the case team that may be supporting the client in the community.
• **Appointment of a lead agency** – if it is the outreach worker’s wish or the client’s wish for the rehabilitation organisation to no longer be the lead agency, it is important to designate an agency to coordinate interventions and undertake the overall case management. There may be a hand-over meeting or phase.

• **Ongoing commitment from all participating agencies** – commitment is sought and given by all agencies and the client to ensure this process achieves a successful outcome. Timely communication is integral to the success of the model and enhancing the possibility of optimising client outcomes.

Source: Adapted from Van Aaken & Burton cited in Criminology Research Unit (2007: 14).

The PROP post-release case management model is asserted to be more effective, thorough and innovative than the simple two-worker agency exclusive model because ‘it is the inherent flexibility built into this model that ensures that the client’s needs are met in a holistic and timely manner’ (Van Aaken & Burton cited in Criminology Research Unit 2007: 15).

Thus, the continuum of care is an important element of the post-release transition into the community for each individual client that participates in residential rehabilitation. For example, issues such as employment and housing will be significant undertakings for some clients, who need referral and assistance in embarking on a new drug-free lifestyle of wellbeing. It is the task of the agency to ensure clear protocols are designed, and that high quality intra-agency and inter-agency working relationships are in place in order to care for the client post-release in a flexible and relevant manner. In other words, communication and collaboration are as important to the work of outreach staff as they are to staff working on campus. The promotion of things such as client self-advocacy, self-determination, recovery, empowerment and independence will assist the agency in slowly decreasing their assistance towards the end of the continuum of care, with the aim of reaching the point of the client achieving a level of wellbeing in the community where they no longer require contact or support.

**Evaluation and Performance Indicators**

Once the implementation process of setting up is completed, it is another undertaking to assess the efficiency, effectiveness, impact and outcomes of new projects or interventions. To put it simply, the next stage is to determine what works, how, why and for whom. But this does not necessarily denote the pragmatic and blunt question of ‘what works’, but involves both qualitative and quantitative research using different methodologies to contribute depth of
understanding and an evidence base regarding different facets of the project and interventions. There are two different types of evaluation research:

1. **Formative evaluations** are used during the task of progressively forming a programme or project. They are conducted with the intention of providing information that can be responded to reflexively within the programme; information that used to adjust or inform the conduct of the programme. In other words, the focus of formative evaluation is upon process’ (Favilla, Goh, McDermott, Meadows & Wadsworth 2007: 245).

2. **Summative Evaluations** aim ‘to summate information relating to a programme. It is often aimed at assessing the overall value of a programme or activity in question to inform judgments about whether or not it should continue. In other words, summative evaluations are about outcomes’ (Favilla et al. 2007: 245).

There are significant distinctions between the two, and choices must be made as early as possible as to which type of evaluation will be undertaken.

There are various reasons for conducting an evaluation. Favilla et al. (2007: 246-247) assert that evaluation is important:

- For accountability purposes: services and programs are accountable to funders, service users, service providers, the community in general, as well as the various professional communities.
- In order to know what works in a situation, and what does not work.
- In order to monitor what is being done.
- In order to generate knowledge, especially in regard to value, merit, worth, and significance.
- In order to test out or verify what is known.
- In order to keep a programme response to changes in needs, attitudes, or the priority given particular issues on the public agenda.
- Individually or in groups, service providers may engage in evaluation because:
  - They want to know about the efficiency of their own practice.
  - They want to explore and understand their own experience.
  - They want to participate in or play a part in effecting systemic or organisational change, or consider changes to existing treatment and intervention practices.

Favilla et al. (2007) assert that an evaluation is incomplete unless the suggested changes for improvement that emerge from it are realistic pragmatic recommendations are enacted.
Evaluations are an increasingly utilised assessment tool in organisations, but there can sometimes be difficulty in enacting all recommendations and implementing organisational change for a variety of reasons.

It is important to define key terms and concepts and establish what is meant by these commonly used terms in evaluation research and organisational monitoring. Quality assurance is about ‘standards that are set for a product or service, and where, if the production meets the standards, the client or consumer is thereby assured of quality’ (Favilla et al. 2007: 254). It is a simplistic idea that is difficult to assess and implement in practice (Favilla et al. 2007). However, as with many sectors in health care, there are often policies, plans, benchmarks or standards that apply to the whole sector and are governed by nationally recognised healthcare institutions or national or state governments. A good quality assurance programme should include the following elements: ‘problem-identification; problem assessment; implementation of measures to reduce or eliminate problems; and evaluation and monitoring of the effectiveness of implemented changes’ (Favilla et al. 2007: 255). In addition to this, there are the popular terms ‘continuous quality improvement’ and ‘total quality management’ which build on the quality assurance model through promoting the concept of quality management (Favilla et al. 2007). Quality management is ‘concerned with best practice and continuous improvement in patient care, delivery of service, staff satisfaction, and financial responsibility, and seeks potential for excellence at local, national and international levels’ (Favilla et al. 2007: 255).

*Reservations regarding evaluation research*

The most basic premise or aim of evaluation is to assess the merits and effectiveness of ‘programmes that are designed to improve the welfare of people, organisations, and society’ (Shadish et al. 1991, cited in Christie 2003). It is increasingly becoming one of the most commonly used researched methodologies in the fields of criminal justice and health (Travers 2005a). Despite its increasing popularity and widespread use, it is certainly not without its detractors, who raise some compelling points that all researchers should have an awareness of.

One of the main criticisms of evaluation research, at a basic level, revolves around the old proverb ‘He who pays the piper picks the tune.’ A more complex political critique stemming from that criticism is the perception that evaluations always ‘present an upbeat picture of organisations struggling with and overcoming problems in a process of ‘continuous improvement’ that must reflect the views of those who commissioned the research’ (Travers 2005a: 40). Thus, hierarchies of power, managerial bias, and vested interests are part of the political climate and organisational context in which the research takes place.
Another criticism of evaluation research is that it does not utilise methodology or academic standards that are rigorous or objective enough (Travers 2005a). Two points are relevant to this: the majority of evaluation studies rely mainly on quantitative statistics which are deemed ‘unimaginative’, and statistics within small-scale evaluations are often readily adopted at face value without necessarily having stringent validity or reliability (Travers 2005a). In addition to this, it is noted that convincing organisations that more thoughtful and rigorous evaluation (which inevitably require more time and money, and may have a higher likelihood of generating criticism) is worthwhile is a difficult undertaking (Travers 2005b). These criticisms of academic laxness can be overcome by utilising skillfully designed evaluation research that is relevant, valid, interesting, and offers insight into the project or interventions being analysed. In order to do this, a multiple method approach using multiple data sources will add a richness and soundness to the data obtained, using quantitative and qualitative to complement each other, thus painting the whole picture in a multi-dimensional and context specific way.

There are also various challenges that can be experienced in conducting evaluation research of a high standard. Freeman (2003) conducted an evaluation of Australia’s first drug court. The evaluation was quite comprehensive and incorporated rigorous data collection on elements such as monitoring, cost-effectiveness, health and well-being, and a process evaluation (Freeman 2003). Concerns were expressed from different parties and the researcher experienced challenges in the following areas:

- **Demand on resources** – conducting the evaluation placed pressure on the workload of the staff being researched would not have otherwise occurred.
- **The need for a broader approach** – there was apparent distrust of researchers, and concerns about relying heavily on quantitative statistics that missed the qualitative and anecdotal stories of success that might occur.
- **Measure of drug use** – drug use was a key measure of health and well-being, but getting a reliable measure of drug use while on the programme proved difficult.
- **Reporting pressures and outcome expectations** – dealing with reporting findings that fell short of some stakeholders’ expectations is always a risk with evaluation.

Source: Freeman (2003: 2-6)

The point made for the need for a broader approach due to distrust of researchers and an absence of in-depth qualitative communication and information is something that is not unique to this specific evaluation. In research on the relationship between evaluation researchers and drug court practitioners, a key finding was that ‘as in many areas of social policy, researchers and practitioners rarely talk to one another… There were several reasons cited, but they all spoke generally to a single theme: the cultural divide between research and practice’ (Centre
for Court Innovation 2007c). The challenge of integrating evaluation and seeing researchers as an important member of the team in taking the programme forward into the future is important to overcome.

Freeman (2003: 7) concludes that ‘while the drug court was successful in achieving its objectives, it was not as successful as some had anticipated, and received a cool response from some stakeholders.’ Different definitions, measures and perceptions of success amongst stakeholders reflect different interests and realistic or unrealistic outcome expectations.

The wider body of literature on Australian drug diversion initiatives suggests that evaluations need to take a more holistic approach to encompass the diversity of factors involved (Wundersitz 2007). Inadequate cost related data and analysis can lead to conclusions that are not based on extensive evidence and comprehensive consideration of the diversion project.

The development of performance indicators

Measuring performance and progress is a multi-faceted and intricate activity, especially within an alcohol and other drug rehabilitation service that deals with clients with complex needs. A process of development, implementation, and testing of performance measures takes place within the organisation, before it is then possible to compare performance indicators with other collaborative agencies within the health and justice sectors. Thus, performance measures can be used for internal and external accountability. Some key suggestions and guidelines to developing performance indicators for alcohol and other drug services have been outlined, (those written by researchers in the United States are referenced, and those written by the authors are unreferenced):

- A carefully designed mission and values statement should reflect the areas within which the organisation or agency wishes to measure performance (McCorry, Garnick, Bartlett, Cotter, & Chalk 2000).

- Measurement of external accountability is important for accreditation, sectoral regulation and development. This implies a pre-existing agreed upon standard that exists within the sector. Responsibility for performance measurement ‘exists at the service delivery level – this reflects the process of care’ (McCorry et al. 2000: 636).

- Pre-entry identification of prospective clients, referral, and efficiency of service engagement in rehabilitation are important measures of performance pertaining to getting clients to enter rehab. Barriers to accessibility should be identified in light of performance measures if clients are failing to enter the programme.

- Treatment engagement and treatment retention rates are key performance indicators.
• Amount and efficiency of referral and integration of care for clients with complex needs should be measured.

• Post-release, outreach and the continuum of care – how a system of care organises its services to support the individual’s post-exit sobriety is an important indicator of performance (McCorry et al. 2000: 639). The maintenance of treatment effects should be measured to appraise individual client outcomes post-release.

• Quantity and quality of communication and collaboration should be mapped as part of the evaluative process. This may be measured from the day-to-day workings of case workers in collaborative practice with other intra-agency and inter-agency practitioners.

Also, the acronym SMART is used in many organisations to describe how performance measurement and evaluative practice should be designed:

• Specific,
• Measurable,
• Achievable,
• Realistic, and
• Time-bound

While relatively simplistic, this approach ensures that workers are not placed under pressure to achieve vague, unrealistic, or perpetual goals with no specificity or detail of what they are aiming for.

Evaluation research as a reflexive process of high quality data collection

The Centre for Court Innovation has conducted an informative assessment of transitions and developments in research into drug courts and court mandated diversion, and the researchers suggest the need for ‘moving beyond “do they work?”’ (Cissner & Rempel 2005). Action research is suggested as an effective tool or method of collecting data within the context of a drug court. Important areas of information are treatment programme feedback; consequences of compliance, non-compliance, graduation or failure; criminogenic and legal needs; and a case manager survey (Rempel 2005: 14). Performance indicators will vary in nature and degree of specificity according to the level of information required to assess the effectiveness of a programme or intervention. They need to be individualised and targeted at levels of productivity and areas of intervention that are the focus of evaluation.
An example of good practice in evaluating a service was conducted by researchers from Turning Point Alcohol and Drug Centre, titled an ‘Evaluation of Primary Health Services’, which provides beneficial areas of focus and high quality evaluation methodology. The project reviewed 12 primary health services and other programmes funded by the Local Drug Strategy ‘Saving Lives’ policy in Victoria (Norman, Mugavin, & Swan 2006). Key areas covered in the evaluation research were: the profile of clients, accessibility of primary health services, holistic model of health care, empowerment model of care, assessment and intervention plans, staff profile, continuity of care, client access to other services, and data collection and reporting data (Norman et al. 2006). A number of data sources were used to contribute to research data collection, including a self-assessment questionnaire for managers, client snapshot surveys, existing service information, and a collaborative review process (Norman et al. 2006).

Box 2.c contains a compilation of questions asked of more senior staff members to answer on behalf of their service. Some of the questions were accompanied by Likert scales (ratings scales) to indicate the extent to which a specific issue or action occurs.
Box 2.c: Good Practice Evaluative Questions

The following are excerpts of some of the questions asked of Primary Health Service managers in a self-assessment survey:

- What is the philosophy of your service? What are the goals and/or objectives?
- What specific services are available through your service, and at what times and days?
- Please indicate how your service provides the following to clients: a comfortable space, a feeling of safety, a friendly environment, good location, good staff, appropriate open hours, multicultural environment, non-appointment based system, non-judgmental approach, and a relaxed service.
- How do clients access your service? Outline a variety of processes of referral.
- How has your service made itself accessible to your general target group?
- How has your service made itself accessible to any special needs groups? Please identify these groups and specify your strategies for each group.
- How are the needs of clients assessed?
- How are intervention/care plans developed? How are these plans implemented?
- Please provide an example of how you provide continuity of care in your organisation.
- List the other agencies/professionals with which this programme has contacts/links with on a regular basis. Specify referrals to co-located services and external services.
- Are clients supported to have an active role in improving their health and wellbeing? How?
- Please present some (anonymous) individual case examples that reflect your client group.
- Please describe the target group of this service.
- Please outline your staffing profile. Include all staff who work at the service.
- What staff supervision arrangements, if any, do you have within the service?
- What kinds of ethical issues do your staff encounter as part of your work?
- Describe any problem areas or concerns encountered with respect to service provision.
- What is the best thing about this service?


Some of the areas covered are primary health service specific, but there are other facets that can be generalised for assessment of a variety of services in the alcohol and drug sector.

It is important that evaluation research data collection and monitoring be built in to the existing service delivery context. A ‘culture of evaluation’ can be developed in which evaluation is not encountered by staff or clients as threatening or invasive, but as a continuous positive and supportive process of affirmative reflexivity and improvement (White & Coventry, 2000).
Volume 2 provides further articulation on the practical elements involved in conducting evaluation.

Involving clients in development, evaluation and organisational change

In a first of its kind, new research has been conducted on the level participation and consultation in service delivery of clients through the Treatment Service Users Project. Both service providers and service consumers were interviewed, as well as the consultation of service consumer organisations. The study shows that 71.9% of service providers and 70.4% of service consumers supported the involvement of consumer representatives in decision-making and evaluative appraisal (Mundy 2007). However, current levels of client participation in mid-level or higher-level workforce development and organisational change are in need of improvement beyond simply using token-effort measures. The study found that:

In those drug treatment services which do encourage consumer participation, activities are mostly ‘low level’ (such as complaints systems and suggestion boxes) or ‘middle level’ (such as supporting consumers to produce their own educational resources or involving them in certain aspects of staff training), but rarely ‘high level’ activities such as membership on boards or management committees that make key organisational and policy decisions (Mundy 2007: 26).

These findings demonstrate a power imbalance between practitioners and clients which can impede dialogue and effective collaboration between the two groups (Mundy 2007). This is counterproductive to service engagement: ‘people are more likely to walk away from a service if they don’t have a stake in it and have no input in the way it is delivered. And above all it is a basic right of consumers to be consulted in relation to their service needs’ (Mundy 2007: 27).

Consumer/client participation in workforce development provides a positive opportunity for strategic service delivery planning and improvement. Quality assurance and quality improvement should be inclusive of client perspectives, and any evaluation of programmes and interventions should involve client advocacy and input that is significant and used in a meaningful way to inform and direct organisational change.
Conclusion

Volume 1 of this Report has provided a review of literature that is pertinent to the topic of residential drug rehabilitation. The first part offered a survey of existing projects, programmes and services in several different jurisdictions. Key approaches and concepts of intervention were identified, and the orientation and activities of practitioners was discussed in various service contexts. Emergent issues and difficulties in the field generally were also noted, particularly with respect to the use of ‘ice’ and ‘benzos’.

As described in part two of this Volume, it is evident that there are strong inter-connections and dynamic relationships between the different sections reviewed: philosophy as a driver of practice: drugs; philosophy as a driver of practice: service; principles of good practice: the client; and principles of good practice in relation to service provision. The complexity of practice that practitioners navigate on a daily basis is reflected in these fluid inter-connections and relationships.

Throughout this Volume, there are clear themes that emerge and are raised repeatedly in the literature for different areas of practice:

- The importance of specific evidence-based interventions for different client groups
- Integration of client services, integrated care, and a holistic client-centred approach
- Client competency development and strengths based practice
- Individual agency and client participation in a variety of areas, especially case planning and service delivery evaluation processes
- Collaboration and communication, with high levels of commitment, partnership, and concerted input from all relevant stakeholders
- The importance of aiming towards benchmarks or specific criteria in enacting organisational change and high calibre of service delivery

These themes are key strategic elements integral to attaining good practice in residential drug and alcohol rehabilitation.
The case studies and models reviewed in this Volume all contain a specific focus or element that contributes towards good practice – it is through the gathering together of the strengths from each case study and model that an overall picture of good practice takes shape.

The Model of Residential Drug Rehabilitation presented in Volume 2 represents an amalgamation and condensation of the strengths and principles gained from the literature review contained herein. It builds upon these to provide a literature-based/evidence-based practical model that is intended to assist agencies in designing successful interventions in this area.
References


Turning Point (2006a) *Strategic Directions and Goals 2006-2010* Fitzroy: Turning Point Alcohol and Drug Centre.

Turning Point (2006b) *Turning Point Alcohol and Drug Centre Annual Report 2006* Fitzroy: Turning Point Alcohol and Drug Centre.


Websites and Resources

- Alcohol and other drugs: a website for general practitioners and health professionals, Australia. www.aodgp.gov.au
- Alcohol Education and Rehabilitation Foundation, Australia. www.aerf.com.au
- Alcohol and other Drugs Council of Australia. www.adca.org.au
- Arbias (specialists in alcohol and substance related brain injury), Australia. www.arbias.org.au
- Australian Drug Foundation. www.adf.org.au
- Australian National Council on Drugs. www.ancd.org.au
- Centre for Court Innovation (especially drug courts), America. www.courtinnovation.org
- Alcohol, Tobacco and other Drugs Council of Tasmania. www.atdc.org.au
- Centre for Youth Drug Studies, Australia. www.cyds.adf.org.au
- Drug Info Clearinghouse, Australia. www.druginfo.adf.org.au
- Hepatitis Australia. www.hepatitisaustralia.com
- International Council on Alcohol and Addictions. www.icaa.ch


• National Drugs Campaign, Australia. www.drugs.health.gov.au

• National Drug Research Institute, Australia. www.ndri.curtin.edu.au

• National Drug Strategy, Australia. www.nationaldrugstrategy.gov.au

• National Institute on Drug Abuse, United States. www.drugabuse.gov

• Service Standards for Addiction Therapeutic Communities, United Kingdom. http://www.rcpsych.ac.uk/pdf/Service%20Standards%20for%20Addictions%201st%20edition%202006.pdf

• Tackling Drugs, Changing Lives Campaign, Home Office, United Kingdom. www.drugs.gov.uk

• Tasmanian ATOD Services Review 2007, Department of Health and Human Services. www.dhhs.tas.gov.au

• Tasmanian Council on AIDS, Hepatitis and Related Diseases. www.tascahrd.org.au


• Tasmanian Law Reform Institute. For the research paper on the drug court pilot, see: http://www.law.utas.edu.au/reform/

• Turning Point Alcohol and Drug Centre, Australia. www.turningpoint.org.au

• Turning Point Healthy Liver Clinic. http://hlc.turningpoint.org.au

• United Nations Office on Drugs and Crime. www.unodc.org

• We Help Ourselves, Australia. www.whos.com.au

• World Federation of Therapeutic Communities. www.wftc.org

• Youth Substance Abuse Service, Australia. www.ysas.org.au