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# Alcohol and Other Drug Treatment for Criminal Justice Clients

## Service Provider Engagement Summary

(Not Government Policy)

**Alcohol and Other Drug Treatment for Criminal Justice Clients: Service Provider Engagement Summary**

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# Introduction

In 2015, the Mental Health Alcohol and Other Drugs Branch (MHAODB), Queensland Police Service (QPS) and Department of Justice and Attorney-General (DJAG) commenced discussions to review and reform the Police Drug Diversion Program (PDDP) and Illicit Drugs Court Diversion Program (IDCDP). Specifically, expanding the PDDP from cannabis to all illicit drugs, enabling delivery of the Drug Assessment and Education Sessions (DAES) by telecommunication technologies and simplifying the appointment rescheduling processes. The PDDP and IDCDP will be referred to as Police Court Diversion (PCD) throughout this document.

In 2016, the Drug and Specialists Courts Review: Final Report (DSCR) was released. The DSCR made 39 recommendations including the reinstatement of a drug court in Queensland and development of an overarching framework to support offenders with problematic alcohol and other drug (AOD) use. In recognition of the early intervention approach of police referral to AOD treatment, diversion was included in the scope of the review.

Recommendations 2 and 3 of the DSCR provide principles for interventions in a criminal justice context and framework while recommendations 4, 5 and 6 advise government to consider expanding pre-arrest and post-arrest options for minor drug offences, review and rationalise Brief Intervention (BI) programs and consider a generic integrated assessment, referral and support scheme (now known as Courtlink). The DCSR also encourages policy makers to consider the needs and culture of Aboriginal and Torres Strait Islander people when designing programs and treatment.

In order to discuss and explore opportunities in relation to AOD service provision for clients referred from the criminal justice system (CJS), officers from the MHAODB met with AOD treatment service providers (services) across the state between August and November 2018[1]. The primary aim was to identify opportunities to develop contemporary treatment approaches aligned with the recommendations of the DSCR. The focus was on PCD and Drug and Alcohol Assessment and Referral (DAAR) program, engagement also facilitated discussion about AOD treatment options and programs available to clients referred from other police and court programs and clients referred from probation and parole. Engagement with service providers assists the MHAODB, as a system enabler, to drive quality and clinical improvement agendas for Queensland Health, and make informed contributions to whole of government policy

This report provides a summary of themes identified by service providers across the state by referral point from the criminal justice system. It is acknowledged that there were local differences across the state, however, this report discusses commonalities.

# Summary of Findings

Numerous treatment options and programs are available, some of which have been developed specifically for CJS clients. The delivery of Brief Intervention (BI) programs, specifically PCD and DAAR, was largely consistent. Some services felt that the DAAR program was duplicative of the PCD programs and were uncertain of its effectiveness.

Services reported that a single BI is suitable for most PCD and DAAR clients, however, in some circumstances it would be beneficial to offer follow-up sessions (within the same AOD service) to reaffirm the client's commitment to change and allow further exploration of issues.

[1] Note: One further engagement in January 2019

Telephone delivery was considered a helpful option for people who have difficulty accessing services and is more efficient for some services, particularly those delivering the diversion programs in regional and remote areas. However, services felt there should always be an option to participate face-to-face. Perspectives on group sessions was mixed among providers; those that did not deliver group sessions were not supportive of this modality for PCD. Services were strongly supportive of expanding PDDP to include all illicit drugs and streamline the rescheduling process and introducing a police warning or caution prior to referral to a diversion program.

While there was consistency in the delivery of programs provided by single organisations across multiple locations, there was considerable variation between services in relation to referral, programs and treatment models for other CJS clients, particularly probation and parole clients. For example, residential rehabilitation programs range between 6 and 12 weeks with varying levels of individual counselling and tailored treatment. While some services ran specific programs on behalf of Queensland Corrective Services, most treatment services provided the same treatment responses and programs as those for the mainstream population. Services reported that regardless of whether a client was formally referred for treatment through the CJS, a high volume of clients have had contact with the justice system.

Services also reported an increase in referrals from the CJS in recent years and acknowledged that a collaborative working relationship with the CJS is important to achieving positive outcomes for clients, the community, health and criminal justice sectors. Generally, communication and referral pathways between health service providers and the CJS is positive and seamless. However, some issues were raised regarding the appropriateness of referrals, program delivery, engagement, and communication and information sharing.

Services acknowledge the need to streamline pathways from CJS into AOD treatment and revise current approaches in accordance with the principle of treatment matching the needs of the client. Some services suggested an improved model based on triage, whereby CJS clients are referred to a program or treatment type after an initial AOD assessment. A few services further suggested the AOD assessment process is performed under a centralised model. Offering pre-and post-treatment support was seen as beneficial to both clients and services.

Services supported the notion of expanding the range of pre-court options, such as revising eligibility criteria for the PDDP to include all illicit drugs and introduce adult cautioning or warnings.

The benefits of AOD treatment for people referred from the CJS is well recognised. While acknowledging that AOD dependence can be a chronic relapsing condition, services spoke of the positive outcomes that can be achieved by working with these client groups.

# Service Engagement Approach

Officers from the MHAODB met with organisations providing AOD treatment to people involved with the CJS during late August, October and early November 2018. MHAODB met with a mix of state funded non-government organisations (NGOs) and AOD treatment services from Hospital and Health Services (HHS) (see appendices). Most meetings occurred onsite at the AOD treatment service. Where this was not possible, meetings were conducted via teleconference.

# Police and Court Diversion

Police and court diversion programs are viewed as an important part of the treatment spectrum. A variety of programs currently exist including the PDDP, IDCDP, DAAR, QMERIT and Courtlink. These programs differ regarding eligibility and the stage of the CJS where referral may occur.

## Common themes

- The demographic of PCD and DAAR clients and treatment delivered is very similar.
- Polydrug use is common and often alcohol is the primary drug of concern.
- A BI is suitable for most PCD and DAAR clients, however, it in some circumstances it would be beneficial to offer follow-up sessions (within the same AOD service) to reaffirm the client's commitment to change and allow further exploration of issues.
- Individual sessions are preferred to group sessions for PCD as they allow sessions to be specifically tailored to meet the needs of clients. However, group sessions have been introduced in some metropolitan areas with high-volume referrals to improve efficiency, address client needs and reduce wait times for appointments.
- Telephone delivery was identified as beneficial for people who have difficulty accessing services but is not suitable for people with severe AOD dependence or those with complex needs.
- Some providers suggested updating the Police and Court Diversion Service Provider Manual to include more detail about the therapeutic intervention.
- Consideration should be given to developing a suite of resources for PCD clients.
- PCD eligibility criteria excludes many people from participating, particularly Aboriginal and Torres Strait Islander people for a variety of reasons.
- Services were strongly supportive of expanding PDDP to include all illicit drugs and streamline the rescheduling process.
- Introducing a police warning or caution with information and education as a step before offering a diversion to brief intervention was also well supported.
- QMERIT clients have a higher level of criminality and substance dependence than PCD and DAAR clients.
- QMERIT is a well-regarded program model with positive client outcomes reported.
- As Courtlink has recently been established, little is known about the program and clientele.

## PDDP, IDCDP and DAAR

Diversion programs provide an opportunity to identify and address emerging problematic substance use and are often the first interaction the diverted person has with an AOD treatment service. The PCD programs and DAAR are an opportunity intervene early and give clients a positive experience of AOD services to encourage clients to return in the future if needed. Some services stated that the DAAR program was duplicative of the PCD program and were uncertain of its effectiveness.

### About the clients

The demographic of PCD participants is broad; however, the majority are non-Indigenous males between 18 and 25 years of age who are not substance use dependent. The DAAR cohort is very similar to the PCD cohort, but are slightly older.

Services described four types of PCD of clients:

- *Non-illicit drug takers.* These clients do not use illicit drugs. They were referred to PCD after accepting responsibility for a friend or family member, were residing in a share house or travelling in a car where drugs or paraphernalia were found. This is a small portion of the clients referred to PCD.
- *Action takers.* These clients recognise the negative impacts of substance use and engage well in the BI. These clients include those that have ceased substance use prior to the BI as they were "scared" by their interaction with the CJS.
- *Pre-contemplators*. These clients do not intend to change their behaviour. Their attendance is solely to comply with the police direction or court order. This group includes "happy users" who do not recognise problems associated with their substance use as well as people who recognise their use causes problems but do not wish to change their behaviour.
- *Complex clients*. This is a small proportion of clients who vary in their stage of change. These clients are substance dependent, commonly experience anxiety and depression and many have a history of trauma. Low literacy is of high prevalence. It was noted by several services that clients with complex needs benefit more from AOD treatment when other issues, such as housing and employment are also being addressed. This group also includes clients who use substances to self-medicate for physical and/or mental health issues.

## Drug Trends

Although most people were referred to these programs for cannabis related offences, commonly another substance is the primary drug of concern (PDOC); often alcohol.

The number of clients who use methamphetamine, specifically crystal methamphetamine (ice) has increased in recent years but is declining again. Some providers stated this downward trend in ice use has not been seen among Aboriginal and Torres Strait Islander people. People who use ice are more likely be substance dependent than people using other drug types. While injecting drug use is less common, it is common among people who use ice or steroids.

Services reported that polydrug use is common among people referred to PCD. Finally, there has been an increase in cocaine use in some areas.

## Eligibility

Some services thought the eligibility criteria too restrictive, and as a result excludes many people who would benefit from participating in PCD, particularly Aboriginal and Torres Strait Islander people. For example, Aboriginal and Torres Strait Islander people who have a history of violent offences, are apprehended for other minor offences in addition to drug possession, have been advised not to plead guilty and are more reluctant to be interviewed by police. Further, alcohol is more likely to be the PDOC and is not included in the eligibility criteria for PCD.

People apprehended with multiple substances (likely among people who engage in polydrug use) are ineligible for PCD. Given the increase in polysubstance use, this exclusion criteria are likely to exclude proportionately more people over time.

## Referral to PCD and DAAR

Services stated the referral process for PCD and DAAR worked well. However, fluctuations in referrals impact appointment wait times and staffing levels. In regional, rural and remote areas it can be difficult to recruit staff to assist managing sudden increases in demand. Where demand decreases, it may be necessary to end contracts for casual staff.

Numerous services reported they received clients who had been given incorrect information about PCD, indicating a potential lack of understanding among police and court staff about the type and format of interventions delivered through PCD. For example, some clients were told they would only need to watch a DVD or attend a group program. Other clients arrived at a session anxious about sharing information in a group or being identified. This misinformation was identified by some services as detrimental to delivering an effective BI as client's expectations were different and it therefore takes longer for the clinician to develop rapport and trust with the client. Services suggested it would be beneficial to provide clients with information about PCD at the time of referral.

Some clinicians stated that there may be less willingness from police and courts to offer diversion programs to Aboriginal and Torres Strait Islander people. It was also noted by a few services that alcohol use is more prevalent than other drugs and is most problematic in the community, however, very few people are being referred through the DAAR program (as the only program that includes alcohol).

It was identified that providing feedback to police and court staff about referral and treatment outcomes may encourage greater referrals and acceptability of diversion programs.

## The DAES

### Screening and Assessment

The assessment tools and therapeutic approaches utilised in the delivery of PCD and DAAR were mostly consistent across the state. The duration of the BI ranged between one and two hours, varying by service, mode of delivery and client.

The Queensland Health Biopsychosocial Assessment Tool was well regarded and used by all services who deliver PCD. Some services suggested minor changes would improve the tool. ASSIST was used by services who deliver DAAR. The DASS21 and Kessler 10 were also being used by most services. A few services also use a suicide risk assessment tool where clinically indicated.

Depending on the clinician, assessment is completed as a stand-alone part of the intervention, followed by information and education, while other clinicians conduct assessment throughout the session utilising a narrative approach.

### Intervention

All services who deliver PCD and DAAR utilise psycho-social treatment approaches such as Cognitive Behaviour Therapy, Motivational Interviewing, Mindfulness and Stages of Change during the BI. Some services stated that being able to access resources supporting these approaches via rediCASE was helpful, while other services had their own versions.

Providing education and information about drugs and the law is a common component of the BI. Services reported that many clients hold limited knowledge about the legal consequences of drug possession and use, including the legal consequences of living or being with someone who has drugs or paraphernalia in the house or car. Additionally, people visiting from other countries were often unaware of Australian drug laws.

Some services also reported that clients compare themselves to their social and family groups. Social and family groups may be a source of support and assist with positive behavioural change. However, clients whose family and social groups also participate in or enable risky substance use may find it more challenging to change their behaviour. For some clients, risky substance use can be normalised among peer and family groups These clients may be unaware that their level of substance use is higher than the general population and associated with harm. Therefore, providing information and education about alcohol consumption and substance use in Australia formed an important part of the BI. It was also

noted that clients in small towns may find it particularly difficult to find and establish new relationships with people who do not partake in substance use.

The Police and Court Diversion Manual was acknowledged as an important tool to achieve a level of consistency in the delivery of PCD between services. A few services suggested the manual could be improved by including more guidance on the therapeutic aspects of delivery. Many services also stated that a library of print and online resources for clients would be helpful.

**Referral**

Clinicians felt that the majority of PCD clients benefit from one BI session. However, it was also identified that approximately one third of clients would benefit from a follow up appointment or multiple sessions of counselling. These sessions could be used to reinforce a client's commitment to change and explore topics that were not covered or that required further discussion. There was no consensus on the amount of sessions that would best match the PCD cohort. This may be due to the variety of clients referred to PCD and DAAR.

Under the existing service agreements with NGOs for the provision of PCD and DAAR, services are unable to offer an additional session as the funding is for a single session BI. Generally, services with a larger range of other programs or counselling services offer and refer clients within their service. Services that deliver fewer or no alternative programs and/or services in their area are unable to see the client again and refer to services external to their organisation where available. Services believed that regardless of whether the referral is internal or external to their organisation, there is low client demand and uptake for this.

It was also reported that clients who are offered referrals to other programs or services frequently expressed a desire to see the same clinician as they felt comfortable with the clinician and wanted to avoid re-telling their story. It would be beneficial to share client information between referring agencies to minimize the amount of information clients need to tell the new service provider/clinician.

**Modality**

Most services deliver BI's via individual face-to-face sessions, five services were participating in trialling telephone delivery and three services delivered group sessions.

*Group Sessions*

Group sessions are delivered in locations with high demand and have reportedly improved appointment wait times and service efficiency as less clinical time is lost when clients do not attend.

Services that delivered the group sessions follow the same format and include very similar content. Sessions are offered as youth or adult only with a maximum of 15 people. Clients participating in a group session self-complete an assessment form which takes approximately 15 minutes. The assessment form is then provided to an administration staff member or counsellor to review while the group information and education session is delivered. Group sessions are run on a didactic model utilising a power point presentation to limit the disclosure of the participants' drug use, personal issues or offending history. The session is facilitated by a counsellor who talks the group through the power point presentation of approximately 45 minutes duration. Clients then wait for the counsellor to provide individual feedback on their assessment in private area. Depending on numbers, some clients may wait up to 45 minutes for this feedback.

Participants who are deemed not appropriate for group work such as clients from non-english speaking backgrounds, mothers with babies or people with certain mental illnesses will be seen individually by another counsellor. Identifying clients who are unsuitable for group work occurs upon attendance to the service.

Services that did not deliver group sessions were generally not supportive of this modality for PCD. Primarily, these services stated that clients need to feel comfortable disclosing personal information and life experiences to gain the most from their participation in PCD. In the circumstances where someone was told incorrectly that their diversion would be in group format, services reported that these clients expressed concern about participating in this format. Further, people living in less populated areas were more likely to know the clinician or others participating in a group session. Among Aboriginal and Torres Strait Islander people, dynamics between family groups may improve or impede attendance and participation in group sessions.

Concern was also expressed that services may offer group sessions to improve service efficiency, however, some providers thought that this potentially meant less session times being available for participants making it difficult for clients to participate and complete sessions.

*Telephone*

Opinions about telephone delivery varied between services and clinicians. Generally, clinicians who had experience delivering telephone counselling were more supportive of this modality.

Services identified many benefits to telephone delivery. Specifically, telephone delivery is beneficial for clients who have difficulty accessing a face-to-face service such as people who live in regional or remote areas, work or reside interstate or internationally, parents and carers and people experiencing some mental health conditions.

It was suggested that some clients may engage better and disclose more by telephone as this modality is less confronting than face-to-face interventions. Additionally, clients who participate in a telephone intervention may feel less anxiety and experience less stigmatisation than when required to attend a service. Telephone delivery was considered more cost and time effective for clients and services who travel long distances to participate in or deliver the program.

However, the absence of non-verbal cues makes it more challenging to develop rapport and identify areas for further exploration and discussion. Many services stated that targeted training for clinicians would be required to support the implementation of telephone delivery.

Many clinicians thought face-to-face delivery had greater impact as it is easier to establish rapport and identify areas for further exploration. Clinicians also thought that clients view the ramifications of not attending a face-to-face session with greater significance than the ramifications of not attending a telephone session. Most services noted that telephone delivery is not suitable for people with severe substance dependence or complex needs without an existing relationship with the clinician.

*Videoconferencing*

Videoconferencing was also discussed with some services with general agreement that this modality is not appropriate for Aboriginal and Torres Strait Islander people and for people experiencing paranoia, hallucinations and delusions. However, videoconferencing may help some clients to feel more comfortable in obtaining support and it may offer a practical solution where face-to-face attendance is challenging or not an option. Videoconferencing has been used in custodial settings and telehealth is increasingly being utilised in primary health care.

However, it is likely that there is limited physical access within the community to videoconferencing technology with secure connections such as Pexip. Connectivity and data costs was also identified as a barrier to videoconferencing.

**Rescheduling**

Services stated that the current PCD rescheduling process (which legislatively restricts the decision to reschedule to the arresting police officer or magistrates court) is onerous, inefficient and frustrating for

clients, services, police and courts. It was suggested that the Diversion Coordination Service may be best placed to take the responsibility of rescheduling, rather than police or courts. Services reiterated the importance of maintaining a clear distinction between the provision of treatment and support from law enforcement.

### Workforce

Most services required clinicians delivering PCD to hold an undergraduate degree in human services or another related field, such as psychology. A few services utilise volunteers and students on placement under the supervision of qualified employed staff. A few services employ Aboriginal and Torres Strait Islander counsellors who deliver sessions to Aboriginal and Torres Strait Islander people and non-Indigenous clients. Importantly, this enabled clients to choose to speak with an Aboriginal and Torres Strait Islander counsellor or non-Indigenous counsellor.

Workforce recruitment and retention was frequently identified as a challenge, particularly in regional, rural and remote areas. Some areas have vacant positions for months, impacting on service provision.

## Other police programs

### Police Referrals

Several services reported that referrals receive from the generic Police Referrals program are often inappropriate. Specifically, when the service contacts the client, the client does not remember the referral, does not want to engage with the service or is not experiencing problematic substance use. It was suggested that low uptake may be due to clients accepting referrals “in the heat of the moment” and that clients are in the pre-contemplative stage of change. Services identified that a large proportion of people referred through the Police Referrals process were uncontactable.

## Other court programs

### QMERIT

Services were supportive of the QMERIT program, with several services eager to see QMERIT expanded to other locations as recommended in the QMERIT Pilot Program Evaluation; Report 2. These services stated the program would benefit the people living in their communities and noted location inequality in therapeutic justice programs available across the state.

Several services spoke about the different approaches adopted by the two QMERIT sites regarding abstinence versus harm minimisation, the amount of urinalysis testing and consequences of positive test results and varied levels of stakeholder engagement.

### QICR and Courtlink

Courtlink is a new bail-based program offering case management and referral services. At the time of MHAODB’s engagement, DJAG was actively implementing Courtlink in a number of sites (totalling 5 by 2019) across Queensland. As such, most services had not been involved with Courtlink, however, were pleased to hear the model would replace the existing Queensland Integrated Court Referral (QICR) program. Services were supportive of a case management approach and felt this would overcome the inefficiencies and poorly targeted QICR referral processes. Regarding QICR, many services expressed concern about the lack of privacy and confidentiality as client information was shared via email broadly and unnecessarily with unrelated service providers. Some services stated that Courtlink has the

potential to improve outcomes and provide a more positive experience for all stakeholders, particularly clients.

A couple of services expressed concern about processes related to client engagement and participation in QICR and Courtlink. Additionally, services noted that no additional funding has been provided to deliver AOD treatment services to QICR and Courtlink referred clients – consequently these clients are assessed and treated in line with existing public triage and funding arrangements. Service providers discussed the need to balance the information sharing and reporting expectations of the justice system with the role of health service providers and the importance of maintaining a therapeutic alliance with clients.

### Queensland Indigenous Alcohol Diversion Program

Several services referred to the Queensland Indigenous Alcohol Diversion Program (QIADP) which was a pre-sentence bail based court diversion program for Indigenous people whose alcohol misuse contributed to their offending. QIADP operated in Cairns (including Yarrabah), Townsville (including Palm Island) and Rockhampton (including Woorabinda) from 2007 to 2010. After an assessment was completed, the participant was referred to multiple agencies to address problematic alcohol use.

Services reported that client outcomes from the QIADP program were varied. In some areas the program facilitated case and service collaboration and was identified as filling a gap in therapeutic justice responses.

# Prison, Probation and Parole

## Common Themes

- The extent of collaboration between services and Queensland Corrective Services (QCS) varies across the state.
- The majority of AOD treatment provided to prisoners is delivered by the NGO sector.
- A wide variety of AOD treatment programs available for people referred from QCS exist. A few of these programs are specifically for people on probation and parole (P&P).
- Clients referred from prison, P&P are often difficult to engage, complex and require wrap-around support, including life skills training.
- Alcohol is the most common primary drug of concern, followed by methamphetamine.
- Services don't separate people who are on P&P within their service, however, it is important to be mindful of the complex dynamics within client groups.

### About the clients

Most clients referred from QCS are over 35 years of age. There is a high prevalence of low literacy, history of trauma, unstable housing and limited life skills such as food preparation and employment related skills. Many clients referred to services by QCS are in the pre-contemplative stage of change.

Several services stated that many clients of AOD treatment services have criminal histories. Clients recently released from prison were often recognised as having the highest risk of relapse in the first month (post release), coupled with this being the most difficult time to engage with a client. The importance of harm minimisation, particularly in this high-risk period, was acknowledged.

Many services reported that clients referred by QCS are difficult to engage. This may be due to some common factors experienced by this cohort such as unstable housing and lack of access to transport, as well as being in the pre-contemplative stage of change and a limited understanding and preparedness for participating in AOD treatment. Most services who deliver AOD treatment to people on P&P attempt

to contact the client numerous times, which has improved engagement and attendance. Many services reported that QCS often referred clients to AOD services without providing adequate information to either the service or the client. It was also reported that QCS may send clients to treatment to meet the requirements of their order rather than the clients having an intrinsic desire to address their AOD issues.

## Drug Trends

Alcohol is the most common primary drug of concern, followed by methamphetamine. Opioid use is less common, however, a couple of areas stated the use of Subutex is problematic for some clients.

Some services were concerned about increased demand on Opioid Substitution Treatment (OST) services due to the implementation of OST in Queensland prisons.

## Interventions

A variety of programs are offered to clients referred from P&P. While a small number of services offer dedicated programs for prison or P&P clients, most treatment services provided the same treatment responses and programs as those for the mainstream population. Most programs are based on CBT, MI, Mindfulness and ACT. Program duration ranged between 4 and 12 weeks and may be delivered at a residential rehabilitation facility, in the persons accommodation, within the community or at the P&P office.

Many services stated that “wrap around” programs are most effective for this client group due to their lack of life skills, complex needs and the effects of institutionalisation. Services suggest that clients who spent a large proportion of their life in prison would benefit from structured programs that include developing detailed living routines.

Several services prefer to offer psycho-educational rolling group programs as entry intervention for P&P clients. This approach aims to address the inefficiencies experienced as a result of high non-attendance rates for this cohort. Clients that demonstrate engagement are referred for individually tailored treatment.

## Interface with Prisons, P&P

In general there appeared to be mutual respect between AOD services and QCS in their respective roles of providing AOD treatment and keeping the community safe. AOD services saw a combined effort to work with clients to address their AOD issues. However, the extent and nature of collaboration between AOD treatment providers and QCS varied across the state. While some services reported positive relationships with QCS, many reported difficulties with engagement, referrals and information sharing. Many services stated the extent of involvement and collaboration between services and QCS is strongly associated with individual staff in the roles rather than agreed process and policy.

A couple of residential rehabilitation services developed Memorandum of Understanding's (MOU) with their local QCS office which helped maintain a collaborative working relationship despite changes in staffing. For example, an MOU enabled timely information sharing, greater flexibility in the provision of urinalysis and allowed clients to report to P&P via telephone instead of face-to-face to avoid disruption to participation in AOD treatment.

Services acknowledged the need to adhere to regulations and legislation in sharing health information in relation to justice and court matters. Generally, this consists of a brief statement about attendance and engagement. The amount of information received from P&P at the time of referral varied depending on the P&P officer. Most services would like to receive more information about screening, assessment and AOD treatment the client has/had received while under the care of QCS. Importantly, numerous services reported receiving inadequate information about the clients' criminal history and any pending charges. This information was imperative to ensuring staff safety and the safety of other clients. However, services also recognised that people who self-refer may have a criminal history and pending charges but this information is not requested and therefore unknown to the services.

The majority of AOD treatment provided to prisoners is delivered by the NGO sector, as such there was little involvement between HHSs and QCS. Some HHSs reported receiving letters from prisoners applying for parole requesting access to AOD treatment.

Services stated that it is very difficult to provide in-reach to clients in prison and only a few services were currently providing treatment to people in prison. Most AOD programs delivered in prison are funded by QCS or Primary Health Networks. Only one service utilised their own funding source to deliver a prison based program. QCS has recently released a Request for Offer to deliver AOD treatment to QCS clients based in prisons and in the community.

A few services had previously worked with QCS to upskill P&P staff to conduct screening and deliver basic AOD programs through training and co-facilitation. The aim of this effort was to reduce the referrals from QCS for clients with low level AOD dependence. However, due to a high turnover in P&P staff the benefits of the training and cofacilitation model were not sustained.

# AOD Sector Challenges

A variety of other challenges were raised about the AOD sector more broadly, however, these issues may also impact on clients referred from the CJS.

## Drug Trends

Services have seen an increase in problematic use of prescription medications; mainly opioids. Many services referred to the 1980's and 1990's when heroin use in Australia peaked. Services stated that while the current issues are also with opioids, the clients, behaviours and reasons for use are different and that treatment responses need to reflect these differences.

Several services reported an increase in the harmful use of steroids. However, services also stated that it is difficult to ascertain the true amount of steroid use in the community as services have minimal interactions with this cohort. While these clients may access the Needle and Syringe Program (NSP) typically they do not identify as illicit drug users and do not wish to engage in other AOD support services or participate in community engagement activities.

Poly drug use and rapidly changing drug trends were commonly reported.

## Residential Rehabilitation

The following section relates to feedback received from service providers funded for residential rehabilitation[2]. Services operated under Residential Rehabilitation (RR) or Therapeutic Community models. However, this section will refer to these services Residential Rehabilitation.

Many areas identified a need for additional RR services. In some areas, there were issues with accessing current RR services due to age limitations and cultural barriers. Additionally, current RR services have different pricing structures which impacted access for some clients and influences which RR service a client attends.

Recent changes to the Centrelink sickness benefits criteria was also noted as problematic for RR services and clients. Clients are now required to have a job plan or receive study related payments. A medical certificate alone is no longer sufficient. As a result, RR may be unaffordable for some clients and each RR service is required to work with multiple employment service providers.

Finally, the variety of RR service models was raised on numerous occasions. For example, some services offer a 12-week therapeutic community while others offer six-week programs with a mix of individual and group counselling based on Motivational Interviewing and Cognitive Behaviour Therapy. To varying extents, most services had reviewed or are currently reviewing their service models, to ensure they are evidence informed. It was acknowledged that different approaches, treatment models and program durations will be more suitable or preferable for different clients based on their individual circumstances.

## OST

Several services reported the need for more OST prescribers and dispensing pharmacies. For example, one service stated there were two pharmacies in their greater area; one provides doses for people on methadone and the other provides doses for people on buprenorphine. As such, the treatment program prescribed is often a reflection of where you live, rather than what is clinically indicated.

Concern was also expressed that the demand for prescribers and dispensing pharmacies would increase with the introduction of OST in prisons. Further, current dispensing pharmacies may choose not to offer this service anymore, if increased demand changes the balance of clientele. Any further reductions to the number of dispensing pharmacies would greatly impact the broader community

## NSP

All AOD services were supportive of NSPs. However, there is a need for more NSPs and in some areas greater resourcing for current NSPs. A couple of services also noted the NSP in their area was poorly resourced and as a result, the NSP was not ideally located and is unable to provide the services of a primary site (e.g. counselling).

[2] NOTE: not all Queensland Health Residential Rehabilitation Services were involved during the engagement process

# Appendix A

## Brief Program Descriptions

### Court Link

Court Link utilises a case management approach to connect people to treatment and support services for housing, employment, drug and alcohol, health and other social needs. A person can be assessed to participate in Court Link if they are appearing before the Magistrates Court charged with any criminal offence, regardless of whether they will plead guilty or not guilty.

Referrals can be made by a magistrate, the police (including at the watchhouse), the individual, their legal representative, family or others. There is no limit to the number of times a person may be referred to Court Link.Court Link commenced in Brisbane in November 2017, Cairns in June 2018 and Ipswich and Southport in November 2018, replacing the Queensland Integrated Court Referral Program (QICR).

More information can be found at https://www.courts.qld.gov.au/services/court-programs/court-link

### Drug and Alcohol Assessment and Referral

The Drug and Alcohol Assessment Referral (DAAR) is a state-wide program was established in 2014 as part of the Safe Night Out Strategy. People whose substance use has contributed to factor their offending behavior may be referred to the program by a Magistrates Court as part of a recognizance order or bail condition

The program consists of a one-off 60-90 minute BI delivered face-to-face or by telephone delivered by a non-government organization.

More information can be found at https://www.courts.qld.gov.au/services/court-programs/drug-and-alcohol-assessment-referral-course

### Illicit Drugs Court Diversion Program

The Illicit Drugs Court Diversion Program (IDCDP) is a state-wide program established in 2006. People apprehended with small amounts of illicit drugs for personal use in accordance with specific sections of the *Drugs Misuse Act 1986* may be eligible. The program operates under a legislative framework specified in the *Penalties and Sentences Act (1992)* (for adults) and the *Youth Justice Act (1992)* (for young people) in any Queensland Magistrates or Queensland Childrens Court. The program consists of a one-off 60-90-minute BI delivered individually face-to-face, in a group or by telephone. The program is delivered by a mix of non-government organizations and Hospital and Health Services.

More information can be found at https://www.courts.qld.gov.au/services/court-programs/illicit-drug-court-diversion-program

### Police Drug Diversion Program

The Police Drug Diversion Program is a state-wide program established in 2001 under section 379 of the Police Powers and Responsibilities Act (PPRA) (2000). Individuals arrested for possession of 50 grams or less of cannabis, and/or possessing a thing for use, or which has been used, for smoking cannabis may be eligible. The program consists of a one-off 60-90-minute BI delivered individually face-to-face, in a group or by telephone. The program is delivered by the same mix of non-government organizations and Hospital and Health Services as the IDCDP.

More information can be found at https://www.police.qld.gov.au/programs/drugs/pddp/

## Police Referrals

The Police Referrals initiative has been operating for over a decade whereby frontline operation police may refer individuals to external support providers to address health and social issues. When community members consent to a Police Referral they will be contacted by a service provider external to the QPS within a few business days. Contact will usually commence with a telephone call or an email. Assistance will be offered aligned with the needs of the referred individual and the service provider capabilities. Follow-up service provision may include personal contact via telephone or face-to-face, or information provided via email or post. Information on the nature of services provided is a matter between the referred individual and the service provider, and is not provided to QPS.

More information can be found at https://www.police.qld.gov.au/programs/police-referrals.htm

## Queensland Indigenous Alcohol Diversion Program

The Queensland Indigenous Alcohol Diversion Program (QIADP) was a voluntary pre-sentence bail based court diversion program for for Aboriginal and Torres Strait Islander people whose alcohol misuse contributed to their offending. QIADP operated in Cairns (including Yarrabah), Townsville (including Palm Island) and Rockhampton (including Woorabinda) from 2007 to 2010. After an assessment was completed, the participant was referred to multiple agencies to address problematic alcohol use.

More information can be found at https://www.premiers.qld.gov.au/publications/categories/reports/assets/alcohol-diversion-recidivism-study.pdf

## Queensland Integrated Court Referral

People appearing in a magistrates court may have been eligible for the QICR program as part of a bail condition or upon sentence through a probation or recognisance order. Clients were referred to service providers for assistance with problematic substance use, mental illness, impaired decision-making capacity and homelessness or risk of homelessness.

A Case Assessment group chaired by a QICR facilitator was established in each location whereby local service providers would meet to identify appropriate referrals. QICR operated in Brisbane, Cairns, Ipswich and Southport between 2016 and 2018.

More informing can be found at https://www.courts.qld.gov.au/services/court-programs/queensland-integrated-court-referrals

## Queensland Magistrates Early Referral Into Treatment

The Queensland Magistrates Early Referral into Treatment (QMERIT) program is a 12 to 16 week bail program established in 2006 in Redcliffe and Maroochydore. The program targets individuals charged with offences committed in conjunction with illicit drug-use who volunteer to undergo drug and alcohol treatment whilst on bail. Treatment may include withdrawal support, substitution pharmacotherapy, behavioural change strategies and counselling, and/or group programs and/or residential rehabilitation. The participant will regularly return to court at the discretion of the Magistrate to monitor their progress.

More information can be found at https://www.courts.qld.gov.au/services/court-programs/queensland-magistrates-early-referral-into-treatment

# Appendix B

## List of Services Engaged

| Provider | HHS Area | Meeting Date |
|---|---|---|
| Lives Lived Well | Gold Coast | 28 August 2018 |
| The Salvation Army | Gold Coast | 28 August 2018 |
| Metro North MHAODS | Metro North | 29 August 2018 |
| Goldbridge Rehabilitation Service | Gold Coast | 2 October 2018 |
| Townsville MHAODS | Townsville | 4 October 2018 |
| The Salvation Army | Townsville | 4 October 2018 |
| BlueCare | Townsville | 4 October 2018 |
| North West MHAODS | North West | 5 October 2018 |
| Mackay MHAODS | Mackay | 9 October 2018 |
| Healthy Options Australia | Mackay | 9 October 2018 |
| Rockhampton MHAODS | Central Queensland | 10 October 2018 |
| Lives Lived Well | Central Queensland | 10 October 2018 |
| Bundaberg MHAODS | Wide Bay | 16 October 2018 |
| Bridges Aligned Service | Wide Bay | 16 October 2018 |
| Anglicare Southern Queensland | Wide Bay | 16 October 2018 |
| Hervey Bay MHAODS | Wide Bay | 17 October 2018 |
| Anglicare Southern Queensland | Darling Downs | 23 October 2018 |
| Healthy Options Australia | West Moreton | 23 October 2018 |
| Queensland Aboriginal and Islander Health Council | Cairns and Hinterland | 24 October 2018 |
| Youth Empowered Toward Independence | Cairns and Hinterland | 24 October 2018 |
| Lives Lived Well | Cairns and Hinterland | 24 October 2018 |
| Community Services Tablelands | Cairns and Hinterland | 25 October 2018 |
| Cairns and Hinterland MHATODS | Cairns and Hinterland | 25 October 2018 |
| Anglicare Southern Queensland | Metro South | 30 October 2018 |
| Gold Coast MHAODS | Gold Coast | 31 October 2018 |
| Anglicare Southern Queensland | Gold Coast | 31 October 2018 |
| Darling Downs MHAODS | Darling Downs | 9 November 2018 |
| Torres and Cape MHAODS | Torres and Cape | 13 November 2018 |
| South West MHAODS | South West | 15 November 2018 |
| Metro South MHAODS | Metro South | 9 January 2019 |

N.B Central West was not included in the engagement process due to staffing changes occurring within the MHAODS.

# Abbreviations

| | |
|---|---|
| AOD | Alcohol and Other Drugs |
| BI | Brief Intervention |
| DAAR | Drug and Alcohol Assessment and Referral |
| DSCR | Drug and Specialist Courts Review |
| HHS | Hospital and Health Service |
| IDCDP | Illicit Drugs Court Diversion Program |
| MHAOD | Mental Health Alcohol and Other Drugs |
| NGO | Non-government organisation |
| NMDS | National Minimum Data Set |
| NSP | Needle and Syringe Program |
| OST | Opioid Substitution Treatment |
| PDDP | Police Drug Diversion Program |
| P&P | Probation and Parole |
| QCS | Queensland Corrective Services |
| QMERIT | Queensland Magistrates Early Referral into Treatment |