ENHANCING AOD TREATMENT ACCESS FOR OFFENDERS

– Scoping of Issues and Recommended Strategies

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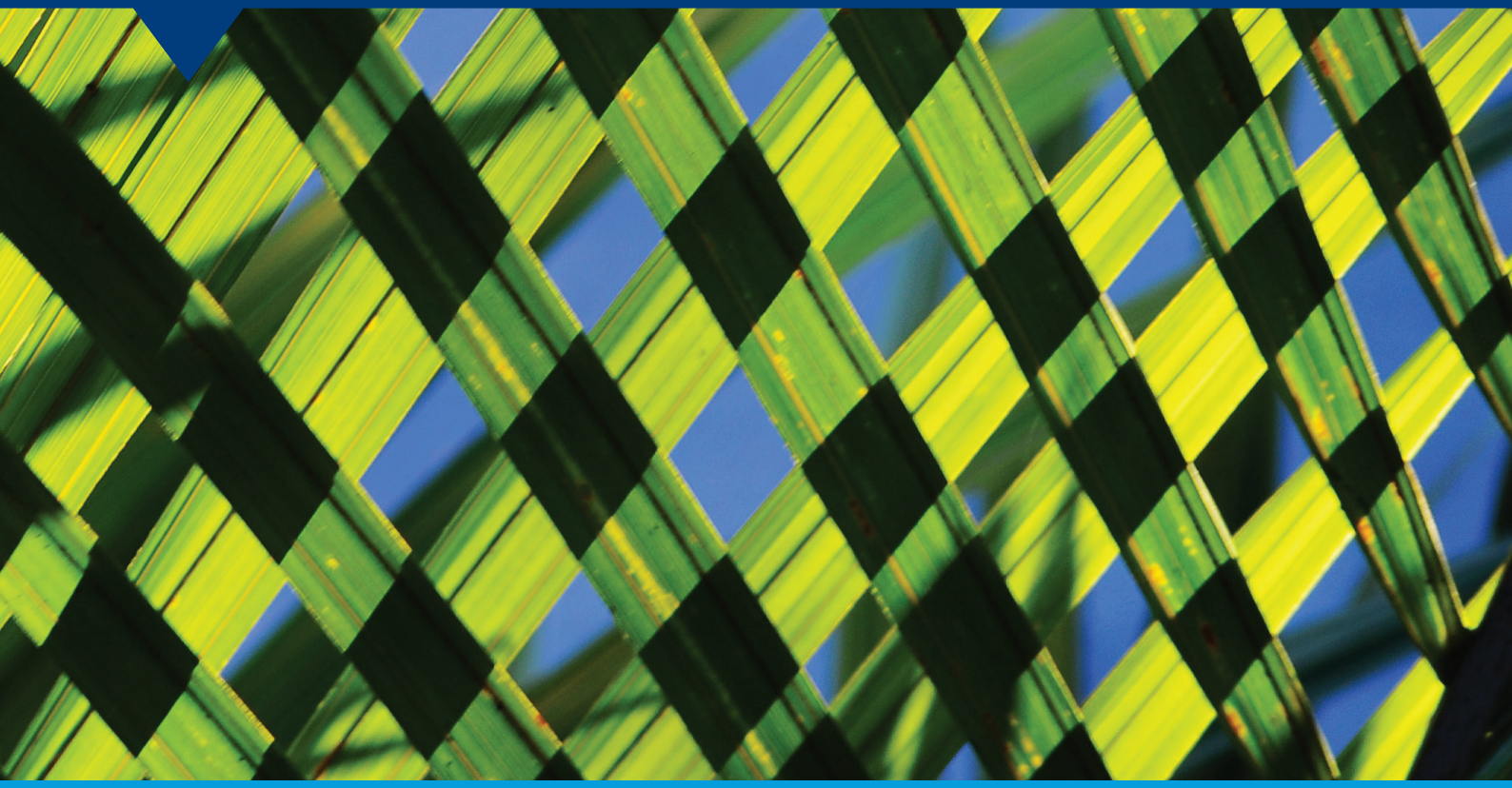

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WORKING TOGETHER TO MAXIMISE POSITIVE OUTCOMES

AOD Provider Collaborative

Enhancing AOD Treatment Access for Offenders – Scoping of Issues and Recommended Strategies

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Summary of Key Points

- Both prison and community probation service based interventions have a role in reducing re-offending. The understanding of the link between alcohol and drug use and offending is widely accepted in the literature, so supporting offenders to address and maintain changes in their drug and alcohol use will arguably support them to begin new lives free of offending.
- Evidence shows that treatment works, options include residential treatment, methadone prescribing and a range of less intensive alternatives such as individual counselling, as well as holistic support to address some of the underlying issues that trigger drug misuse, such as housing, mental health or relationship issues.
- Alcohol and drug treatment as part of a health approach focuses on improved wellbeing, reduced AOD use and improved functioning across biological, psychological and social domains compared to the Justice system with a focus on reducing offending. This results in very different approaches to how services are designed and delivered. Both systems are driven by different measures of success, and consequently interventions that achieve both sets of objectives will invariably rely on inter-sector collaboration and a systematic approach to the design of interventions and models of care.
- To ensure the best outcomes for each person, practitioners need to have knowledge of each other's sectors. The attitudes of the respective workers towards people who have offended and towards people with mental health and/or addiction problems need to be appropriate for effective cross-sector collaboration to occur.
- Effective working relationships are necessary if outcomes for people with AOD issues involved in justice settings are to improve, however collaboration and working inter-sectorally has historically been a difficult ideal to achieve.
- Access to a holistic range of services building on existing strategies, mainstream programmes and a wide range of AOD treatment options should be made more available and easy to engage with for offenders as they re-engage in the community.
- Maintaining people in aftercare programmes once their treatment is completed is an important step in treatment. People's engagement with Corrections offers an opportunity to build on treatment gains and ensure aftercare programmes are utilised effectively for people as they begin to make changes around their AOD use.
- Services which offer a beginning-to-end support system for drug-misusing offenders may hold promise for the NZ context. Through and after care as an approach enables tailor-made treatment based on an individual's wider health and support needs and are at the heart of these types of systems
- Many AOD services in Counties Manukau are involved in Corrections service provision yet easy to access information about the types of services that are provided currently, the procedures for outreach and referral is not readily accessible.
- Understanding what best practice is for relationships between AOD, Corrections and Justice is an emerging area of research as cross-sector practice models become common place.
- Further review on the level of service user involvement in this area of practice is needed to improve understanding on what is currently available in the Counties Manukau region.

Purpose

In 2009 Counties Manukau DHB established an AOD Sector Development Group for the Counties Manukau based AOD services, to develop collective projects that would enhance service delivery for service users. The AOD Provider Collaborative brings together 17 organisations delivering alcohol and other drug (AOD) treatment or related services within Counties Manukau. The group focuses on system-level initiatives that can effect positive change for service users and the workforce alike.

Sharing information and resources with the AOD workforce and wider sector, in this case services and clients involved with Justice and/or Corrections, is a focus of the group, as is increasing accessibility for all people needing treatment for AOD issues. Clients referred from the Justice sector comprise a substantial number of AOD referrals for services in this Collaborative group and understanding what treatment exists, and the ways clients and their families can access treatment effectively is important.

The aim of this report is therefore to provide information that will inform AOD treatment and pathways of care for people involved with Justice and/or Corrections in the Counties Manukau DHB catchment area. It will utilise relevant literature and offer some recommendations to inform future treatment pathway planning and meet the project requirements. These include how the following broad aims may be better understood:

- How people who have AOD problems, and who have been released from prison, are on remand, or have received a deferred sentence, can achieve increased access to recovery support.
- How services that support offenders living in the community can increase access to information about community-based AOD treatment services and other recovery supports.
- How collaborative relationships between AOD treatment providers, Department of Justice and the Department of Corrections can be enhanced.

Objectives

1. To discuss current and relevant research and evidence regarding programme models for offender treatment relevant to the addictions sector as they work with Departments of Justice and Corrections.
2. To understand optimum pathways for service users who are seeking treatment for AOD use.
3. To recommend optimum treatment models for offenders both inside of prison and in the community, especially as this relates to the CMDHB catchment area.
4. To inform the development of pathways of care for people involved with Justice or Corrections who are seeking AOD treatment.
5. To recommend low cost, high impact options for immediate implementation to facilitate and increase access to current community services.

Background

With a high prevalence of drug related crime in the CMDHB catchment area, many of the clients seen in CMDHB AOD services are also involved in the Justice and Corrections systems. There is a need to better understand the pathways between Health, Justice and Corrections and additionally, the specific needs and current evidence-based treatment options for offenders.

There are many current government policies which are aimed at addressing AOD issues as well as criminality within New Zealand. It is important that consistency amongst policies prevails when progressing the work with offenders seeking AOD treatment. It is especially important that the treatment models that are offered have high levels of efficacy and are well grounded in evidence of what works. With the launch of the National Drug Policy[1] , there is a higher level of emphasis on addiction as a health issue and that it is something that touches all New Zealanders.

Matua Raki, as New Zealand's primary workforce development agency in the addiction sector, has provided guidance in '*Supporting people with mental health and/or addiction problems who are involved in the justice system*.' (http://www.matuaraki.org.nz/resources/supporting-people-with-mental-health-andor-addiction-problems-who-are-also-involved-with-the-justice-system-a-reflective-workbook/569)[2], and this document has been referred to throughout this review. Additionally, a number of larger programmes such as the Alcohol and other Drug Treatment Court and Drug Treatment Units within prisons are currently operating and are making significant contributions to the treatment of this population group.

The need, however, for more information and more accessible pathways has been expressed by people using services, and is now expected of all involved sectors at a governmental level as a move towards more consumer driven care models is adopted[3]. In the past there has been a more silo approach, but now there is a desire for more understanding and integration to better serve service users/offenders, their families, as well as the wider community. This review will discuss the approaches currently being provided for this population, as well as other evidence based approaches.

[1] Inter-Agency Committee on Drugs (2015). *National Drug Policy 2015 to 2020*. Wellington: Ministry of Health.

[2] Matua Raki (2014). *Supporting people with mental health and/or addiction problems who are involved with the justice system: A reflective workbook*. Wellington: Matua Raki.

[3] Health Workforce New Zealand (2011).*Towards the Next Wave of Mental Health & Addiction Services and Capability: Workforce Service Review Report.* Wellington: Ministry of Health.

Context

Counties Manukau District Health Board serves a population of 524,500 people (2015/16 estimate). Its people tend to be younger, comprise a higher proportion of Pacific Island people, and proportionally more people are in the most deprived section of the wider population than the national average.[4]

These factors and their corresponding determinants of health will impact how AOD services are designed and delivered in this region for the offender population. From a population health perspective, and given the confluence of factors above, this population composition has also resulted in a larger number of Counties Manukau people needing the concurrent services of Health, Justice and Corrections.

Nationally, the prevalence rates for substance use issues (as well as problem gambling) in the prison population are much higher than the general population. Approximately 60% of community based offenders have an identified AOD need and 87% of prisoners have experienced an AOD problem over their lifetime. Further, 50% of crime is committed by people under the influence of substances[5]. Compounding this within New Zealand, offenders also have high rates of co-existing mental health and substance use disorders which are often undetected and under-treated[6].

Historically, cross-sector collaboration has been limited, driven by individual government agencies protective of budgets and constrained by a lack of understanding on how to work with each other's population groups. The Health and Justice sectors have separate goals, but share clients as many Justice clients are also represented in the AOD treatment population. In an effort to pool resources and work more effectively in an increasingly constrained fiscal environment, greater understanding of how we can improve service provision is needed. Also required is incorporating evidence based treatment and working in ways that will provide accessible and responsive care within custodial and community settings.

As one of the largest catchment areas for individuals with mental health and substance use disorders, infectious diseases, and chronic health conditions, the criminal justice system needs to be informed on how to best treat its population[7]. An opportunity exists to integrate health care across these important public health domains, and in this case, effectively provide AOD treatment into custodial and community sentence environments. If we are able to access and

[4] http://www.health.govt.nz/new-zealand-health-system/my-dhb/counties-manukau-dhb/population-counties-manukau-dhb

[5] Brinded PM, Simpson AIF, Laidlaw TM, et al. (2001). Prevalence of psychiatric disorders in New Zealand prisons: a national study. *Australia and New Zealand Journal of Psychiatry* 35: 166–73.

[6] Indig D, Gear C, & Wilhelm K. (2016). Comorbid substance use disorders and mental health disorders among New Zealand prisoners. Wellington: New Zealand Department of Corrections.

[7] The Council of State Governments Justice Center. (2011). Frequently asked questions: implications of the federal health legislation on justice-involved populations. Retrieved July 9, 2012 from http://reentrypolicy.org/jc_publications/faqs-implications-of-the-federal-legislation-on-justiceinvolvedpopulations/FAQs_Federal_Health_Legislation_on_Justice_Involved_Populations_REV.pdf

treat offenders effectively during their custodial sentences this may offer an opportunity to alleviate the strain on the current provision of AOD treatment in the community.

Enhancing links to treatment available in the community will also support offenders as they return to their daily lives and family/whanau, and enhance treatment efficacy. Supporting people during this transition has been shown to be a crucial time to provide intervention to enhance post-treatment effectiveness[8].

Current AOD Programme Models Used in Auckland

Currently intensive and community based treatment programmes are not widely available to offenders. When offenders are sentenced to community based sentences, demand for AOD treatment services inevitably rises stretching the health resource further. Despite a number of AOD programmes operating in both the custodial and community settings in Auckland, all targeting offenders at different stages of their sentences and treatment, information about these services is not readily accessible.

The following section presents a discussion of services currently available in different settings but is not exhaustive and may not be fully inclusive of current services or programmes in development.

CADS Offender Programme (COP)

The CADS Offender Programme started in 2008 and was originally called 'Effective Intervention Programme'. Currently COP is serving 14 probation sites in the Auckland region by providing assessments and AOD interventions, such as groups and individual counselling, to offenders who are on community-based sentences or those who are on parole. CADS is currently developing interventions to help offenders who are on Community Work sentences for minor offending (information about this is not currently available). CADS COP receives approximately 3000 referrals annually from all Probation sites in the greater Auckland region. COP is contracted and funded by Waitemata DHB on behalf of the three Auckland metro DHBs.

CADS Pre-release Assessment Programme

The purpose of CADS pre-release assessment is to serve as an efficient interface between prison management of offenders and CADS treatment programmes based at Community Probation Services (CPS) in the Auckland region. It aims to reduce the gap between the point when a client with AOD issues is released from prison and the point when the same client engages with AOD treatments arranged by CPS.

[8] National Institute on Drug Abuse, & United States of America. (2006). *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research Based Guide.*

Currently clients are seen for pre-release assessments at the correctional facility where the client is based. Eligibility is for offenders who are to be released back into community within three months from their CADS pre-release assessment dates, including those who are being considered for parole by the Parole Board. Offenders release/parole documents will carry 'special conditions' to allow them to engage with AOD courses/treatments in the community, and they should present with low safety concerns and basic literacy skills. If offenders are seeking residential treatments following release such as that offered at Higher Ground, Odyssey House, or Salvation Army they are not eligible for this programme.

A clinical model of Motivational Interviewing is used during a CADS pre-release assessment. At the end of each assessment session, the CADS assessor will issue a Letter of Treatment Recommendation to each client. The letter will allow the client, once released from imprisonment, to be brought into CADS services immediately without waiting for another CADS assessment at Community Probation Services similar to processes in other jurisdictions. Despite being funded by Waitemata DHB on behalf of the other Metro DHB's in Auckland the CADS pre-release assessment is an intervention separate from CADS pre-release group; they are not related.

CADS Pre-release Groups

CADS pre-release group is one of CADS's initiatives to provide AOD treatment in prison in order to help prepare offenders for their upcoming release from a confined environment into a community environment where AOD issues are commonplace. CAD's pre-release group is based on a Motivational Interviewing approach and with a focus on relapse prevention. Extra components such as emotional regulation, self-strength development, relationship and communication skills are also incorporated into the course. The groups are run weekly for eight weeks. Eligibility is limited to offenders who are to be released within six months, are graduates from other AOD programmes and are self-motivated. The group is limited to twelve participants. This programme clearly stipulates that it is a psycho-educational programme and not a treatment replacement.

Corrections Out of the Gate Programme

Offenders serving short sentences are known to face a range of difficulties on release, including getting access to help they need before, or as soon as they leave prison. Getting access to a range of reintegration support early in their offending experience can steer people away from committing further crime. The Out of the Gate programme is a Corrections supported navigation-style reintegration support service which is available in prisons throughout New Zealand, including all the prisons in Auckland. The main aim of this programme is to smooth the transition back into the community for offenders with a specific focus on accessing support services such as employment, accommodation, education and training, living skills, health/wellbeing, whanau, family and community links. This programme is optional however, and participants must have at least one re-integrative need, be serving a sentence of two years or less in prison, or have been on remand in custody 60 days or longer.

Implementation of this programme began in October 2013 and is now operational nationwide. Corrections' case managers refer suitable offenders to the provider. The provider then meets with the offender to assess individual re-integrative needs, and plan how best to navigate offenders to the help they need. Navigation may involve pick-up at the prison gate, transport to the required services (both government and community), help with paper work, linking with services for whānau/families and children of offenders, and provision of additional services and support if required.

Case managers and probation officers have a key role in supporting offenders who use Out of the Gate services and in liaising with providers. Although AOD issues are seen as a rehabilitative need rather than a re-integrative need, this programme holds promise in supporting offenders in a number of domains which are likely to positively impact AOD use.

Single Point of Entry Programme (nationally)

This pilot project has been led by the Ministry of Health and rolled out in five centres: Bay of Plenty, Waikato, Auckland, Wellington and Christchurch. The two year pilot has been completed and is now anticipated to be implemented nationally. AOD staff employed by the DHB, but situated within Corrections services, has been the main focus of the project.

One of the primary objectives of this programme was to target young Māori men, who are over represented in the justice system, and engage them in AOD services, including early intervention, to reduce re-offending. Prior to the programme's launch, waitlists were often unmanageable and people had relapsed or re-offended by the time any AOD intervention was offered (Bay of Plenty DHB, Private Communication, 2016). A target was set for Addiction Assessors to contact people referred by Probation within 15 days, to offer triage (face to face) and referral on to community based NGO AOD services for follow-up, or hospital for moderate/severe dependence issues. The NGO's then have a further 15 day target for assessment. So within 30 days, clients have been triaged and seen by an AOD provider. This system appears to be working more effectively than the previous adhoc system (Bay of Plenty DHB, Private Communication, 2016).

In the Bay of Plenty, the Addiction Assessor also links with a Court Assessor, who is also part of the addiction service. These two roles work collaboratively and closely together. The Court Assessor assesses offenders pre-sentence, and the Addiction Assessor post-sentence. Information and treatment planning ideas are shared and both practitioners make recommendations to the magistrates regarding AOD issues, and assist them in the process of imposing relevant and appropriate "Special Conditions" on sentences for AOD treatment.

Programmes within Auckland Correctional facilities

Mount Eden Corrections Facility (MECF)

Within Mount Eden Corrections Facility (MECF) increasing numbers of people are being referred to treatment as attempts to reduce re-offending, particularly related to drug use, are made. This creates pressure on the existing AOD treatment system, which is struggling to meet this capacity. The result is increased waiting times for offenders to receive treatment.

Similarly, this also affects people who are given a deferred sentence in Court, who are willing, but unable to access treatment. Anecdotally, people are reported as choosing to be sentenced as opposed to waiting in remand for a treatment bed to become available. The system in its current configuration seems inefficient and further increases barriers for people accessing treatment.

Compounding this situation, there is also limited opportunity to deliver interventions in MECF (and more recently in the Auckland South Corrections Facility). Additionally, there are only ten Drug Treatment Units provided across the country. Assessment is available within MECF by an AOD Practitioner from Odyssey to people on remand as an essential part of entrance and appropriate placement in treatment. However, there are constraints in place for AOD Practitioners to gain access to assess people, such as a limited number of fixed appointment times being permitted, being reliant on prison staff making clients available at these times, and a limited ability to communicate directly with clients. This also serves as a barrier to people accessing timely treatment for AOD issues, and creates additional pressure on an already constrained system exacerbating existing waiting lists.

Drug Treatment Units

In the Auckland region only Auckland Prison at Paremoremo provides a Drug Treatment Unit (DTU) in a custodial environment. This programme uses the Therapeutic Community (TC) model of mutual self-help to bring about positive change in the lives of its clients. This model has been extensively researched and demonstrated as the most effective treatment model in a DTU environment for a diverse criminal justice population[9] . When compared with other treatments, only the TC model was consistently associated with reductions in recidivism and post-treatment drug use. Despite being an effective model for clients to address substance use, particularly in the context of offending behaviours, limited places (144) are available each year in this programme.

AOD Treatment Court

The Alcohol and Other Drug Treatment Court (AODT Court) pilot is designed to supervise offenders whose offending is driven by their alcohol and other drug (AOD) dependency, by providing judicial oversight of their engagement with treatment programmes and rehabilitation support services before they are sentenced. Four providers in the Auckland region (Odyssey,

[9] Mitchell, O., Wilson, D. B., & MacKenzie, D. L. (2007). Does incarceration-based drug treatment reduce recidivism? A meta-analytic synthesis of the research. *Journal of Experimental Criminology*, *3*(4), 353-375.

Higher Ground, Salvation Army and Wings Trust) collaborate to provide this service currently. The desired outcomes of the AODT Court pilot are to: reduce re-offending and imprisonment; reduce drug and alcohol consumption and dependency; positively impact on health and wellbeing; and be cost effective[10].

Court Liaison Roles

The Court Liaison role exists to provide an advisory service to the courts but they are also a point of contact for health professionals who are working with people who appear in court. The central focus of this role is "to detect people with mental health problems who are in the criminal justice system in order for appropriate referral or diversion into mental health services to take place"[11]. Concurrent assessment of a person for co-existing AOD issues is also paramount to offenders receiving adequate treatment.

The Court Liaison roles are usually held by mental health nurses, often referred to as forensic nurses. Health professionals working in these roles need to have competence and confidence in their ability to undertake mental health assessments and screen for alcohol or drug use; a sound knowledge of the mental health related legislation and court process; and the ability to build and sustain relationships with justice and mental health and addiction workers[12]. The Court Liaison role holds a pivotal place in the continuity of care when clients present to court and in their advisory role to the judiciary and health professionals.

Māori Responsiveness

Working with tangata whenua has special relevance because of the client profile of both those in the criminal justice system and those who access addiction treatments services (Māori are over-represented in these services). Current competencies exist[13] for working with Māori, which relates to the application of Māori-centred practice in mental health and addiction settings. The competence framework provides guidance related to the application of vocational and Māori knowledge and skills. A number of agencies currently use Kaupapa Māori models of practice and this also aligns with wider frameworks defining a set of behaviours, values and expectations and how these apply to practice. Māori responsiveness is everyone's responsibility – both Māori and non-Māori.

This review has not focussed on access for specific populations, including tangata whenua. Māori specific programmes are currently run within correctional facilities separate to AOD specific programmes, but have not been specifically included in this review. A further literature review on programmes that would be best suited to both Māori and Pacific populations, as both are over-represented within the offender population, would be useful to add to this more generic review. In particular, contact with services within the Auckland region that provide Kaupapa Māori service, or culturally specific programmes, would be able to inform this review.

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[10] Ministry of Justice (2014). *Formative evaluation for the alcohol and other drug treatment court pilot*. Wellington: Ministry of Justice.
[11] Brookbanks, W. J., & Simpson, A. I. F. (2007). *Psychiatry and the Law*. p.451.
[12] Te Pou (2014). *The physical health of people with a serious mental illness and/or addiction: An evidence review*. www.tepou.co.nz
[13] http://www.tepou.co.nz/uploads/files/resource-assets/Lets-Get-Real-Working-with-Maori-Practitioner-Level-Learning-Module.pdf

Cross-Sector Collaboration

There are differing views about how practitioners should collaborate across the boundaries of the health and justice sectors. The focus for each sector is very different and deciding how information is shared has historically been complicated. An ethical lens is needed when considering how much information should be shared about clients' health progress, if it is not relevant to the justice aspects of the clients' situation. Conditions of treatment as part of sentencing are also a complex consideration. A number of factors such as an offender's readiness to change, their engagement in the sentencing condition process, and the tension associated with providing a therapeutic process within a controlled context, need to be considered.

Alcohol and drug treatment focuses on improved wellbeing, reduced AOD use and improved functioning across biological, psychological and social domains. The Justice system has a focus on reducing offending. This results in very different approaches to how services are designed and delivered. Both systems are driven by different measures of success and consequently interventions that achieve both sets of objectives will invariably rely on inter-sector collaboration and a systematic approach to the design of interventions and models of care.

The health and justice sectors have been traditionally funded and managed separately, and therefore, have also developed in different ways. Despite this, some efforts at collaboration have been successful. With government support, Corrections has worked with the Ministry of Health to expand the alcohol and drug treatment available to offenders in the community. In 2012, Parliament agreed the Vote Health appropriations of $10 million a year for the Drivers of Crime package. From this package, $3.5 million was identified for increasing access to alcohol and drug treatment for community offenders. Corrections worked with the Ministry of Health and with DHBs to expand the treatment available in the community with this new funding.

One programme of note was the 'Single Point of Entry' (SoPE) programme (discussed earlier). Approximately $2 million was allocated to six DHBs (Waitemata, Waikato, Bay of Plenty, Mid-Central, Capital and Coast, and Canterbury)[14]. This programme was unique as it co-located staff from health within a corrections setting, and allowed a true collaborative working relationship to evolve. With the areas of health and justice overlapping, the people responsible for a client's care need to have knowledge of both systems, sufficient to be able to advocate on behalf of the client, and to ensure the best outcomes. The SoPE programme demonstrated a commitment to genuine collegial practice to ensure the best outcomes for clients of both sectors.

In the US context it has been recognised for a number of years that any health care reform or different ways of working will have a major impact on justice-involved populations[15].

[14] Department of Corrections: managing offenders to reduce reoffending, Office of the Auditor General (2013).
[15] https://www.bja.gov/publications/aca-cj_whitepaper.pdf

Leveraging any reform for these populations will require intention, leadership, strategic planning, and deliberate coordination across health, social service, and criminal justice systems[16].

Such cross-sector collaboration for the design of systems should be guided by established principles, such as the need to: understand relevant legislation, regulations, and policies, ensure effective information sharing and coordinate performance measures, evaluation, and financing mechanisms[17]. It could be suggested that the strategic impacts of combining the different sectors needs careful planning and governmental support and direction.

A strategic alignment and convening a health and justice planning council to facilitate collaboration among the stakeholder groups could be useful. It is unknown if such a group currently exists. Corrections do however have dedicated AOD advisory staff that would provide an invaluable source of knowledge of best practice and current networks. A collaborative group would be able to inform upcoming decisions about the types of services that are provided currently, the procedures for outreach and referral, and workforce capacity planning related to justice-involved populations. This type of cross-system collaboration is already underway in the US (New Jersey, New York, Pennsylvania, and Washington) where cross-agency task groups have been developed to address and improve service coordination among their populations. Three of these states have also worked with their local welfare and health agencies to ensure expedited re-engagement for people upon prison release [18], which is a recognised time of high-risk for AOD relapse amongst offender populations. Similar models exist in the United Kingdom context also.

Developing Pathways of Care

A number of pathways have been shown to be effective when supporting offenders seeking treatment, these include:

- A single point of contact for referrals from justice and treatment agencies, ensuring continuity of care as someone moves between custody and the community;
- A single point of contact for self-referrals, appointments, ongoing support, help and information, a 24-hour helpline for clients to access throughout their rehabilitation;
- Appropriate support to those affected by drug use leaving prison or treatment or completing a community sentence and have an ongoing drug treatment need;
- Access to structured treatment interventions, such as motivational engagement approaches and relapse prevention;
- Access, where appropriate, to rapid prescribing in line with national drug policy;
- An established link to specialist health services such as those dealing with AOD and mental health care.

[16] https://csgjusticecenter.org/wp-content/uploads/2013/06/CHJFinal.pdf
[17] The Council of State Governments Justice Center. (2011). Frequently asked questions: implications of the federal health legislation on justice-involved populations.
[18] http://www.naco.org/resources/programs-and-initiatives/smart-justice

Justice and health services are both complicated and ever changing systems. To work effectively together as practitioner groups, balancing the needs for both Justice and AOD services is needed.

Matua Raki, describes the different sector needs as a continuum from control to care. For Justice this involves *controlling* risk in the short term through sanctions:

- Incapacitation / incarceration
- Direct contact
- Supervision of conditions
- Electronic monitoring
- Drug testing /screening
- Restraints
- Setting limits

For the AOD sector, *care* aspects relate to reducing risks through AOD interventions:

- Treatment and programming
- Co-operation and collaboration
- Challenging choice
- Ownership and responsibility
- Teaching and supporting self-risk management
- Communication / upholding limits clearly

When a person is first charged and presents to court, additional support may be needed. Appearing in court is very stressful, so working with a person to enhance their natural supports is important. This window of opportunity represents a chance for both sectors to work collaboratively to achieve improved outcomes for the client. This period may also be very stressful for the person's family or whanau. Identifying the supports available to family and whanau members is important, as is ensuring accessibility to these services.

The concept of 'recovery capital' has gained increasing traction in the past decade. Definitions of recovery in this context involve three components: wellbeing and quality of life, community engagement or citizenship, and addressing substance use[19]. This group's proposed vision of recovery includes two main points: recovery must be voluntarily sustained in order to be lasting, even if it is assisted by 'coerced' or 'mandated' interventions within the criminal justice system; and control over substance use is a key part of recovery, but is not significant on its own. Positive health, wellbeing and participation in society are also central to recovery. See Appendix 1 for the more detailed vision of recovery from these authors.

[19] UK Drug Policy Commission, (2008) *Recovery Consensus Statement*, www.ukdpc.org.uk/Recovery_Consensus_Statement.shtml

Improved access to support for offenders, particularly around health issues, will reduce the future burden on the health system and treatment programmes but this will rely on effective early intervention, and people engaging positively in their recovery.

Evidence Based AOD Treatment Models for Offenders in Community and Prison

AOD treatment that is not of sufficient quality, duration, or not well suited to an offender's individual needs, has been found to not yield meaningful reductions in drug use or recidivism[20]. Evidence based AOD treatment models for offender populations need to target changeable risk factors for problematic substance use to support people to change. It is the targeting, focus and sequencing of interventions to address these risk factors that supports the greatest behaviour change[20]. Structured treatment builds individual capability and capacity to support a life free from problem drug and alcohol use. It also reduces the risk of lapse and relapse and therefore ultimately supports and sustains behaviour change[21].

Improved integration of mental health and AOD treatment has been recommended as an important strategy for improving health and reducing re-offending among NZ prisoners[22]. In particular, ensuring prisoners have access to evidence-based therapies, such as Cognitive Behavioural Therapy for panic disorder and post-traumatic stress disorder; and mindfulness and Dialectical Behavioural Therapy for emotional instability as part of a diagnosed personality disorder. Identifying areas for improved detection, early intervention, treatment, rehabilitation and diversion away from the criminal justice system, are also identified as useful areas to pursue.

Although many similarities across genders exist this is not a one-size-fits-all response. Consideration is needed to design different treatment models for men and women. The prevalence of most mental health and substance use disorders is significantly higher among female prisoners than in men, reflecting their more complex and higher care needs[22]. In particular, incarcerated women have nearly twice the prevalence of anxiety disorders than found among male prisoners.

With the high rates of trauma and post-traumatic stress disorder experienced by women, additional care is needed to ensure their mental health care needs are appropriately met. Without an integrated care plan to address the mental health needs of offenders, relapse to AOD use is highly likely. Working across sectors and ensuring access for offenders to the appropriate treatment is vitally important to address the needs of this highly vulnerable group.

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[20] Mitchell, O., Wilson, D. B., & MacKenzie, D. L. (2007). Does incarceration-based drug treatment reduce recidivism? A meta-analytic synthesis of the research. *Journal of Experimental Criminology*, *3*(4), 353-375.

[21] http://www.corrections.govt.nz/resources/newsletters_and_brochures/journal/volume_3_issue_1_april_2015_desistance/practice_note_building_recovery,_reducing_crime.html Leafe, K.

[22] Indig D, Gear C, & Wilhelm K. (2016). *Comorbid substance use disorders and mental health disorders among New Zealand prisoners*. Wellington: Department of Corrections.

Despite the complexity of offering care to this population, mandated treatment can achieve effective outcomes. The Drug Interventions Programme (DIP) in the UK for example was introduced in April 2003 with the aim of developing and integrating measures for directing adult drug-misusing offenders into drug treatment and reducing offending behaviour. The DIP has helped reduce offending behaviour and increased the number of offenders accessing treatment[23]. These authors compared a cohort of 7727 individuals and found the overall volume of offending after engagement in DIP was 26% lower. Further, half of this cohort showed a decline in offending of 79%. Overall this study showed that levels of offending post DIP contact over a six month period were lower than in the six months before. The idea of through-care (discussed later) is an important factor in this success.

Risk, Needs and Responsivity

In current correctional practice, there are three key ideas that drive assessment and ultimately lead to treatment. These are based on the literature about "what works" with offenders. The mainstream approach to the rehabilitation of adult offenders established the *'risk-needs-responsivity'* model, which suggests that effective rehabilitative services must be matched to each individual offender's risk level, needs and responsivity profile[24].

Risk in this context, is focussed on the *risk* of reoffending (risk of harm to others) and directs decisions on which offenders to target, which drives treatment allocation post-sentence. The major value of assessing risk at the beginning of an offender's sentence is that it assists decision making about who should have priority for programmes. The *need* principle drives decisions about who to target; it assesses the dynamic risk factors, which are aspects of an individual's current functioning related to the occurrence of risk. The need principle suggests appropriate clients for programmes. The final factor, *responsivity* guides the choice about the most appropriate model of intervention. It focuses on a person's capacity and ability to benefit from these change opportunities.

The Department of Corrections assesses eight different rehabilitative needs for those offenders who pose a greater risk of reoffending. These rehabilitative needs are:

- Violence Propensity
- Alcohol and Other Drugs
- Gambling
- Relationship Difficulties
- Offence-Related Sexual Arousal
- Offending Supportive Associates
- Unhelpful Lifestyle Balance

[23] Skodbo, S., Brown, G., Deacon, G., Cooper, D., Hall, A., Millar, T., Smith, J., & Whitham, K. (2007). *The Drug Interventions Programme (DIP): addressing drug use and offending through 'Tough Choices' Research Report 2.* United Kingdom: Home Office.

[24] Andrews, D.A. & Bonta,J. (1998). *The Psychology of Criminal Conduct (2nd edition)*. Cincinnati: Anderson Press.

- Offending Supportive Attitudes and Entitlement

Working in a way that benefits both sectors will therefore need to incorporate current ways of working and foci for Corrections as well as AOD. The areas noted above, (with the exception of offence related sexual arousal, which is catered for as a sub-speciality) are also widely supported within AOD literature as areas of therapeutic focus.

Reintegration Needs

Assessing rehabilitative needs is completed by probation officers pre and post-sentence, but post-sentence there is also a focus on re-integrative needs. AOD treatment agencies similarly will assist offenders to reintegrate into the community when they present for treatment.

There are seven areas of reintegration that are considered by Corrections and highlight areas that need to be supported systemically. The issues are broad and require multi-agency support to be effectively delivered. These areas are:

1. **Accommodation** needs: If clients are living with other offenders, have no accommodation or unsuitable accommodation, or their dependents are at risk of harm from others residing at that address.
2. **Employment** needs: If clients are not in training or education, or have no job.
3. **Financial** needs: If clients have no income source or owe money (including child support, court fines/reparation).
4. **Relationship** needs: If clients have difficulties with important relationships (partner, children, and family/whānau).
5. **Positive Community Support** needs: If clients have no involvement with community organisations, have no hobbies or interests that are non-criminal/AOD related, or have no supportive non-criminal/non AOD using family or friends.
6. **Victim Related** needs: If clients are likely to have contact with a victim that would cause problems for the offender and/or the victim.
7. **Healthcare Continuity** needs: If the client has on-going health issues or problems.

Having a focus on the re-integrative needs of offenders allows systems to collaborate and work on practical support and life skills to allow clients to sustain contact and engagement with an addiction treatment programme, access services and implement changes in their life to address both offending and AOD behaviours. Importantly, a focus on the basic necessities of daily living such as access to housing, employment and training, and prosocial and non-using peers is vital. Without a place to live, an income, or supportive relationships dealing with AOD issues successfully becomes very challenging. AOD treatment services should ensure they are increasing accessibility to both rehabilitative and reintegrative needs.

Through-care and Aftercare

Services which offer a beginning-to-end support system for drug-misusing offenders may hold promise for the New Zealand context. Through and after care as an approach enables tailor-made treatment based on an individual's wider health and support needs and are at the heart of these types of systems.

Through-care is the term used to describe the arrangements for managing the continuity of care provided to drug-misusing offenders, from the point of arrest through to court, sentence and beyond. Very few examples of this exist in the New Zealand context, however the Ministry of Health (MoH) driven pilot project, Single point of Entry (SpoE), discussed earlier is one. This collaboration between MoH and Justice, run since 2014 to embed health funded Addiction Assessor roles within the Corrections work environment, has similar ideologies.

Through-care also allows information about an offender's drug misuse to be provided to prison at the point of reception and details, where possible, what treatment interventions have already been provided in order to ensure continuity of care, including continuity of controlled prescribing such as Opioid Substitution Treatment. Through-care also ensures that progress made by treatment in prison is not lost on an offender's release and that, on release, there is a platform for consolidating the work carried out in prison. This approach can support a reduction in the cycle of reoffending as offenders are referred to partner agencies upon release. The CADS operated programmes within prison have some similarities to this approach.

Aftercare aims to break the drugs–crime–prison cycle, by supporting drug misusing offenders as they are released from custody, complete a community sentence or leave treatment. It is this point where people are most vulnerable and are likely to relapse and return to drug use or crime. Making links with aftercare services as early as possible before the end of a sentence and treatment is widely supported as an effective way to influence these behaviours[25]. The sharing of information cross-sector at this point is very important to facilitate pre-release planning.

Aftercare can involve supporting someone to access drug treatment, as well as accessing 'wrap-around' support that may include help with things like finding somewhere to live, rebuilding family relationships, managing money and getting ready for employment, accessing mental and primary healthcare. It is widely accepted that using a holistic approach to address AOD needs will provide better outcomes[25]. The 'Out of the Gate' programme, which has been rolled out around New Zealand, is an example of linking people with aftercare services.

United Kingdom Exemplar – Drug Intervention Programme

The SPoE system in New Zealand has similar components to the very successful 'Drug Intervention Programme' (DIP) which has been operating for many years in the United Kingdom (UK). The main focus for the UK programme is also a partnership model working and sharing

[25] National Institute on Drug Abuse, & United States of America. (2006). *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research Based Guide.*

information between criminal justice, treatment and aftercare agencies. The DIP has introduced a case management approach, to offer offenders treatment and support from the point of arrest, to sentencing and beyond.

Further, sharing information on the treatment needs of individual offenders allows professional multi-skilled teams to provide tailored solutions[26]. The programme has also successfully engaged hard-to-reach groups aiming to have 1,000 people in treatment and rehabilitation programmes each week, 80 per cent of who have not been in treatment before.

By using this approach, the programme prevents offenders from 'falling through gaps' in the system and supports them at times when, in the past, they have been most at risk of reverting into drug misuse. A case management approach assists prison and probation services by providing access for drug-misusing offenders to assessment and harm reduction advice in police stations and courts and providing early identification of offenders who may be suitable for drug treatment programmes. Multi-skilled practitioners help to identify people suitable for treatment prior to sentence as well as helping to prepare and motivate them if a court mandated treatment condition is imposed by the court. Practitioners compile treatment plans, and facilitate immediate access to appropriate treatment interventions from a wide range of treatment options. This wrap-around approach ensures that information on offenders' treatment needs is made available across collaborating agencies and practitioners so that offenders receive appropriate treatment responses in custody and in the crucial period after release.

A programme such as the DIP programme that offers through and aftercare has been found to improve identification of offenders with AOD issues and provide early low-level intervention. This motivates offenders and reduces the risk of them leaving treatment and reoffending before they have been sentenced. It also assisted with access to post-probation supervision and post-custody treatment provision[26].

Increasing Access to Community Services for Offenders

Building Local Relationships

The relationships between AOD, Corrections and Justice staff will impact on an offender's ability to effectively access the correct treatment for AOD issues. Planning how to build, develop or strengthen those relationships is now needed. Understanding what best practice is for relationships between AOD, Corrections and Justice is an emerging area of research as cross-sector practice models become commonplace. This represents a gap in the current research in New Zealand. Further, as with any community, ensuring relationships are built with those most in need, in this case Māori and Pacific clients and their families, requires cultural consideration. The leaders of both sectors have a responsibility to strengthen the local relationships between the service interfaces which are developing.

[26] http://www.ohrn.nhs.uk/resource/policy/DIPProbation.pdf

Accessibility

Accessibility to the treatment options which are available for offenders, including information on the re-integrative and holistic health and social needs a client has when they re-enter the community, is important. There is a need to be cognisant of the differing literacy and access to electronic media that a client may have, but a number of easy to understand written material and webpages have been shown to be useful in this context.

An example from the UK National Health Service shows a webpage designed for people exiting custody and accessing a range of everyday services such as applying for a passport, applying for emergency housing, registering with a GP, accessing computers, accessing cheap or free furniture and accessing childcare amongst others http://www.impactpathways.org.uk/How-To/. Clear and easy to follow instructions provide offenders and their families increased accessibility to important health and social information. Addressing the holistic health needs, including access to AOD treatment, gives an offender an increased chance to reintegrate successfully into the community and may reduce the chances of reoffending.

Service User Involvement

There is a need for meaningful service user involvement in the design, delivery, assessment and improvement of policies and service provision across the criminal justice system. Clear career routes for former service users that recognise and value the skills that people with convictions possess also should be encouraged[27].

As found in other areas of AOD practice, active service user involvement to inform service delivery and policy has many benefits. There is support from Corrections for a wider use of peer mentoring schemes, as well as clear career routes for former service users so that they can progress to (and from) mentoring roles if they wish. Embedding service users in programmes that provide treatment to this population is likely to increase accessibility. Further review on this area of practice is needed to improve understanding on what is currently available in the Counties Manukau region.

[27] *Practice: The New Zealand Corrections Journal. Volume 3 Issue* 1: April 2015. Desistance.

Conclusion

This review of practice and selected literature has discussed current programme models and treatment approaches available to service users with AOD needs who are also involved in the Justice system. Many differing services and practitioners work with this population group, however historically a lack of cross-sector collaboration has prevailed. The challenge in the future is to build effective working relationships and understand both sectors' measures of success to provide the most effective models of care and interventions for both services and service users.

Providing increased access to AOD treatment for this particular population in Counties Manukau presents an opportunity for the AOD Provider Collaborative to work systemically, particularly in the areas of mapping and disseminating information about services to improve accessibility; investigating ways to improve collaboration across sectors (especially at the practitioner level); and to ensure clear referral pathways are understood and easily accessed for both professionals and those individuals and families involved in the Justice system.

Summary of Broader Recommendations

- Consideration should be given to forming a collaborative planning group composed of representation from key stakeholder groups who have decision making authority and invested commitment. This may assist with addressing systemic issues related to working collaboratively. These stakeholders could include representatives from local government, police, primary care agencies, the judiciary, community health providers, AOD treatment services, corrections, justice, and social service providers such as housing and employment services.
- A programme informed by successful models such as the DIP, focused on through-care could be piloted in a correctional facility such as MECF but would require a strategic and financial commitment from both justice and health sectors to implement, monitor and evaluate.
- Aftercare and through-care are supported pathways of care and represent an area of opportunity for improved service delivery and can be modelled on successful programmes in other jurisdictions.
- Further investigation into the potential role of mentors, the role of peer support and service user involvement to support this population at all stages of their sentence is needed. Peer support may be particularly useful following AOD treatment to assist reintegration into the community.
- With the high rates of trauma and post-traumatic stress disorder experienced by women, additional care is needed to ensure their mental health care and AOD needs are appropriately met.
- A more detailed review of the characteristics of prisoners with unmet AOD treatment needs is another important area for research.

Recommendations for the AOD Provider Collaborative

Mapping of Services

- An operational stock take should be undertaken to ascertain which services are operating in each sector at ground level, given the lag between service implementation and published research or evaluation. A workshop with key stakeholders to begin mapping current availability of services would be helpful.
- This mapping should also review the provision of service user informed, or delivered, practice available to this population currently operating in the Counties Manukau region as this is widely unknown from the available literature.

Cross-sector Collaboration

- To enable practitioners to work across sectors, practitioners should be supported to understand each other's sectors and develop relevant skills. Bringing both groups together to identify professional development needs would be a useful first step.
- Providing training across disciplines and sectors is important to up-skill practitioners in each other's areas of practice. For example, liaison people could visit each service (reciprocal) with presentations and information, in order to build relationships, understand each other's needs and how to work with each other's populations. The provision of training secondments between different services/sectors is also useful for up-skilling.
- Identifying liaison people in both sectors who could be contact points for each service would help to improve collaboration (co-location of practitioners, such as is found in the SPoE programme, is ideal).
- Improving the mental health and addiction literacy and training of the Corrections workforce would be a helpful strategy to improve access to treatment for AOD specific needs for offenders and family/whānau.

Referral Pathways

- Providing information, reducing barriers to AOD treatment engagement, and increasing accessibility, are three system level areas that the AOD Provider Collaborative may be able to prioritise. These efforts should be targeted at primary care, practitioner and offender/family/whānau levels. A focus on increasing accessibility and information around referral pathways for these groups may be a good first step. Identifying potential champions to inform this process would be useful.
- Clear referral pathways into services, including low threshold access to advice and information, needs to be made available to practitioners from both sectors and to all services working with this group.

Appendix 1: Recovery Consensus Statement

The UK Drug Policy Commission Consensus Group:
Developing a vision of recovery – a work in progress[28]

The key features of recovery from problematic substance use:

1. Recovery is about building a satisfying and meaningful life, as defined by the person themselves, not simply about ceasing problem substance use.
2. Recovery involves the accrual of positive benefits as well as the reduction of harms.
3. Recovery includes a movement away from uncontrolled substance use and the associated problems towards health, wellbeing and participation in society.
4. Recovery is a process, not a single event, and may take time to achieve and effort to maintain.
5. The process of recovery and the time required will vary between individuals. It may be achieved without any formal external help or may, for other people, be associated with a number of different types of support and interventions, including medical treatment. No 'one size fits all'.
6. Aspirations and hope, both from the individual drug user, their families and those providing services and support, are vital to recovery.
7. Recovery must be voluntarily-sustained in order to be lasting, although it may sometimes be initiated or assisted by 'coerced' or 'mandated' interventions within the criminal justice system.
8. Control over substance use is a key part of recovery, but is not sufficient on its own. Positive health and well-being and participation in society are also central to recovery.
9. Control over substance use means a comfortable and sustained freedom from compulsion to use, which in many cases may require abstinence from the problem substance or all substances, but may also encompass consistently moderated use and abstinence supported by prescribed medication, peer groups and families.
10. Positive health and well-being encompasses both physical and mental good health as far as they may be attained for a person, as well as a satisfactory social environment.
11. People do not recover in isolation. Recovery embraces inclusion, or a re-entry into society, the improved self-identity that comes with a productive and meaningful role, and also the idea of 'giving back' to society and others, such as family members, who may have been adversely affected by the individual's substance use.
12. Recovery-oriented services need to support the aspirations of each individual to assist individuals build recovery across all the above domains.

[28] UK Drug Policy Commission, (2008) *Recovery Consensus Statement*, www.ukdpc.org.uk/Recovery_Consensus_Statement.shtml