

Enquiry into the provision of alcohol and drug  
rehabilitation services following contact with  
the criminal justice system

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**The Victorian Ombudsman respectfully acknowledges the Traditional Owners of the lands throughout Victoria and pays respect to them, their culture and their Elders past, present and future.**

# Letter to the Legislative Council and the Legislative Assembly

To

**The Honourable the President of the Legislative Council**

and

**The Honourable the Speaker of the Legislative Assembly**

Pursuant to sections 25 and 25AA of the *Ombudsman Act 1973*, I present to Parliament my *Enquiry into the provision of alcohol and drug rehabilitation services following contact with the criminal justice system*.



Deborah Glass OBE

**Ombudsman**

6 September 2017

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# Foreword

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*“My son had to go in and out of prison three times before he had access to the programs. Perhaps he may not have been in the other times if he had been in treatment.”*

Quote from ACSO submission  
to Victorian Ombudsman

In September 2015 I tabled a report into the rehabilitation and reintegration of prisoners in Victoria. That report informs and contextualises much of the work in this enquiry – for example, the striking statistic that over 75 per cent of male prisoners and 83 per cent of female prisoners reported illicit drug use.

The report highlighted the significant issues with access to alcohol and other drug (AOD) treatment programs in prison. It also highlighted that the majority of former prisoners are released into the community with little or no formal support. For those with AOD addiction, that is a situation that makes relapse all but inevitable – thereby fuelling Victoria’s billion-dollar recidivism merry-go-round.

Having tabled the report to wide and encouraging support from individuals, community service organisations, government and others across a range of sectors, I then asked: what now? Having gained detailed knowledge of the broad landscape I wanted to focus on the ‘hinge points’ in the journey of a prisoner’s life where a change in their situation could have broken the cycle of recidivism.

One of these ‘hinge points’ revolves around AOD use: the cold grip of addiction drives a pattern of reoffending, in which too many people cycle in and out of prison. So I decided to look further at this particular sector – paying particular attention to the experience of people in rural and regional Victoria.

As part of this enquiry we met with agencies and individuals with firsthand experience of addiction and the criminal justice system. The single issue that stood out, unsurprisingly, was resources. There are not enough publicly funded rehabilitation beds. Waiting lists for treatment are too long. There is not enough housing for prisoners upon release – too often people without accommodation couch-surf back into bad habits.

But we also found that government and associated agencies are taking some steps to address the issues. As I recommended in the 2015 prisons report, the Drug Court model has been expanded. There is more funding for residential rehabilitation beds, including in regional Victoria. Reforms to the way in which data on AOD treatment programs is collected and analysed are being developed.

While I have concluded the enquiry without launching a formal investigation, I think it is important to produce a document of record that informs the parliament and public of the submissions received and the reforms underway. And, of course, I will be paying keen attention to the rollout of the programs, reforms and funding in this vital area, and will report further as I think fit.

Deborah Glass

**Ombudsman**

# Background

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1. In September 2015 I tabled an *Investigation into the rehabilitation and reintegration of prisoners in Victoria*. The report examined a wide range of factors contributing to both the rise in prisoner numbers in Victoria and the state's high recidivism rate. I reported then:

In the four years between 2009 and 2012, the Victorian prison population rose by just under 11 per cent. In the subsequent three years, this growth more than doubled to 25 per cent. The new Ravenhall prison, with an initial capacity of 1,000, is due to open in 2017, but on current projections, Victorian prisons will again be at capacity by 2019.<sup>1</sup>
2. Those predictions have been borne out. It is a matter of record that Victoria's prison population is at a historical peak and over 7,000<sup>2</sup> men and women are behind bars. Incarceration is now a billion-dollar business in Victoria. Yet the rate of recidivism means that despite this vast cost to the public purse, building more prisons is not making us safer.
3. As I also reported, the links between problematic substance use and offending are strong: over 75 per cent of male and 83 per cent of female prisoners reported previous illicit drug use. With such prevalence, it is not surprising that substance abuse has become recognised as a significant challenge to rehabilitation. At its most acute, this is manifest in the tragically high rate of death and overdose amongst prisoners upon release into the community: Coroners Court data shows that between 2000 and 2010, 120 former prisoners died from drug overdose, an average of one death each month.
4. The 2015 investigation determined that effective alcohol and other drug rehabilitation services – both inside and outside the prison system – are a key plank in reducing recidivism. Recommendation 9 of the report was for AOD programs to be available in all Victorian prisons, a measure supported by the Department of Justice and Regulation (DOJR). In February 2016 the DOJR reported that the implementation of this recommendation was completed.
5. The 2015 investigation also noted:

The effectiveness of prison-based AOD programs is only fully tested once the participant is released back into the community. Yet transitional support services for prisoners with substance abuse issues are inadequate and community-based support services for former prisoners are limited.<sup>3</sup>
6. The 2015 investigation also identified alternative approaches to prison as highly effective in reducing the number of people who come into contact with the criminal justice system for AOD issues – for example, the Dandenong Drug Court, which had demonstrated a 34 per cent reduction in reoffending in 24 months. Recommendation 3 called for further investment in Drug Courts, along with a commensurate increase in the capacity and availability of support services connected with such programs. The recommendation was accepted and in March 2017 the \$32 million Melbourne Drug Court was launched.

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<sup>1</sup> Victorian Ombudsman, *Investigation into the rehabilitation and reintegration of prisoners in Victoria*, September 2015, page 4.

<sup>2</sup> As of 21 August, 7,135; Source: Corrections Victoria.

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<sup>3</sup> Victorian Ombudsman, *Investigation into the rehabilitation and reintegration of prisoners in Victoria*, September 2015, page 6.

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7. The 2015 report attracted much interest from a wide range of government agencies, non-government bodies, individuals and others in the community. As a result I addressed and took part in panels and other discussions at a range of events across Victoria and Australia. From these discussions some common concerns emerged. These themes expand on the findings of the 2015 investigation, in particular on the lack of access to services for prisoners on release as a barrier to their rehabilitation. The particular problems of access in regional and rural Victoria were also highlighted.
  8. As a result, I decided to undertake an enquiry into the availability and effectiveness of alcohol and other drug services following contact with the criminal justice system. The enquiry specifically focussed on:
    - The experiences of former prisoners referred to community based AOD services, particularly in rural and regional Victoria.
    - The effectiveness of community based AOD services across Victoria in preventing and reducing the number of AOD users facing court or prison.
  9. I sought submissions as a way of identifying the issues of concern to Victorians, and to determine whether there were issues to be addressed through formal investigation.
- ## Methodology
10. On 12 December 2016 I announced that I was conducting an enquiry on my own motion pursuant to section 13A of the *Ombudsman Act 1973*. An enquiry is not a formal investigation; its purpose is to determine whether a matter can be resolved informally or whether an investigation should be conducted. While I am unable to exercise coercive powers during an enquiry, the heads of public sector bodies are required to cooperate with the process.
  11. I said at the time, that of interest to the enquiry are the experiences of ex-prisoners and others in contact with the justice system who have engaged, or sought to engage, with AOD rehabilitation services.
  12. I received a total of 23 submissions; 11 from organisations and 12 from individuals, many of them parents.
  13. My investigators met with a number of those who made submissions to explore the issues further. As the matter was conducted by enquiry, we did not hold formal interviews.
  14. While our call for submissions focused on people who had had contact with the criminal justice system, some of the submissions raised broader issues. This paper therefore refers to both 'forensic' and 'non-forensic', or voluntary, contact with AOD services. Forensic AOD users are defined by the Department of Health and Human Services (DHHS) as '... people who access alcohol and other drug treatments as a result of their contact with the criminal justice system'. Voluntary AOD clients are those who have chosen to seek AOD treatment without being referred by a court or as part of a sentence imposed by a court.
  15. Following the meetings and an analysis of the submissions, Ombudsman officers met with senior staff at the DHHS in May 2017 to discuss the key issues raised and to seek the department's response.
  16. Both the DHHS and the DOJR were provided with a copy of the draft report and their comments are included.

# Enquiry

## Submissions

17. While I received relatively few submissions, they identified a wide range of concerns, including:
  - limited numbers of publicly funded residential beds for AOD treatment
  - long waiting times to access services
  - problems accessing housing for prisoners post release from prisons
  - lack of pharmacists dispensing pharmacotherapy services
  - criticism of the range of clinical treatment options
  - lack of regulation of private rehabilitation centres.
18. The most common issue raised related to service availability, with comments and examples illustrating the importance of having services available at the time a person is available and willing to engage in rehabilitation.
19. Although we sought submissions about people's experience of AOD services following contact with the criminal justice system, and on the experience of service users in rural and regional Victoria, of the other issues raised there was little commonality, and these were generally only raised in a single submission.
20. Some submissions from individuals have been used in part or in their entirety as case studies, as the following example illustrates:



### Mrs Z – son denied alcohol rehabilitation due to smoking

Mrs Z's son Mr Z died aged 41 after a long struggle with alcohol addiction and depression.

In January 2016 Mrs Z took her son to a public hospital as he was undergoing severe and very dangerous withdrawal from alcohol. He was treated in the Emergency Department and assessed by a multi-disciplinary team as requiring detoxification and rehabilitation for his alcohol addiction. He was transferred to a public facility, House Q, and was told he was extremely lucky to be able to immediately access a bed.

Mr Z later wrote of that morning:

... easily the most terrible morning of my life. I haven't been that sick, with the shakes (extremely violent), the sweats (heavy droplets from my head), vomiting, not being able to walk, or barely at least.

However the rules at House Q forbid smoking and three days later, he left the service. Mrs Z said:

Sadly, [my son] was unable to stay in [House Q] because by Sunday he was desperate to have a cigarette. We had bought him nicotine patches, puffers etc, all that was allowed, but he was unable to deal with the cravings of giving up alcohol and cigarettes at the same time.

Mr Z tried to address his addiction a number of times after his experience in House Q in 2016. A home detoxification program supervised by his GP failed due to a lack of ongoing professional support.

He again tried to access the public health system but faced long waiting lists. In addition, he was told that when a place was available, he would need to respond immediately, which would not leave him time to arrange time off work.

Mr Z died in September 2016. His mother said:

We will never know if he would have been able to stop drinking dangerous levels of alcohol if he had been allowed to be treated for his addiction and his depression while at [House Q]. How does this fit with policies of 'harm minimisation'? For our son, treating his alcohol addiction, and his depression, even while he continued to smoke, would have been harm minimisation in action. It could have given him many more years of life, and by definition time to stop smoking.

...

[Our son] was a worthwhile human being and deserved better. People with dependency problems are not the 'scum' they are so often portrayed as. They are the sons, daughters, partners, family members, people who need treatment and support, not derision and abuse.

21. The most identifiable themes are set out further below.

## Access to services

22. About 40,000 Victorians access AOD treatment services every year however access to services remains an issue of concern. There are currently 250 publicly funded residential rehabilitation beds in Victoria. Of these, only 15 are located outside of metropolitan Melbourne.
23. A major concern about the lack of publicly funded residential beds in Victoria, especially in rural and regional areas, relates to the importance of having services immediately available at the time a person is willing to engage, to maximise the success of their treatment. AOD users forced onto long waiting lists often disengage from services and the moment to seize the opportunity to change is lost.



### Mrs C – halfway house

Mrs C's son was released from prison in the last year. He has been in and out of prison a few times over the last few years, and the story remains the same: Mrs C says she feels he is released into a situation where he is set up to fail.

When her son was released from prison on a previous occasion, he went into a halfway house with seven other roommates, who Mrs C believes were also drug users. The house was filthy and he was paying \$170 for a room smaller than his cell in prison.

Mrs C said that currently her son is on a six week waiting list to get treatment for his drug use. She says that this isn't much use, as people need to go into treatment when they are ready for assistance.

Mrs C says all her energy now goes into keeping her son alive, and that she's 'a bit over it'. That said, she does hope to see some improvement soon.

24. As a social worker who made a submission put it:

My experience as both a professional and family member is that drug addiction tears apart the fabric of family and social connections. More often than not, individuals with addiction issues have pushed away their closest friends and family. Some of these individuals are also victims of the housing crisis – living on the streets, in unsafe and drug filled boarding houses, or are reliant on ageing parents who do not have the support or skills to help their beloved child. Too often I hear stories of family members being subjected to family violence at the hands of their loved one with addiction...To expect families or friends to shoulder the burden of providing accommodation and support to an individual engaging in day program treatment is to ignore the complexities around drug abuse and addiction.

I believe that we not only need to increase funding to residential rehabilitation programs, but also the Government needs to make a solid and long term commitment to publicly fund access and shorten wait times... A six month wait... is often a death sentence.<sup>4</sup>

25. Jesuit Social Services noted in its submission:

Post release rehabilitation services are critical for highly vulnerable people exiting prison who are subject to an increased risk of death and drug overdose... Current transitional support services for people exiting prison are inadequate, and limited community based supports are struggling to keep up with the increased demand.

26. It also noted:

... people exiting prison commonly have relatively chaotic lives and do not successfully engage with appointment-based supports [hence the importance of developing relationships as a precursor to more formal therapeutic engagement].

<sup>4</sup> Submission from individual, 24 February 2017.

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27. Jesuit Social Services delivers the Connexions program, working with marginalised young people aged 16 to 28, particularly those struggling with mental health and substance abuse. The submission describes the difficulty participants have faced in accessing drug and alcohol rehabilitation programs both before and after release from prison, including the following case study:



### Jason's story

Jason<sup>5</sup> has been participating in the Connexions program since January 2014, predominantly to access counselling. He is currently serving a prison sentence in Ararat, is due for a straight release with no supervision, and is subject to reporting obligations on the Register of Sex Offenders.

Jason has a significant history of homelessness and alcohol dependence and reports that he has only ever offended while intoxicated. He expressed a desire to access a residential rehabilitation program upon release as a 'step-down' from custody, to reduce his likelihood of a relapse and to build his living skills.

Jason's Connexions worker referred him to alcohol and drug rehabilitation services via the central intake, requesting a referral to a residential program. The process was difficult to navigate due to Jason's current incarceration, the regional nature of referrals and Jason's lack of specificity regarding his likely location upon release.

Jason's worker was able to refer him to residential program waitlists, although the worker was advised that Jason would only be able to be placed on the waitlist for one program at a time. Eventually a residential program with a place available was identified, however Jason's referral was unsuccessful as a result of a number of issues, including:

- difficulty obtaining information from Jason due to his current incarceration
- lack of flexibility around the need to have stable housing secured pre-release, and
- lack of capacity to provide support to a person with a history of sexual offences.

Further to this, the inability for Jason to be placed on more than one waitlist for a residential program reduced the likelihood of a successful outcome.

As a result of the difficulty of accessing an alcohol and drug rehabilitation program, Jason has lost motivation to engage with services and will be released from prison without this support.

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<sup>5</sup> Not his real name; case study provided by Jesuit Social Services submission February 2017.

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28. In meetings with Ombudsman officers, the Victorian Association for the Care & Resettlement of Offenders (VACRO) and the Victorian Aboriginal Legal Service (VALS) also described the lack of access to residential rehabilitation beds. VALS highlighted that this was a particular problem in rural and regional areas where there are fewer providers, and where some clients are refused due to previous behaviours, for example, aggression due to mental health issues. For VALS, wait times were an ongoing issue, as was the lack of culturally appropriate services.



### Ms R - mental health and AOD on rehab

Ms R said her son had been referred to a private facility by a psychiatrist. All the other people at the facility were either on bail or parole, and her son, who had no experience of the prison system, felt threatened. Some carried on criminal conduct from the centre, placing her son at risk.

The centre was only staffed from Monday to Friday, during office hours, which meant many of the other clients would openly engage in criminal activity over the weekend. In addition, the lack of staffing meant that drugs prescribed to clients would be dispensed on Friday in doses meant to last the whole weekend, but many clients would take their whole prescription at once to get high.

Ms R said that rehab treatment usually consisted of a single hour-long meeting per day, which often involved simply watching a video. On some occasions a psychologist would come in for an hour.

After suffering a seizure, Ms R's son was kicked out of the centre, and even though he returned for further treatment, Ms R says staff showed little interest in his health issues.

The centre cost \$300 a week, which was covered by her son's disability support pension payment, leaving him with little or no other money. In addition, the centre charged \$1000 extra to have a support worker attend a court hearing with her son to confirm to the court her son was receiving treatment for his drug issues.

Ms R raised significant concerns about the lack of specialised qualifications among staff. She also said the food provided came from a 'foodshare' service that collects and redistributes second hand items or food past its use-by date.

Ms R said the only reason her son went to the service was because the waiting lists for a publicly funded placement were so long. Her son had de-toxed about ten times previously, but had always relapsed while waiting for a place at a publicly funded facility.

On one occasion, while trying to access a publicly funded place for her son, Ms R was told her son's mental health issues meant he would not be suitable for a dedicated AOD service. But she was then told by the relevant mental health service that they could not treat him due to his AOD issues.

Ms R said she had contacted the Department in an effort to get assistance for her son, but the Department was unable to help.

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29. North Richmond Community Health described a number of barriers their clients experienced in obtaining appropriate rehabilitative treatment, including a severe shortage of pharmacotherapy prescribing doctors in Victoria, as well as other social issues that can result in denial of treatment.
  30. The lack of suitable numbers of publicly funded beds in Victoria has given rise to an extensive and largely unregulated privately-run rehabilitation service sector. Due to a lack of regulation, the scale of the sector cannot be accurately quantified, but media and anecdotal reports suggest thousands of people each year engage their services.
  31. Colac Health noted that in its rural area, there is a minimum one month waiting time for inpatient detox.
  32. VALS spoke about delays for clients in meeting a community corrections officer. It described a case where it took two weeks after release for the community corrections officer to meet with its client; these delays - especially in the first two weeks - can have significant consequences.
  33. VACRO told the enquiry that obtaining methadone can be difficult, especially in rural and regional areas, due to a smaller catchment of pharmacists and a lack of willingness among many pharmacists to participate in methadone programs.
  34. Access to secure housing was also highlighted by many submissions as a key issue for individuals with AOD issues.



### Mr T - prison and ice

Mr T is a long term ice user who was released from prison in 2009. He had been involved with the child protection system and the youth justice system prior to entering adult prison on drug charges.

There were no dedicated AOD services at the time for people on a 'straight release', although he got in touch with a community service organisation and found a supportive case worker.

However Mr T's drug use continued and he again sought assistance from publicly funded AOD providers in 2016. He waited two months to get a bed at House X, and says he is aware of people waiting up to six months for a bed.

At House X, Mr T found rehab groups of up to 50 people, which he says made it difficult to properly 'open up'. Mr T ultimately left House X, saying it was run like a prison, and that the service also had women with their children as clients, which he felt made the process very difficult.

Mr T subsequently engaged with a church funded and supported rehabilitation service, where he was able to secure a place for detoxification and rehabilitation. He was referred by a local charity which does not receive any government support.

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35. The Council to Homeless Persons pointed out:

Recent data released by the Australian Institute for Health and Welfare indicates that 29% of Victorian prison discharges expect to exit into homelessness... We know that without housing people are far more likely to struggle to gain employment, to connect to education, and to fulfil any conditions of their release from prison. Homelessness, and the exclusion accompanying it, sets them up for a cycle of drug use, criminal activity and imprisonment – at significant cost to the community, and to state expenditure. The fact that 63% of prison entrants have been in prison previously is evidence of the failure of the current processes.

36. The Victorian Alcohol and Drug Association (VAADA) provided research demonstrating that problems with access to AOD services were exacerbated for ex-prisoners in rural and regional areas:

there is a consensus (from VAADA members) that access to associated housing or mental health services is crucial whilst also challenging for [recently released prisoners]. By way of example, one agency noted that three recently released prisoners were all provided accommodation within the same caravan park, with little consideration of any potential risk related to previous associations within the criminal justice system.

37. Concerns about housing for recently released prisoners were echoed by VACRO, which noted that most recently released prisoners are single men under 40 who do not receive housing priority and can wait up to six years for an apartment, longer in rural and regional areas. VALS also highlighted the housing need and its importance as an issue.

38. The complexity of services required to support the rehabilitation of people with highly complex needs, in particular those with AOD and mental health or other health issues, was also highlighted. The Magistrates' Court of Victoria submission commented:

The systemic issues [in this submission] are complex and inter-related. The consequence is that many accused persons with AOD issues experience long delays in accessing treatment options. When they do receive treatment it possibly does not address the nexus between their substance abuse and offending. This has a flow-on effect to the individual's prospects of rehabilitation. Of particular concern is that the risks of re-offending are not being addressed in a timely manner.

### What is being done?

39. The 2015 prisons report touched on a number of these issues, and the recommendations in that report included:

Investigate options to address post-release housing for former prisoners... [Recommendation 21]

and

[I]nvestigate a 'throughcare' model from prison to community health services, to address the health needs, in particular mental health, alcohol and drug, and disability, of prisoners being released into the community. [Recommendation 22]

40. Both recommendations were supported and are advised to be 'in progress' – the most recent update to Recommendation 22 being that 'Corrections Victoria is working with DHHS to investigate how to improve the current throughcare model.'

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41. In response to the draft report, DOJR advised:<sup>6</sup>

In 2017-18, the Government invested a further \$41.1 million in programs and services to reduce reoffending – including a three-fold increase in the number of prisoners able to access post-release support services.

The Reintegration Pathway for prisoners provides an integrated approach to transitional planning and support that directly targets the seven critical intervention areas which commence on entry to the prison system and continue post release, for eligible prisoners. This has included the introduction of a new pre-release service and post-release service.

The Reintegration Pathway has been specifically designed to target seven critical areas demonstrated by the evidence to be key in effective and successful reintegration of prisoners.

These critical areas are:

- Education and training
- Community and family connectedness
- Mental health
- Alcohol and other drugs
- Employment
- Independent living skills
- Housing

The service operates as a hybrid model combining DOJR staff with contracted services delivered by Community Service Organisations. The pre-release service is delivered by the Victorian Association for the Care and Resettlement of Offenders (VACRO) and is known as the ReLink program, with the post release service delivered by four providers to ensure a state-wide service inclusive of an Aboriginal specific response.

42. The issues surrounding the shortage of services, in particular residential beds and housing, are well recognised. While the adequacy of funding will no doubt continue to be an issue for individuals and community service organisations, the government announced in its May Budget funding for ‘at least 30’ new residential rehab beds, to be available at the end of the 2017-18 financial year, as well as additional funding for community corrections orders to meet increased demand.<sup>7</sup> There is funding to locate land for the building of three new residential facilities in the Gippsland, Hume and Barwon regions ‘which will deliver at least 60 additional beds once constructed’, as well as additional support for people at high risk of overdose or relapse.

43. DHHS noted in response to the draft report:

In total, this means that the government will have provided funding to increase the capacity of residential rehabilitation by 68% once these new facilities are fully operational. This significant investment in new residential rehabilitation beds will seek to reduce waiting times and improve access to services in regional and rural areas.<sup>8</sup>

44. In relation to housing, DHHS advised that while there is some priority housing for AOD clients in the housing stream, it remains a pressure. One of the problems is that people with complex life circumstances often are lacking the life skills to maintain housing. A new program, Turning Point, is providing courses in life skills as part of the therapeutic treatment options.

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6 Letter from Acting Secretary to Ombudsman dated 16 August 2017.

7 [https://www.budget.vic.gov.au/program\\_project/treatment-alcohol-and-other-drugs](https://www.budget.vic.gov.au/program_project/treatment-alcohol-and-other-drugs).

8 Letter from DHHS Secretary to Ombudsman dated 14 August 2017.

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45. In a further update in response to the draft report DHHS advised:
- ... the government has committed \$5.5m over five years to extend homelessness assessment and planning capacity across Victoria's prison system.
- The department also has several joined up initiatives underway with the Department of Justice and Regulation that provide transitional housing pathways for people entering and exiting prison... The housing worker can also provide assistance to people exiting prison to access post release housing and support, including purchased emergency accommodation with the use of flexible funds.
- The department will continue to work closely with the Department of Justice and Regulation to improve housing outcomes for people exiting prisons.
46. The issues with access to services for people with both AOD and mental health needs is also recognised, acknowledged to be very problematic, and an issue the department says it is continually working on. For example, in a residential setting it can be very disruptive to other participants if one of the participants has mental health issues that are difficult to manage. Effective treatment is impacted by all forms of complex behaviours; a centre has to weigh up the impact on that individual versus the overall impact on all attendees at a centre, and its staff. Although most centres have staff who are qualified practitioners in mental health and addiction issues, the focus and balance of staff varies from facility to facility. While there is an ongoing necessity to attempt to balance the capacity of the provider and the mix of current clients, it remains, and is likely to continue to remain, a difficult issue trying to provide a service for people with challenging behaviours.<sup>9</sup>
47. DHHS also indicated that the difficulties in treating for dual diagnosis and smoking are particularly problematic. There are different clinical views on what treatment is most effective; some centres, for clinical and OHS reasons, will not allow attendees to smoke while undertaking AOD rehabilitation. However a number of centres do not have this restriction so there are provider options.
48. DHHS currently requires all providers to treat a minimum of 20 per cent forensic clients in order to ensure that individuals seen as 'difficult' are also able to access treatment.

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9 Ibid.

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## Intake and assessment

49. Several submissions raised the issue of double handling at the intake and assessment point as a concern, although others saw it as a benefit. The current process has a centralised intake and assessment, with a client then referred to a treatment provider.
50. Other submissions raised concerns about practical problems occurring at the assessment stage, including the complexity of life circumstances for an ex-prisoner, who may have a number of different caseworkers, that make it more difficult for the ex-prisoner to seek help as they are unable to develop the necessary strong and trusting relationships.

### What is being done?

51. DHHS recommended to the Minister in November 2016 that the process be decentralised, and this has now been agreed. Training on this process for providers is currently underway.
52. ACSO is currently working with DHHS and Corrections Victoria to review and develop a specialist forensic AOD assessment which will incorporate ASSIST, an assessment tool developed by the World Health Organisation that identifies the level of harm associated with a person's drug use.

53. In a further update in response to the draft report, DHHS advised:

Following extensive sector engagement, new intake and assessment arrangements took effect from 1 July 2017. These new arrangements see the assessment function being devolved to treatment providers, meaning that treatment providers can build therapeutic relationships earlier...

The new arrangements:

- Maintain a statewide approach to client pathways
- Recognise that assessment is an important part of building the therapeutic relationship and thus needs to be conducted by treatment providers
- Retain an intake function that allows for clear points of access for eligible drug treatment clients
- Create a faster pathway for clients to access treatment providers and reduce disruption in care pathways
- Are expected to improve capacity for face-to-face assessment provision.<sup>10</sup>

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<sup>10</sup> Letter from DHHS Secretary to Ombudsman dated 14 August 2017.

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## Data collection and analysis

54. A number of submissions raised questions about the lack of analysis of programs, and their effectiveness. Concerns were also expressed by service providers about the adequacy of information being passed to them. For example, they may be referred to someone with AOD issues, but not know the person also has mental health issues and an acquired brain injury. VACRO told us that once an offender is released into the community, it does not know if the ex-offender continues with AOD treatment they may have been receiving in prison.
55. The Centre for Mental Health and Health Policy told us:

Improving substance-related outcomes for people released from prison will require building the evidence base, but the Victorian Department of Justice has, historically, seemed reluctant to engage with researchers; particularly those interested in the health of prisoners and ex-prisoners, and particularly when those researchers insist on making their research findings public.

In summary we argue that important gaps in the evidence base preclude development of targeted, evidence-informed responses to substance-related harm in people released from prison. Further gaps between evidence and policy suggest scope for policy reform to achieve better outcomes.

56. The Magistrates' Court of Victoria submission highlighted significant issues with AOD providers and information and data supplied to the court, especially the poor quality of AOD reports tendered as official documents:
- They have been found to lack objectivity, to be factually incorrect and contain grammatical errors. In some cases, due to their poor quality, program staff have not tendered the reports to the presiding magistrate.

## What is being done?

57. The Victorian Auditor-General's Office (VAGO) recommended in 2011 that the then Department of Health update its data collection for the AOD sector. The most recent information from DHHS is that the new data collection system commenced on 1 July, with an 18 month implementation period. DHHS is expecting all providers to be compliant by the first quarter of 2019. The quality of reports remains a matter for the providers, however.
58. The key shift is to record outcomes rather than inputs, and DHHS believes the new system will help in identifying and managing the varying needs of different clients, such as those who have a need for mental health treatment in addition to their AOD issues.
59. In a further update in response to the draft report DHHS advised:

The new approach to data collection will allow the sector to develop a better understanding of how clients travel through treatment services and by imp[roving] data quality, allow for more accurate assessment of system performance and client trends.

Importantly, the [new Victorian Alcohol and Drug Collection] will capture both baseline and outcome measures across a range of domains, including substance dependence, mental health, physical health, employment and quality of life. This will allow stronger understanding of the outcomes of alcohol and other drug treatment for clients, helping to drive service delivery over time.<sup>11</sup>

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<sup>11</sup> Letter from DHHS Secretary to Ombudsman dated 14 August 2017.

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## Funding models

60. Understandably, many service providers were concerned about the level and basis for their funding. VALS, for example, pointed out that it is only funded to assist 20 clients across Victoria, where other services have a region of the state, which impacts on the support it can provide to Aboriginal and Torres Strait Islander peoples.
  61. A number of providers remain concerned about the funding model, which is based around measuring units of work, rather than outcomes. For example, a provider is funded on the number of counselling sessions it provides but there is no funding tied to whether those sessions were effective or not.
  62. Concerns were also expressed about the funding for forensic, as opposed to voluntary, services. With voluntary clients, providers are given full payment for a series of treatments regardless of attendance at all appointments in that series. For forensic clients, providers are only paid for the sessions actually provided to the client.
  63. Eastern Access Community Health (EACH) made the point that government funded rehabilitation facilities are mandated to hold a mix of voluntary and forensic clients, which can create internal tensions, and that the government should consider a forensic-only rehabilitation model to focus on the needs of this cohort.
  64. The Magistrates' Court of Victoria also questioned the efficiency of the current model used for AOD:

Concerns have been raised that there is very little difference between the types of AOD treatment provided to forensic and voluntary clients, and that participants do not have access to a sufficient range of treatment options. These would include residential and non-residential rehabilitation and detoxification programs. These concerns highlight the need for greater variety in the treatment options available to forensic participants. This would ensure interventions can be targeted to each participant's needs.
  65. The Centre for Mental Health and Policy says that funding goals beyond simply reducing recidivism should be explored:

... existing services are funded largely on the premise that they reduce recidivism. Although this is clearly an appropriate goal, it is not the only outcome that matters. Improving health outcomes for people released from prison is important on human rights grounds. Further, gaps between evidence and policy suggest scope for policy reform to achieve better outcomes.
- ### What is being done?
66. The current funding model was amended in 2013. It is based around measuring units of work rather than outcomes. This structure creates challenges for providers dealing with forensic clients, and also those engaged in work in rural and regional areas.
  67. Funding models are likely to continue to evolve and a transition to the market model being used by the National Disability Insurance Scheme is seen in the sector as likely. Further work is also likely to be needed to ensure that the treatment available to forensic clients is delivered as effectively as possible.

# Conclusions and further action

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68. There can be no doubt that drug and alcohol addiction, with its huge impact on individuals, families, crime rates, and the community as a whole, is a matter of significant social concern. This enquiry did not attempt to scope the broader issues, but to consider the impact in relation to released prisoners, following my 2015 prisons report.
69. It is not surprising that the submissions have highlighted once again that access to rehabilitation services, including the provision of secure housing to support rehabilitation prospects, remains the dominant concern for individuals and organisations.
70. A consistent theme was that timely access to services is essential for the best chance of successful treatment. Long waiting times for inpatient detox services, particularly in rural and regional areas, are a major hurdle in the provision of AOD services and ultimately, effective rehabilitation.
71. As noted, we received relatively few submissions and apart from access to services, we identified no other consistent theme or administrative action suitable for further investigation.
72. The low number of rehabilitation beds per capita in Victoria compared to other states is well documented, as are wait times to access services, and I note the steps being taken by DHHS to respond to the pressing issue of resources. While it can only be considered a step towards meeting the overall need, the 2017 budget has included an increase in funding for general residential AOD treatment, including an increase in the number of available beds, especially in rural and regional areas.
73. Many submissions also highlighted the importance of access to secure housing and the impact this has on individuals with a history of substance abuse, especially those being released from prison. This issue, which I first raised in my 2015 prisons report, remains a high priority. The recommendation from that report remains current, and I will continue to monitor it.
74. Other reforms, such as implementation of a new data collection system, and a decentralisation of the intake and assessment process, are underway.
75. Some of the issues raised, such as the lack of regulation over private providers and the quality of AOD reports are outside my jurisdiction; although I note the recent increase in jurisdiction granted to the Health Complaints Commissioner by the *Health Complaints Act 2016*, now extending to private AOD providers, which should provide for greater scrutiny in this area.
76. The provision of pharmacotherapy services, especially in rural and regional services, is patchy and can have a harmful effect on people in AOD treatment, especially those in rural and regional areas. This largely falls outside the Ombudsman's jurisdiction but DHHS is aware of the issue.
77. The issues raised in the submissions are undoubtedly serious and require major, long-term government investment. But it is also apparent that the government is taking action; any recommendations I might make could do little more than mirror recommendations I made in the prisons report, which were accepted and which I continue to monitor. While funding, and the allocation of funding, will require close attention, I do not think a formal investigation by my office at this stage would take the matter further.
78. I will continue to monitor the issues raised in this enquiry and any complaints we may receive, and in light of those, to consider whether further investigation is required.



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