Western Australian Network of Alcohol & other Drug Agencies

WANADA Submission to Proposed Alcohol and other Drug Model of Service for Delivery at Casuarina Prison

About WANADA

The Western Australian Network of Alcohol and other Drug Agencies (WANADA) is the peak body for the alcohol and other drug education, prevention, treatment and support sector in Western Australia. WANADA is an independent, membership-driven not-for-profit association.

WANADA is driven by the passion and hard work of its member agencies, which include community alcohol and other drug counselling; therapeutic communities; residential rehabilitation; intoxication management; harm reduction; peer based; prevention; and community development services.

Introduction

WANADA commends the Department of Justice for approaching the specialist alcohol and other drug service sector for feedback on the Proposed Alcohol and Other Drug Model of Service for delivery at Casuarina Prison (Proposed Model of Service).

Consultation and additional information required
WANADA's submission is informed by sector consultation, including:

- the outcomes of a sector forum, attended by 16 organisation representatives and consumers; and
- additional individual organisation consultations.

In this initial consultation period, a number of topics were identified that require further clarification, exploration and discussion. Additional information needed to support further consultation has been summarised in **Attachment A**.

We hope that the Department of Justice will use this submission to inform and facilitate further discussion with the sector at the stakeholder meeting in June 2019, and to progress the Proposed Model of Service in Casuarina.

Rationale for NGO Service Provider
WANADA strongly believes that the proposed service model should be delivered by a non-government organisation (NGO). An NGO service provider is best placed to:

- apply knowledge and experience of the required modified therapeutic community model;
- appreciate the application of 'community as method' and what is required to maintain the integrity of the model principles;
- negotiate the bridging of therapeutic and corrections requirements in an offender management environment;
- effectively support consumer empowerment (in a setting that is typically disempowering) that will strengthen co-design and engagement;
- apply continuous quality improvement principles, particularly as they apply to the delivery of culturally responsive practice; and
- provide the necessary strong connections to community services and re-connection to the community for sustained outcomes.

The successful implementation of a modified therapeutic community within Casuarina Prison will require a paradigm shift of the staff employed for offender management as well as those providing the treatment

program. Achieving this necessitates a partnership approach, where the combined expertise of corrections and specialist alcohol and other drug treatment services collaborate in an environment of mutual respect and learning. The required partnership approach must be complemented by systems support, particularly given the setting is in a maximum security estate.

WANADA would welcome the opportunity to discuss this submission. Please contact Ethan James at 08 6557 9400 or at ethan.james@wanada.org.au.

Analysis of the model as a whole

Strengths of proposed model

The strengths of the therapeutic community model is well evidenced - including when modified for prison settings. If effectively implemented and managed the Casuarina modified therapeutic community has the potential to deliver significant outcomes for individuals, communities and the broader corrections system.

WANADA has been informed that the Women's Alcohol and Other Drug Prison at Wandoo has achieved notable outcomes to date. The experiences from this program - noting the obvious differences in the facility, size and population - should inform the Casuarina project.

Weaknesses

WANADA recognises the complexity of the corrections system, and that the proposed modified therapeutic community will be operating within a maximum security prison. The Proposed Model of Service falls short in describing how this complexity will be managed. Implied in the Propsoed Model of Service is the need for a paradigm shift, of offender management staff and prison culture. This has both systemic and service-related implications. It is hoped that these 'weaknesses' can be addressed through an appropriate governance structure.

Despite different philosophies of treatment and corrections, there is a shared overall objective of achieving safer communities.

Risks and benefits relating to the model

For therapeutic community residents

- Risks – The most significant risks regarding residents within the program relate to their potential interactions with the mainstream prison population.

  A person's protective factors to operate within a prison culture will need to be addressed through psychosocial treatment and support offered in the program. As a result, there are therapeutic and offender management risks associated with their being exposed to the mainstream prison population without systems support.

- Benefits – There are a range of benefits for people who will access the modified therapeutic community, including participation in an evidenced and effective treatment model, with a strong focus on reintegration.

  The treatment will be focusing on the underlying factors contributing to their current circumstances (including problems associated with alcohol and other drug use and offending) with the view to effect behavioural change. If the model is effectively applied, current evidence indicates positive and sustained outcomes will be achieved.

  Residents may be more willing to address related health issues, such as accessing hepatitis C treatment while in the prison setting. This will have further benefits in terms of improved health and wellbeing.

For therapeutic community staff

- Risks – There is a risk of being unable to effectively adapt and operate within an offender management environment. This however, will be largely ameliorated through sufficient planning,

collaboration willingness, resourcing and workforce development (including recruitment, training, supervision and support).

- Benefits – The therapeutic staff will benefit from shared learnings, resulting in an appreciation of both therapeutic and corrections requirements. These learnings will have relevance when applied in therapeutic settings in the community, and will inform stronger partnerships, evaluation and evidence.

For corrections staff

- Risks – There is a risk of being unable to make the required paradigm shift associated with supporting the delivery of the modified therapeutic community model. As with therapeutic community staff, this can largely be addressed through sufficient planning, collaboration willingness, resourcing and workforce development (including recruitment, training, supervision and support).
- Benefits – The benefits are likely to include learning about different methods of achieving outcomes, less critical incidents and improved work conditions. This could result in improved retention rates and staff wellbeing.

For the Department

- Risks – To maintain the model's integrity, initially the unit may have to be filled in stages to reach capacity. This will support the model principle (i.e. to ensure that there are sufficient residents in later stages to provide peer support and mentoring to newer residents). As the full program capacity can only accommodate approximately 2% of the current male prison population (compared to approximately 10% of the female prison population accommodated at Wandoo) the overall achievements will not as immediately evident. These risks have implications for public and departmental perception.

  Introducing a significant program such as a modified therapeutic community will require the Department to actively manage political, departmental and community expectations. This will likely include resistance to change. Communications and change management planning will address these risks.
- Benefits – There are a range of benefits for the Department, the most significant indicator being cost savings due to reduced critical incidents and recidivism. It is hoped that success of the model will provide the evidence for consideration of this model at other WA prisons – particularly at lower security prisons.

For families

- Risks – There will be a need for family members to be informed of and supported to understand the treatment requirements, including potential support that would benefit the resident's reintegration into the community. A potential risk is insufficient resourcing being allocated to support this.

  Where family members and significant others require alcohol and other drug treatment and support, this should ideally be coordinated and resourced to facilitate positive reconnection as a part of reintegration.
- Benefits – In many cases there will be significant benefits for family and significant others associated with the program. Effective treatment delivery and reintegration will result in improved health, wellbeing and relationships for the prisoners and family members. With support, family members and significant others' will be more aware of treatment and support options available, including for themselves.

For the community

- Risks – If the model of service is effectively applied, including reintegration, there will only be benefits for the community.

  There may be a risk to the program, however, if there is inadequate community understanding or appreciation of its intent, fuelled by a misperception that treatment is a "soft option". Leadership by

responsible ministers and the Department staff must reinforce the need for more than just a punitive response to addressing offending behaviour and reducing reoffending.

- Benefits – Community benefits are numerous, but include: cost savings; improved health and wellbeing; and improved community safety.

Addressing identified concerns

Sector feedback indicated the need to maintain a significant focus on governance, planning and design, staff development and evaluation. These processes must support effective change management, and address the likely tensions that will arise through the differences between offender management and therapeutic approaches.

Governance
A 'strong governance mechanism' is identified as needed in the Proposed Model of Service, however, a governance structure is not provided.

WANADA believes that a clear governance structure must be described prior to further consultation, planning and program development. This level of transparency is essential, given the expected linkages between: the alcohol and other drug unit; the mental health unit; and the mainstream prison estate including the health and vocational/education services.

While seamless service delivery is a stated intent, the governance structure must minimise any blurring of the boundaries of the linked specialist programs' approaches, to maintain the integrity of the distinct models.

Sector consultation suggested a governance structure where the alcohol and other drug and mental health units both report directly to the prison superintendent. This will ensure:

- the unique requirements of both units are equally considered;
- both units can maintain distinct management mechanisms; and
- there are established avenues for negotiation and collaboration for best care coordination.

Planning and design
Significant change and risk management are required to successfully implement a modified therapeutic community within the complex corrections system. It is essential that all major stakeholders, including the therapeutic community service provider, are included in supporting change management and risk amelioration strategies. A shared appreciation of the specialist expertise that each party brings to the program will facilitate a collective commitment to making the model work.

A staged approach to achieve initial full capacity of the program is a potential example of the treatment provider's requirements that will need shared appreciation. A staged/'slow-fill' approach will enable:

- the establishment of a strong therapeutic community culture (that needs to be solidly embedded from the start); and
- maximising the model's staged effectiveness and efficiency - with sufficient residents held in later stages to ensure peer mentors for new residents.

Efforts to develop and implement the therapeutic community should also be complemented by a communications plan, to promote the unit and increase stakeholder awareness and support. Engagement of all stakeholders in the development and implementation of a communications plan is essential.

Staff, development and capacity
Feedback from the sector services identified staff capacity and capability as key issues requiring further consideration in the Proposed Model of Service.

- To maximise program effectiveness and model integrity, staffing hours for the treatment provider should reflect the usual treatment-active hours of a community therapeutic community, rather than a 'business hours' Monday-Friday approach. It is important that the proposed model can support treatment staff on-site from approximately 7.30am to 8pm at night, 7 days per week.
- Shared engagement in recruitment was also suggested, to ensure both treatment and corrections staff are suitable to enhance the modified therapeutic community within the prison environment.

- It is important that there is a shared (program and corrections) approach to staff development incorporates:
    - comprehensive service specific orientation and induction that supports improved understanding of the unique operating environment;
    - clarity of distinct roles and responsibilities;
    - relationship management with conflict resolution processes;
    - continuous quality improvement systems processes; and
    - ongoing supervision for both therapeutic community staff and prison officers.

Evaluation
WANADA supports the Department's intent to rigorously evaluate the program. Evaluation needs to capture individual, service and system outcomes and learnings to support continuous quality improvement.

- Individual (resident) outcome measures may include reduced alcohol and other drug related harm and recidivism, together with improved health, wellbeing and community connection. The TICP principles of safety, trustworthiness, choice collaboration and empowerment should also be measured.
- Service success needs to determine effective implementation of the therapeutic community service model, with outcome measures determining compliance with therapeutic community principles (see below). Additional service outcome measures should include: reduced critical incidents, adverse union reports from corrections staff and stress leave; and improved perception of staff safety and job satisfaction.
- System outcome targets need to include representative proportion of Aboriginal participation and successfully completing the program in prison. Systems outcome measures would include sustained outcomes for all participants, measured at the end of stage 2 and stage 3 and potentially with longitudinal follow-up.

Additional key principles for the proposed model?

The Key Principles outlined in the document are the Trauma Informed Care and Practice Principles. WANADA recommends that key principles from therapeutic communities, as per the Australasian Therapeutic Communities Association website, are also adopted. These include:

- holistic and multidimensional approach;
- staged approach; and
- community as method.

Model Components and Stages

Model Components
Feedback received from the sector suggests that the model components are typically addressed in any treatment model, are not necessarily distinct, and are applied based on individual needs.

To support the cultural responsiveness of the service model, there should be additional consideration regarding how Aboriginal ways of working can be further incorporated within the model components.

Entry Point, Referral and Assessment
There was general support for the exclusion criteria within the Proposed Model of Service, with a caveat that individual assessment may override these standard exclusions. It is recognised, however, that the capacity of the unit is limited to meet the needs of the prison population that would benefit from participation in the modified therapeutic community.

There were concerns raised regarding the custodial services' role in providing the initial entry point for potential assessment for the alcohol and other drug program. The concern was that this may limit access by certain population groups, specifically Aboriginal or CaLD prisoners, who may be reluctant to self-identify for consideration. Appropriate, culturally secure promotion of the program was identified as needed.

To support the integrity of the model, it is important that the entry and referral processes are transparent.

It remains unclear whether people in pharmacotherapy will be supported to access the modified therapeutic community. WANADA understands that there are a significant prison cohort currently accessing pharmacotherapy who could potentially benefit from the program. There is an appreciation that people on pharmacotherapies may require additional program management – with implications on all staff capacity and capabilities.

Assessment into the unit must be conducted in partnership between the service provider and corrections. This will ensure the full and balanced consideration of factors such as:

- offender management needs;
- alcohol and other drug and related treatment matching needs;
- individual fit with the current therapeutic community cohort; and
- implications for the established 'culture' of the modified therapeutic community.

Initial Stage - orientation and stabilisation

WANADA understands that people will be entering the program from prisons from throughout WA. People accessing the program will have varied histories and experience within the mainstream prison system. It is not clear whether orientation and stabilisation will occur within the mainstream prison (Casuarina and/or other prison) or within the unit. Input from the sector is needed to inform the most appropriate site for, and process from, this transition stage.

The sector appreciates the recognition, as stated in the Proposed Model of Service, that prisons present a traumatic environment, potentially contributing to existing trauma. This stage (orientation and stabilisation) will need to take differing levels of trauma and institutionalisation into account.

Stage 1 – Primary Treatment

The Proposed Model of Service does not comment on how the modified therapeutic community will interface with Individual Management Plans (IMPs). The extent to which the treatment delivered within the program will be recognised within IMPs is unclear. It is important that the risk of duplicative efforts is avoided and the benefits of participation in the modified therapeutic community is recognised.

Stage 2 – Developing recovery capital

Sector feedback regarding Stage 2 indicates that there are a number of additional issues that must be considered, particularly given the unit will be located within a broader, maximum security prison estate.

Residents' coping mechanisms and protective factors will have been challenged and addressed within the modified therapeutic community. This has potential implications for a person's ability to effectively operate within the mainstream prison culture. "Testing the waters" within the mainstream prison population may introduce both therapeutic and offender management risks.

A resident's access to other activities within the broader prison estate (e.g. visits, vocational programs and prison industries) must be supported systemically to minimise therapeutic and offender management risks. Program assessment and managing the timing and nature of participation in these activities will be essential.

WANADA recommends that Stage 2 is amended to specifically address how peer and/or mentor roles, the gratuity system, and the rewards/consequences system are expected to operate within the unit. This is particularly relevant for people who are coming to the unit from minimum security prisons. It is important that these systems do not inadvertently disincentivise people from engaging in and completing the modified therapeutic community.

Stage 3 – Reconnecting to the community

Effective reintegration and ongoing support is essential to sustain health and wellbeing outcomes, ensure public safety, and reduce the risk of recidivism. This will require resource consideration, building on existing transition programs. People exiting the modified therapeutic community need priority access to appropriate community services and support.

The first few hours of a person's release are important to ensure effective reintegration. The importance of ensuring seamless support is essential. NGO services offer strong linkages with the community service

system, with pre-existing partnerships and experience that will enable timely access and ongoing support to meet the individual's needs in the community.

The Casuarina modified therapeutic community must be perceived as a pathway out of prison.

A number of current prison processes require further analysis and integration within the Proposed Model of Service. Given the maximum security environment of the unit, it must be determined the extent to which people will have access to:

- day release (section 95) or staged exposure to outside the prison;
- the Prisoner Employment Program (low security); and
- direct release from Casuarina.

It is currently unclear whether the resident will require initial transfer to a minimum security prison prior to release. The transfer back to any mainstream prison, even if to a Drug Free Unit or minimum security facility, present therapeutic risks that will need to be mitigated. Time in any mainstream facility, after exiting Stage 2, must be minimised.

The Parole Board's approach to assessing parole eligibility and conditions following participation in the modified therapeutic community, also needs to be clarified to address any barriers to effective reintegration.

It is important that the Parole Board is:

- informed of the modified therapeutic community's intent and service delivery nature (there may be an opportunity to hold hearings within the therapeutic community); and
- supported with a resident's individual reintegration plan developed by the service provider, ensuring seamless access to the recommended suite of quality service options. These options will necessarily take into consideration regional, rural and remote exit support and service availability.

The Proposed Model of Service should consider how a resident will be supported if parole is denied and their Stage 2 treatment program is completed. It is unclear whether the individual will remain within the unit, or will be transferred into the mainstream prison system.

Mental health unit

WANADA notes that the information on the proposed model of care for the mental health unit is limited. We have focussed our feedback on the collaborative aspects of the proposed models and defer to specialist mental health service representatives, such as the WA Association of Mental Health (WAAMH), regarding the mental health service model design.

The proposed dedicated mental health unit has the potential to complement the alcohol and other drug unit, particularly in regards to residents with co-occurring low prevalence mental health concerns.

Barriers to joint operations

Both units need to work in partnership, however there are some clear distinctions between the service models that must be acknowledged and reflected in the services' design.

- The mental health unit is expected to support people requiring subacute and acute mental health care from the mainstream prison population (including remand), and as needed to support the stabilisation of residents in the alcohol and other drug modified therapeutic community. The cohort in the mental health unit will comprise both voluntary and involuntary admissions.
- The alcohol and other drug unit will be accessed by people on a voluntary basis only, with a specific time left on their sentence. If provided by an NGO, the service will likely be able to also support residents experiencing high prevalence mental health concerns that co-occur with problems associated with alcohol and other drug use.

A strong understanding of both units' service delivery will be required, so as to ensure appropriate referrals or transfer between the units. For example:

- It is essential that the mental health unit recognises the risks associated with certain medications for people with problems associated with alcohol and other drug use, especially in relation to prescribing medications that are drugs of dependence.

- It is important that alcohol and other drug issues of the resident of the modified therapeutic community are not triggered as a result of access to the mental health unit – including through association with others in the mental health unit.
- To maintain the integrity of the alcohol and other drug unit, the sub-acute mental health unit will need to focus on achieving stabilisation as a priority before a resident can be returned to the modified therapeutic community.
- The mental health subacute unit is expected to include psychosocial practices and the development of life skills. It is important, for any person referred through the modified therapeutic community, that the different service approaches are complementary.

Addressing Barriers

The governance, management and partnership structures are not well defined within either proposed models of service. These structures are essential to support the integrity of both service models.

Consideration should also be given to staff development and training resources that support a shared awareness and understanding.

Aesthetic design of the proposed alcohol and other drug unit

The alcohol and other drug unit must be aesthetically designed in a manner that supports inclusiveness and the principles of the modified therapeutic community. Consideration should be given to:

- furnishings that support a sense of homeliness (e.g. rugs, couches);
- fixtures that incentivise people to seek referral to the unit (e.g. personal television, fridge);
- artwork that is inclusive of all cultures accessing the modified therapeutic community;
- landscaping that supports communal activities, such as a meeting circle; and
- the capacity to showcase art made by residents who have since completed the program.

WANADA recommends that residents are consulted about what furnishings and aesthetics would best increase engagement, inclusion, participation and wellbeing.

Attachment A

Additional Information Required to Support Consultation and Inform Proposed Model of Service Amendments

The additional information required to inform sector consultation and feedback on the Proposed Model of Service have been collated below. References to relevant sections of WANADA's submission have been included, for additional context.

Risks and Benefits Relating to the Model (pp. 2-3)

- How does the Department intend to manage interactions between residents of the therapeutic community and the mainstream prison population, so as to minimise therapeutic and offender management risks?
- Will the Department consider and support a staged approach to initially reach operating capacity of the modified therapeutic community?
- Will family members and significant others of residents in the modified therapeutic community be informed and supported?
- How does the Department intend to build community understanding and appreciation of the important role of the modified therapeutic community within the corrections system?

Addressing identified model concerns (pp. 4-5)

- Can the Department provide detailed draft governance and management structures for the unit, and the expected linkages with the mental health and the mainstream prison estate?
- Will the Department consider, and resource, the 24 hour staffing requirements of the treatment provider?
- Will the Department consider shared corrections and treatment service engagement in staff recruitment processes?
- Is there scope to provide input into the proposed evaluation of the modified therapeutic community, so that it captures individual, service and system outcomes and learnings to support continuous quality improvement?

Model Components and Stages (pp. 5-7)

- Given the significant cohort currently accessing pharmacotherapy within the prison system, has the Department considered how people on pharmacotherapies will be supported to access the modified therapeutic community?
- Can the Department provide clarity regarding how custodial services will perform the initial entry point for potential assessment for the alcohol and other drug program?
- How does the Department intend to promote the alcohol and other drug program to specific population groups?
- Can the Department provide clarification regarding whether it sees orientation and stabilisation occurring within the mainstream prison or within the alcohol and other drug unit?
- Can the Department provide clarification regarding how the modified therapeutic community service will interface with Individual Management Plans (IMPs)?
- Regarding "testing the waters" within the mainstream prison population as part of Stage 2 of the proposed modified therapeutic community program, how will therapeutic and offender management risks be ameliorated?
- Can the Department provide additional information regarding how peer and/or mentor roles and the gratuity and reward/consequence systems are anticipated to operate within the unit?
- Can the Department provide further information regarding the availability of, and access to, existing prison processes (i.e. day release, the Prisoner Employment Program, and direct release)?
- How is the Department approaching supporting the Parole Board's awareness and alignment of the modified therapeutic community?