# Alcohol and Other Drug Treatment within the Context of the Criminal Justice System

## A Review of the Literature

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February 2005

Australian Government
**Department of Health and Ageing**

State Government
**Victoria**

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# EXECUTIVE SUMMARY

This literature review is submitted to the Victorian Department of Human Services' Drugs Policy and Services Branch, as the first part of the Forensic Workforce Training Program project and has been written by the Research, Development and Projects division at Caraniche Pty Ltd.

The purpose of the literature review is two-fold. First, it provides a critical review of current best practice in forensic alcohol and other drug (AOD) treatment and secondly, it provides an analysis of the methodologies employed in developing and delivering effective training programs for AOD workers in the criminal justice system. These findings in combination with the Training Needs Analysis undertaken by the Youth Substance Abuse Service will provide the framework for the development of the Forensic Workforce Training Program.

The literature review consisted of three phases, namely on-line database searches, web-based searches and specific website searches. The searches were guided by three content areas comprising:

1. current best practice principles in the provision of drug and alcohol treatment.

2. current best practice principles applied by AOD workers when working with forensic clients.

3. the nature, scope and efficacy of training programs developed for AOD workers working with forensic clients.

# INTRODUCTION

Over the past 20 years there has been a considerable shift in approaches to alcohol and other drug (AOD) issues. These shifts have been precipitated by enormous volumes of research that has influenced the development of evidence-based theories of drug and alcohol addiction that underpin the development of treatment programs. An understanding of the developments in each of these areas is essential for the provision of any substance abuse program as it is for the development of clinical skills for those who work with AOD clients. It is all the more important for cases of drug and alcohol treatment that are delivered within a forensic context and with clients who are involved in the criminal justice system.

Recent evaluations of forensically-based drug and alcohol programs worldwide reflect a promising deviation from previous perceptions of 'nothing works' to an era of practice that is driven by rigorous program evaluation and evidence-based service delivery. The following review of the literature outlines some of these shifts in approaches, underscoring current best practice principles for the delivery of drug and alcohol treatment programs to a forensic clientele. The review also critically evaluates training programs that are established for the up-skilling of workers who work with AOD clients within a forensic setting.

# THE DRUG-CRIME CYCLE

The relationship between illicit drug and alcohol use and criminal activity has been widely established in both the literature on criminal behaviour and on drug use (Anglin & Perrochet, 1998; Walters, 1998; Graycar, 2001). American studies indicate that between 40 and 80 percent of male arrestees in urban areas test positive for drug use, and over 80 percent are reported recidivists (Wexler & Lipton, 1993). Similar results have been found in Australian studies, and recent figures show that between 50 and 80 percent of Australian detainees are in prison for drug-related offences or were drug-affected or dependent at the time they committed the crime (Australian Bureau of Criminal Intelligence, 2000; Makkai & McGregor, 2001). These figures suggest that the relationship between substance abuse and crime is often very complex and research indicates that a large number of people who are convicted for minor drug offences have no prior criminal record (O'Callaghan, Sonderegger & Klag, 2004). In fact, their involvement in criminal activity, is precipitated by the need to finance their drug habit, or is a consequence of intoxication (Makkai, 1999).

There is also evidence that crime predicts substance abuse across different cultures (Moss & Kirisic, 1995) and over a period of time (Stice, Myers & Brown, 1998), and that drug using offenders commit more crime than non-drug using offenders (Walters, 1998). Furthermore, as the extent of use increases, the frequency and severity of crime escalates, with some studies showing that active heroin use accelerates the users' crime rate by a factor of four to six (The Forensic Psychology Research Group, 2003).

Over the past two decades the subject of drug-related crime and its reduction has been the topic of intense debate and speculation in justice jurisdictions. Given the relationship between drug use and crime, for many dependent users the outcome is clear: frequent contact with the criminal justice system. The Australian Institute of Criminology is currently conducting a three-year project (involving the Northern Territory, Tasmania, Queensland and Western Australia), entitled 'Drug Use Careers of Offenders', which seeks to measure drug use, including illicit drug use, among sentenced offenders and to examine the intersection of drug use patterns and criminal careers. Drug users who are criminally involved usually sit at the high risk-need end of the drug using spectrum. Crime and imprisonment tend to occur after an extended period of drug use and represent

the peak of the drug users' career. Criminally-involved drug users usually have more severe drug problems, have been using for long periods of time, have more health problems, less connectedness to social supports and have significant lifestyle problems (Wexler & Lipton, 1993).

The relationship between drug use and crime has received considerable research attention. Clearly, different types of crime will be related to drug and alcohol use in different ways. It is self-evident that while some crimes are drug-specific (such as drug possession, use, and/or sale), others are not. Illicit drug use will, however, often create an economic need that leads to acquisitive offences (Gossop et al, 1998; Degenhardt et al, 2005). Research in Australia has suggested that heroin users commit considerable numbers of acquisitive crimes (Maher et al, 1998).

Although crime and substance use co-exist, the relationship between the two variables may not be causal (MacGregor, 2000). Four key groups that engage in drug-related crime have been identified (McGregor and Makkai, 2001):

1. individuals who possess and use drugs on a small scale (e.g., for recreational purposes) but are not involved in criminal activity;

2. people who engage in drug dealing, trafficking and manufacturing but are often not users of drugs;

3. substance abusers who commit crimes to support their drug habit; and

4. individuals who use drugs and commit crimes but their activities are not causally related.

As a result, an important question for AOD workers working with forensic clients is the extent to which substance use is a causal factor in an individual's offending, or in other words, the extent to which substance use might be considered as criminogenic (Andrews et al, 1990). The purpose of such a line of inquiry will inform decision-making about the most appropriate treatment options. The literature unequivocally demonstrates that within this self-perpetuating, cyclical nature of drug use and crime in offenders, in order for substance abuse treatment to be effective, it cannot focus purely on drug use, but must also address offending behaviour and challenge offender culture. This is considered to be vital in order to reduce both relapse and re-offending for individuals caught within the criminal justice system.

# ALTERNATIVES TO INCARCERATION

Since the relationship between drugs and crime appear to be inextricable, the sanctions for such drug-related crimes typically start with punishment, including fines and/or community service orders (O'Callaghan, Sonderegger & Klag, 2004). Contemporary research has recognised that incarceration for drug-related offences does not necessarily result in a reduced crime rate, nor does it appear to deter others from committing crimes (Andrews et al, 1990). In fact, evidence suggests that incarceration increases the chances of repeat offending (Brand, 1993). Scientific research has shown that until now few punitive strategies and interventions have produced positive outcomes (Vander Waal et al, 2001).

In recent years, the national drug policy in Australia has adopted a policy of harm minimisation that is to be achieved through supply reduction, demand reduction and harm reduction strategies (Ministerial Council on Drug Strategy, 1998). An important component of the approach that provides an alternative to incarceration involves the combined use of therapeutic interventions and diversion programs to reduce drug/alcohol consumption.

## Alcohol and other drug treatment

Numerous studies have shown that substance abuse treatment produce positive behavioural and psychological changes in alcoholic and drug-related populations and represents a cost-effective form of intervention (Anglin, Brecht & Maddahian, 1989; Holder, Longabaugh, Miller & Rubonis, 1991; McLellan et al, 1992; Miller & Flaherty, 2000). The most thorough review of alcoholism treatment outcome gave efficacy ratings to 211 studies categorised into 30 different treatment methods and 11 specific alcoholism treatment approaches (Miller, 1995). Treatment approaches with the highest efficiency ratings included brief intervention approaches (including motivational enhancement), skills training strategies, marital/family therapy (including cognitive behavioural marital/family) and cognitive behavioural approaches.

A further review provides convincing evidence of the efficacy (reduction of drinking, fewer severe relapse episodes, abstinence, etc.) of a wide variety of communication skills training and cognitive behavioural training (Monti et al, 1995). The specific skills training and approaches included:

- rehearsal of communication skills;
- assertiveness training modelling;
- behavioural rehearsal of assertiveness skills;
- refusal skills;
- enhancing expression of feelings;
- problem analysis and production of adaptive responses;
- role-playing, modelling, and video feed-back; and
- cognitive restructuring.

In Victoria, training resources have been developed for AOD workers that describe the use of a number of different psychotherapeutic methods (such as Cognitive Behaviour Therapy, Rational Emotive Behaviour Therapy, Narrative Therapy, Reality Therapy, Transactional Analysis and Solution Focused Therapy) with different AOD populations (Connelly, Roeg & Lee, 2003; Connolly & Roeg, 2004).

Although the international literature has established that some treatment approaches may do better than others, the next step in AOD research was to determine the efficacy of treatment when matched to client needs. Project MATCH was an eight-year multi-site study in the United States designed to test the general assumption that treatment outcomes can be improved by carefully matching individuals, based upon their personal characteristics, to specific therapeutic approaches (Project MATCH Research Group, 1997). A total of 1,726 individuals with alcohol problems of varying severity were randomly assigned to one of three individually delivered treatments:

- Cognitive-Behavioural Therapy – A 12-session program based on principles of social learning, with the emphasis being placed on helping the client build social and coping skills to deal with problems rather than using alcohol;
- Motivational Enhancement Therapy – Designed to increase motivation for and commitment to change, consisting of four sessions over 12 weeks; and
- 12-Step Facilitation – A 12-session 12-step facilitation therapy designed to help patients become engaged in the fellowship of Alcoholics Anonymous.

Significant and sustained improvements were achieved across all three treatment groups with respect to drinking outcomes, indicating all were effective in producing change in clients. Contrary to the hypothesis, no significant differences were, however, found among the three treatments for patients with moderate to severe psychological problems (Project MATCH Research Group, 1997).

These results are interesting when compared to those AOD clients involved in the criminal justice system. In contrast to generalist AOD clients, several studies have shown that criminal justice clients do as well as, if not better than other clients in drug abuse treatment and that the criminal justice system involvement helps clients stay in drug abuse treatment (Collins & Allison, 1983; Collins et al, 1988; Hubbard et al, 1988). Differences have also been found when clients have been matched to the kind of treatment being delivered, also known as the 'responsivity principle' (Andrews et al, 1990), such that AOD clients with more severe sociopathy and psychopathology receiving Cognitive Behavioural Therapy had slower relapse rates whereas AOD clients with little sociopathy and psychopathology did better in inter-actional therapy (Kadden et al, 1989). Similarly, coping skills training has been found to be more effective than inter-personal therapies with alcohol clients who have anti-social or sociopathic patterns (Kadden et al, 1989).

In addition to the principle of matching therapeutic models to the learning style of the individual, perhaps one of the most important principles in the general offender rehabilitation literature is known as the 'risk principle' (Andrews et al, 1998). The risk principle suggests that programs are more effective when their intensity is matched to the level of risk of re-offending of the individual offender. Surprisingly, there is very little emphasis in substance abuse intervention at targeting risk despite convincing evidence of the risk of recidivism of substance abuse offenders. A recent meta-analysis investigated the extent to which substance use factors predict recidivism, finding a mean effect size of 0.10 between substance use and general recidivism (Dowden & Brown, 2002). Combined alcohol and drug problems were most predictive of recidivism (0.22), followed by drug use (0.19), parental substance use (0.13) and alcohol use (0.12).

These findings suggest that not only is substance use appropriately regarded as a risk factor for offending, but that some types of substance use are higher than others. In particular, those with combined drug and alcohol problems are at particular risk of re-offending. It follows from the risk principle that the most intensive services should be offered to

this group. One reason for the apparent lack of attention given to risk assessment in many substance use programs is that these programs have commonly been direct applications of community health-based approaches to offender populations (The Forensic Psychology Research Group, 2003). In health models, the focus of treatment is on meeting clinical need and on improving the health and well-being of clients. The approach is based on a stepped care model whereby failure to respond to treatment leads to further assessment and referral on to more intensive or alternate treatment programs (Sobell & Sobell, 1999). In contrast, the risk principle suggests that higher risk offenders should receive programs that are more intensive and is therefore likely to be useful in treatment planning for substance using offenders (The Forensic Psychology Research Group, 2003).

The above findings of AOD treatment efficacy have several important implications for treatment planning and delivery with AOD clients within the criminal justice system:

1. Motivational enhancement should be an integral part of any program for the substance abuse offender.

2. There should be a strong emphasis on social/coping skills training and clients should be encouraged to use other community supports.

3. Findings support the broad spectrum application of cognitive-behavioural treatment as an effective approach in changing AOD abuse patterns.

4. Clients with alcohol and drug problems benefit from longer term treatment (approximately one-year) and the criminal justice system can play a crucial role in the engagement of clients in this process.

5. Treatment with substance abusing offenders has a dual goal of reducing relapse as well as re-offending and as such must focus on substance abuse treatment, risk of re-offending, criminogenic needs of the offender and must be responsive to their learning style. Thus, challenging anti-social attitudes and hostile beliefs, reducing criminological harm, and improving emotional and impulse control are specific target areas that should be considered (McMurran, 2000). Other components thought to be valuable include inter-personal skills enhancement (e.g., assertiveness, negotiation and communication), relapse prevention (preparing the client to maintain change by identifying situations where there is a high relapse risk), and lifestyle modification (The Forensic Psychology Research Group, 2003).

6. Collaborative relationships should be maintained with criminal justice agencies such as courts, community corrections, juvenile justice parole boards, etc. in order to enhance therapeutic outcomes. In fact, a review of 11 studies on compulsory substance abuse treatment and concluded that research "supports the use of the criminal justice system as an effective source of treatment referral, as well as a means for enhancing retention and compliance" (Farabee, Prendergast & Anglin, 1998:4).

## Diversion programs

Diversion programs view illicit drug use as a health rather than a criminal justice issue and are based on the premise that society should be concerned about the welfare of drug users who come into contact with the criminal justice system (O'Callaghan, Sonderegger & Klag, 2004). The objectives of diversion programs as outlined in 1996 by the Alcohol and Other Drugs Council of Australia (ADCA) include harm-reduction at both individual and community levels and aspire to provide a holistic approach to individual needs and comprise of cautioning programs, referral programs and drug courts. Typically diversion programs are restricted to non-violent and/or first-time offenders and employ coercive strategies in which offenders are confronted with the decision to do something about their drug problem or face legal consequences (The National Illicit Drug Strategy Diversion Initiative, 2002). Although, the benefits of using coercive strategies has been widely debated in the field (Wild, et al, 1998), evaluations conducted in Britain and America have demonstrated that diversion schemes can be effective (Belenko, 1998; Peters & Murrin, 2000).

Many of the programs currently running in Australia have not been evaluated and are poorly documented (ADCA, 2003), and of those that have been evaluated, studies have yielded a mixed and inconclusive pattern of findings (O'Callaghan, Sonderegger & Klag, 2004), resulting from a number of conceptual and methodological problems. However, in general, findings from evaluations conducted so far suggest the importance of a number of components in order for these schemes to be successful (McGregor & Makkai, 2001):

- a pro-active work mode;
- a working style that wins the respect and trust of substance abusers;
- adequate resourcing;
- a capacity to provide ongoing support;
- appropriate treatment services for referral purposes; and
- adequately resourced treatment services for referral of substance-addicted offenders.

It appears that treatment providers have a crucial role within these diversion schemes, and are, therefore, encouraged to consider whether they are equipped to welcome large numbers of clients who are diverted from the criminal justice system into their programs. Furthermore, existing treatment programs may have to be adapted to suit clients with a criminal history, because these clients are likely to require more intense and supervised treatment (O'Callaghan, Sonderegger & Klag, 2004). Moreover, treatment staff may need additional training in order to deal with the specific needs and problems of this group of individuals. In order to ensure successful engagement in long-term treatment of these clients, treatment providers are also encouraged to establish effective links with community networks such as literacy programs, social services, mental health services and adjunctive health-care services. Given the importance of the two-way flow of clinical information between treatment providers and criminal justice diversion programs, treatment providers will also need training in the justice context and forensic issues that pertain to their role.

# PROVIDING AOD TREATMENT WITHIN THE CONTEXT OF THE CRIMINAL JUSTICE SYSTEM

## Introduction

For AOD treatment and non-custodial sanctions to be combined effectively, criminal justice systems and AOD treatment systems need to co-operate and collaborate at two levels. First, formulation of joint interventions that target both criminality and AOD abuse, and, second, development of shared programs and procedures that span their respective systems (Makai, 1999). As discussed earlier, criminal justice systems and AOD treatment services operate within different frameworks and maintain different goals. In combining treatment and non-custodial sanctions, the two systems work towards joint ends with the same group of client-offenders. Those efforts are more likely to be successful if the two systems understand and acknowledge their different responsibilities and goals, and work to find common ground that will allow each to be successful in meeting them.

## Understanding the attitudes and perspectives of the treatment provider and the criminal justice system

In order to ensure that appropriate training models are developed for AOD workers it is imperative to understand the cultural mindsets of the two systems. One of the primary differences between the two systems is the focus of responsibility. Criminal justice systems are charged with carrying out justice and maintaining public safety; while AOD treatment systems assume responsibility for assisting individual clients to recover. As a result criminal justice systems have responsibility for public safety, which requires the supervision and surveillance of offenders while treatment systems attempt to influence or modify clients' behaviour in the least restrictive manner possible, consistent with treatment needs (Hubbard et al, 1988).

Such differing responsibilities lead to very different views of and relationships with clients/offenders. The treatment system depends on engaging the client psychologically and developing a therapeutic alliance between the treatment provider and the individual. The criminal justice system's interaction with the offender on the other hand is bifurcated, juggling the need for surveillance in order to protect the community with the effort at rehabilitation. Thus, by making treatment part of the offender's sentence, the sentencing function of the courts makes treatment part of sanctioning the offender's behaviour. To the treatment system, treatment is not punishment, but exists to serve the best interests of the client.

These differences in responsibility and intent can obscure and impede the ability of the two systems to work together toward a common goal (McMurran, 2000). Other impediments by way of misperceptions and misconceptions continue to undermine the effective functioning of the two systems. Treatment professionals often believe that the criminal justice system is overly focussed on punishment and control to the detriment of considering the client as one who is in need of treatment for a verifiable disease (Hubbard et al, 1988). This, however, is an absolute responsibility, to be vigilant about any threats the offender poses to the community as even a minor infraction may be an emerging pattern of law-breaking. Also, from the perspective of treatment systems it seems that criminal justice systems lack realistic information about AOD treatment and its associated costs. This is a real issue in terms of resources as unrealistic mandates may be placed on offenders that may have the unintended effect of setting up the client-offender to fail in treatment. This 'piling on' of sanctions can conflict with treatment and has the effect of making criminal justice systems seem uncommitted to the long-term process of treatment, recovery and rehabilitation.

Finally, practitioners within criminal justice systems often believe that treatment professionals pamper offenders (Prendergast et al, 2002), that they are uninformed about criminal justice issues (Belenko, 1998), that they are unconcerned about public safety (Collins et al, 1988), and that they abuse confidentiality requirements to hide client information vital to the justice system (McMurran, 2000). Treatment professionals are also seen as unwilling or unable to stretch the boundaries of their treatment plans and programs to accommodate the requirements of the particular jurisdiction and its client-offenders.

While criminal justice systems are usually concerned about community safety and are focused on changing undesirable behaviour, the two systems operate from very different concerns and responsibilities. These alternative positions produce, in turn, very different operating principles, values and procedures. Although differing principles exist, a sound collaboration between these two systems, underpinned by education and training, could achieve the desired goal of effective service delivery.

## The ingredients of successful collaboration: Enhancing the AOD worker's effectiveness with clients in the criminal justice system

AOD treatment providers must understand the goals, language and operational responsibilities of the criminal justice system in order to develop effective AOD treatment plans for substance abusing client-offender. Since the 1980s the Centre for Substance Abuse Treatment (CSAT) in America has provided technical assistance in the provision of cross-training programs. Early efforts focused on probation officers and treatment staff. More recent efforts have focused on creating multi-disciplinary teams of staff from a spectrum of the systems that collaborate to engage and retain client-offenders in treatment. The Centre has developed a number of treatment improvement protocols that provide guidelines for more effective service delivery by AOD treatment providers within a criminal justice system setting:

- ensure that personnel in the treatment system understand the intent of sentencing for each offender.
- to avoid operating problems, ensure that those in each system clearly understand the scope and responsibilities of both the justice and treatment systems.
- understand the other system's view of the individual offender.
- understand how perceived treatment failures can constitute a violation of the law.
- be clear about which system's discipline will prevail in which situations.
- communicate clearly and work to develop a common language.
- agree on the features of a case plan and develop case management strategies.
- understand the terms and conditions facing the client-offender.
- be certain of confidentiality principles and relay this to the client.

## Understanding the Intent of Sentencing

The justice system endeavours to ensure that sanctions are consistent with the intent of the sentence. In considering collaboration, the question of the goals of sentencing becomes very important. Treatment personnel need to ask "What is the court trying to achieve for this individual by this sentence?" Too often issues of intent are not discussed and only later do justice and treatment systems discover that they were starting from different premises.

The intent and goals of sentencing come into play on two levels. First, it is crucial that treatment providers understand the full terms and the purpose of the sentence in each case they are involved. The more specific the court can be about the outcomes that are desired, the easier it will be for the provider to meet these expectations. The criminal justice decision-makers have a responsibility to articulate quite clearly what treatment should be provided, the extent and duration of this treatment and the setting in which it should be provided, accompanied by any other conditions on the sentencing order. At times it may require that the program or counsellor contact the Court or the Community Corrections Officer to get this information.

Secondly, the agents of the criminal justice system (judges, magistrates, prosecutors, defence solicitors/barristers and Community Corrections Officers) must understand the capabilities and limitations of the treatment program's services. They must be familiar with its procedures to the extent that these will effect the court's expectations. It is therefore, crucial that treatment providers take responsibility for informing these decision-makers about available treatment programs and what they are realistically capable of accomplishing.

## Understanding the Impact of Differing Goals

Opportunities for disagreement are frequent in any case, in which treatment providers and the criminal justice system are both involved. Such disagreements typically arise when the goals and objectives of the two systems are in conflict. The primary responsibility of agents of the criminal justice system is security, which includes protection of the surrounding community by controlling the whereabouts of offenders at all times. This manifests in rigid rules, mandatory reporting requirements, restrictions in housing and occupational opportunities and strict repercussions in the event that any of these conditions are breached. For treatment providers on the other hand, assisting client-offenders through the difficult and painful process of recovery may mean wanting the rules to be flexible and facilitative of what is best for the individual client.

While the treatment provider has to understand that security is the chief priority of criminal justice agents, staff within the criminal justice system can appreciate that a successfully treated offender is less likely to commit crime following treatment. Hence, communication between these players at all stages of the treatment process goes a long way in fostering collaboration and understanding in optimising rehabilitative efforts for the client-offender.

## Understanding that Treatment Failure can Violate the Law

To the treatment provider, relapse is a step in the process of recovery. To the courts, it may be considered a violation of the law or a violation of the conditions of the sentence. The two communities need to better understand the respective positions on factors such as relapse.

When a client-offender receives a sanction that includes treatment, a perceived program failure can constitute grounds for revocation. While missing scheduled treatment appointments, for example, may be viewed by treatment personnel as part of the denial process, it may be considered a violation of probation or parole by those in the justice system. Such distinctions need to be discussed and clearly understood, both by those working in treatment and by those working in justice-related fields, as well as the client-offender. To this end, a treatment contract should cover issues of negative behaviour, as well as rewards associated with compliance and eventual successful completion (CSAT, 2004).

The use of contracts is very important to inform the client-offender clearly what the consequences will be if she or he is found to be non-compliant with rules and regulations. The client-offender and the treatment provider must understand what behaviours will get him or her back in court or lead to a different sanction. Guidelines might be clearly stated as follows (CSAT, 2004:TIP 12):

- every program has a set of rules and expectations, and the client will be in jeopardy if he or she fails to comply with those rules and expectations;
- any violation of the law means the client-offender is in legal jeopardy;
- compliance with all the conditions of probation or parole, particularly special conditions arising from the offender's crime, is mandatory; and
- failure to appear in court as directed constitutes a violation of the law.

The failure to comply with the requirements of a treatment program does not have to mean automatic revocation. Some programs have had success with using defence counsel to intervene using therapeutic jurisprudence principles (Wexler, 1990; 1998). When a violation occurs, the program informs the defence counsel who negotiates with the prosecution, the Community Corrections Officer and the treatment personnel, functioning as an advocate for the offender in bringing about alternative sanctions, such as intensifying treatment.

## Communicating Clearly with a Common Language

Collaboration between justice and treatment systems to achieve more effective treatment outcomes for offenders requires the two work together to achieve clarity in their communication with each other. The criminal justice system comes with it own jargon, as do treatment providers. Miscommunication can occur when common words are believed to have universal meaning but, in fact, do not. For example, "classification," is used by criminal justice workers as if it were synonymous with "assessment," which is the expression used most commonly by treatment professionals. The differences in these terms are important. Classification usually refers to a system for determining how much supervision an offender requires because of the risk he or she represents. Assessment is usually associated with a determination of the social, psychological, or healthcare needs of an individual. Another commonly used term that generates much confusion between the two systems is

'relapse prevention'. Some in the criminal justice field assume that to prevent relapse, increased surveillance is required to deter AOD use. Their belief is that increased scrutiny will minimise offender relapse. To treatment providers, relapse prevention is problem solving – a process of understanding the individual's pattern of AOD abuse and its triggers, and then creating individualised strategies to deal with those issues.

Being aware of the discrete language that is used in the criminal justice system is of critical importance to the treatment provider and being able to communicate in a language that is comprehensible to its workers is of fundamental importance if effective treatment is to be provided to the client-offender.

## Effective Case Management Strategies

Virtually all the elements that have been discussed as necessary to collaboration between the treatment and justice systems can be included as elements of effective case management. Case management typically consists of assessment, planning, linking, monitoring and advocacy (Marlow, Marlowe & Willetts, 1983). The monitoring function is especially valuable because the early identification of new problems and the recognition of recurring problems can frequently prevent a crisis (Weil & Karls, 1985). Within the criminal justice system, a case management approach assumes that the criminal justice worker and the treatment provider view themselves as partners in a common effort to get the client-offender in recovery from AOD abuse and living a crime-free life. From that starting point, justice system and treatment personnel can co-operate in setting goals for the client-offender, responding to undesirable or order-violating behaviour, and adjusting to the terms of probation or parole and/or the type and intensity of treatment.

Effective case management begins with good information: information about the other agency; its responsibilities, policies and practices; and its expectations of clients. This information can reveal important and necessary differences between the agencies and can help to build respect for complementary roles. The importance of a multi-agency collaborative approach to treating substance-abusing clients in the criminal justice setting is underscored in the research (Martin & Inciardi, 1993). In this example, such case management strategies are argued to be particularly important to address gaps in a sub-group of the population that have disruptions in their lives because of police and court

processes, in addition to the perceived stigma of a criminal record and disruptions in occupational and social activities due to incarceration. The authors also argue that if case management is combined with legal sanctions to enforce participation in treatment, it is more likely that clients will remain in treatment and thus receive needed services.

Collaboration and case management between treatment providers and correctional officers can be fostered in many ways. One approach that has been successful, invites community corrections workers to be present during the client-offender's intake process, which gives the officer insight into the client's problems (Springer, McNeece & Arnold, 2002). In this instance, case discussions between the worker, the treatment provider, and the client-offender were scheduled monthly. This gave both professionals insight into the client's situation with a full range of conditions and prevented the client-offender from manipulating one person against the other. Using this approach, the worker and the treatment provider share responsibility, flexibility and decision-making.

When treatment and justice personnel have developed collaborative working relationships, their response to negative behaviour, such as relapse, is based on trying to achieve common goals for the client-offender. The criminal justice system is much more likely to trust clinicians to make decisions and treatment personnel are more likely to base their decision on clinical grounds with full consideration of security and public safety.

In jurisdictions where comprehensive case management is practised, it has been recommended that the treatment provider might consider preparing joint reports with community corrections agencies or even appear together before the court or parole board to address issues pertaining to the client-offender's progress (CSAT, 2004). This kind of feedback has proved to be helpful to these decision-makers not only in deciding immediate cases, but also making well-informed decisions in future cases (Springer, McNeece & Arnold, 2002).

## Working with Indigenous AOD Clients

Alcohol is commonly regarded as a problematic issue for many Indigenous offenders. In a study conducted in Western Australia involving Indigenous offenders, participants viewed alcohol as an important contributing factor to violence among their peers (Mals et al, 2000). Participants also reported that in remote areas they believed that all violent crimes committed by Indigenous men were alcohol-related. Such views are supported by criminological data, whereby some research has suggested that alcohol use could be a factor in up to 90 percent of all Indigenous contacts with the justice system (Hazelhurst, 1987). Moreover, research has shown that in over one-half the incidents of homicide and serious assault committed by this offending population, also involved the use of alcohol.

While an association between alcohol and offending in Indigenous populations is apparent, there have been few accounts of how or why such links exist. It may be that the socio-economic position of minorities is a better guide to alcohol use and alcohol-related violence than culture/ethnicity per se (Ward & Baldwin, 1997), or that alcohol is a response to other areas (non-criminogenic) of need. In one Australian survey, Indigenous participants were in general agreement that Indigenous male offenders (particularly younger generation, urban-dwellers), suffered from low self-esteem and a pervasive sense of frustration, anger, and powerlessness and lack of identity (Mals et al, 2000). Some informants did, however, note that these problems were less marked in remote communities where men typically had a more secure sense of identity.

The research data suggests that Indigenous client-offenders will have high rates of alcohol use giving rise to a number of responsivity issues involved in treating criminally-involved Indigenous clients (Jones et al, 2002). There is currently little data from which to base the effectiveness of different types of treatment modality for Indigenous substance abusing offenders and consequently a dearth of content-related training material to assist with up skilling of clinicians working with these client-offenders (The Forensic Psychology Research Group, 2003).

There are a number of barriers that AOD professionals can encounter when working with Indigenous clients that have the potential to influence program outcomes. These include:

- demands placed on workers to respond to intensive drug and alcohol needs of many clients and their related support needs. These contribute to the creation of a complex environment in which to focus on and develop specific skills;
- limited policies and practices in workplaces, related to such areas as case management and supervision;
- a wide range of skills and experience of course participants;
- limited skills and confidence of participants in writing and report preparation; and
- limited training resources with direct relevance to practice in Koori communities in Victoria.

As a result, training programs for AOD professionals working with Indigenous forensic clients should include a number of training strategies in response to these factors:

- a focus on case management strategies, in order to assist workers in structuring their casework, and develop skills to negotiate roles with workers from allied services and indigenous communities;
- projects that assist participants to apply relevant skills in the workplace;
- workplace assessment interviews, which seek to confirm demonstration of all areas of competence in the workplace, and to enhance structured feedback from supervisors to course participants;
- flexibility in enabling participants to be assessed at levels relevant to their skills and experience;
- development of a resource of tutors, providing the potential for all course participants to access a tutor; and
- development of training materials that draw on practice examples and models from experienced workers.

## Negotiating the Issue of Clinician Confidentiality in the Criminal Justice System

A flow of information between agencies and clinicians in relation to clients is necessary to facilitate an effective and co-ordinated assessment and treatment planning process (ACSO, 2004). On occasion, AOD clinicians will be required to provide assessment reports to the courts, make recommendations with regard to sentencing and treatment options for substance abuse offenders, and provide information directly related to the offender's progress in treatment. While co-operation with the criminal justice system workers is necessary, issues of confidentiality are paramount as is adherence to correct procedures for the disclosure of information.

It is recommended in the literature that staff in both systems should be given specific training in the confidentiality guidelines that apply to the professional bodies to which AOD clinicians are members, as well as legislation that prevails in the jurisdiction of practice. These regulations should be thoroughly understood by staff that come into contact with the AOD abusing offender.

Criminal justice workers and some AOD treatment providers occasionally interpret confidentiality regulations as obstructions to getting required information. Most AOD treatment personnel, however, consider confidentiality a key element of the treatment system because it builds clients' trust in the treatment process (Springer, McNeece & Arnold, 2002). Offenders, in particular, may have a great deal of fear about entering AOD treatment and may not consider treatment if they are not assured that their confidentiality will be protected. AOD workers are placed in a particularly precarious position when dealing with client-offenders and should be sufficiently apprised of their obligations towards their clients and the legal system. Specific areas of training should include:

- the purpose of confidentiality regulations;
- the general confidentiality rule – both specific professional guidelines and state and federal legislations;
- types of consent forms and their use.
- use of consent forms in inter-agency communications about the offender; and
- exceptions to the general rule (e.g., duty to disclose in circumstances of threat to self or others, court-ordered disclosures, reports of child abuse and neglect, etc.).

Although confidentiality is important in developing rapport to facilitate treatment gains, within the criminal justice context, treatment providers in certain jurisdictions are charged with the responsibility of reporting critical incidents (breaches of the order) to the relevant criminal justice workers. Failure to do so will undermine the use of treatment and intermediate sanctions. Treatment providers, however, should convey to the appropriate authorities the importance of treatment continuity and work with them to generate alternative solutions instead of the workers taking unilateral action that could potentially disrupt the gains made in treatment (Wexler, 1998). Understanding and supporting treatment continuity does not mean that criminal justice organisations are expected to ignore such violations. It does mean that they will work with treatment providers and their own colleagues to develop other responses to order-violating behaviour short of revocation to prison. Such alternative responses are useful and appropriate in many cases and for a variety of violations.

Finally, treatment providers require clear protocols about when a treatment provider should communicate with the supervising Community Corrections Officer and the content of that communication. Professional guidelines as well as legislation regarding client confidentiality must be observed, as some information may not be appropriate for communication to criminal justice workers. Further consideration should be given to the content and frequency of treatment reports to the criminal justice system and the related issues of confidentiality requirements should be covered in inter-agency protocols and staff should be rigorously trained in these areas (CSAT, 2004).

## The nature of the therapeutic alliance with the AOD offender

Thus far, the focus of the discussion has been on best practice principles in harnessing and optimising the collaborative efforts between treatment providers and criminal justice workers in order to enhance the effectiveness of therapeutic interventions with AOD client-offenders. Another area that is unique to criminal justice systems, and hence worthy of examination, is the special characteristics of this population of AOD offenders that are quite discrete from those AOD clients that seek voluntary treatment (Springer, McNeece & Arnold, 2002).

Treatment providers should recognise that AOD offenders are not a homogenous group (Anglin & Maugh, 1992). There are differences among offenders, even among those of the same age and gender who have the same cultural, ethnic, social and economic background (Dowden & Brown, 2002). These differences include personality, patterns of AOD abuse, health status, socialisation, educations, family, job training, urban and rural influences, and mental functioning. Offenders also range from seriously antisocial individuals who prey on people in their communities, to those who are more pro-social and have family and community support systems (McGregor & Makkai, 2001). Very often, these disparate characteristics are risk factors to their involvement in the criminal justice system, but also serve as barriers to engaging the client-offender in treatment.

## Barriers to Engaging the Client-Offender in Treatment

The client-offender comes to treatment with many internal barriers and obstacles that can inhibit treatment effectiveness and the client's progress. The characteristics of offenders that serve most often as barriers to treatment include (CSAT, 2004):

- a history of failure;
- alienation form social structures and the governmental agencies that typically and repeatedly have major impact on them;
- a sense of hopelessness that anything can make a difference in their lives;
- cynicism about the opportunities offered by social service agencies;
- a tendency to manipulate systems that affect them;
- unrealistic expectations of treatment;
- a culturally supported belief that treatment is for people who are weak; and
- the perception that treatment is punishment.

The nature of these barriers, accompanying resistant behaviour by the client-offender and strategies to address them are discussed in more detail below.

## Experience with Failure

Client-offenders typically have more substantial experience with failure and less experience with success than the voluntary treatment-seeking population (McGregor & Makkai, 2001). Therefore, orienting the client-offender towards small accomplishments in the treatment process is an important task, particularly during the early stages of treatment. Treatment programs and community corrections officers should work together to build-in small success opportunities for clients so that they gain confidence as they progress through treatment and complete supervision requirements. These can include making and keeping an appointment, having a negative urine drug test, or completing a homework assignment. Successful treatment plans will build-in small structured steps that the client-offender can accomplish with relative ease.

## Negative Self-Defeating Attitudes and Beliefs

Client-offenders bring to treatment both the classic patterns of addiction behaviour and the particular experiences of having reached the point of engaging in criminally deviant and destructive behaviour (to themselves and others) to maintain their addiction. Their status as both addicts and offenders who have been forced into treatment and who may also be facing severe penalties for their criminal actions often enhances their sense of hopelessness with their situation. Some client-offenders do not perceive their AOD abuse as a problem or its treatment as a priority. In the face of all the other problems that they may have, they are often more focussed on collateral needs such as those for housing, medical care and employment (Anglin & Maugh, 1992). The typical client-offender has little to show for years spent in school and in training and treatment programs and often consider treatment providers' promises as meaningless (Dowden & Brown, 2002). Prior contacts with law enforcement and criminal justice organisations have in their experience resulted in few consequences and as far as they are concerned neither threats of imprisonment nor promises of treatment are kept.

Motivation to attend treatment is widely regarded as a key issue if treatment programs are to be effective (Hall, 1997; McMurran, 2003). One study reported that almost one-third of pharmacologically dependent offenders did not want treatment for their drug problem (Incorvaia & Baldwin, 1997). A significant contribution to the field has been the development of models describing how people move through predictable series of stages as the costs and benefits of their substance use varies (Prochaska & DiClemente, 1986 & 1996). These models of change suggest that rehabilitation efforts should be targeted at the individual's location in this cycle of change. For example, those offenders who may be reluctant to enter formal treatment may be provided educational programs aimed at improving their motivation. An alternative strategy has been to develop different types of intervention designed to specifically encourage participation in treatment. The technique of motivational interviewing (Miller & Rollnick, 1991) and motivational enhancement therapy (Project MATCH Research Group, 1997) has been particularly influential in this area.

At a practical level, these engagement techniques can be built into the treatment being provided so that client-offenders can overcome alienation, hopelessness and cynicism and work towards a process of recovery. Small steps can be built into the program ensuring that success is possible, promises are kept, positive and negative consequences of behaviour are delivered quickly and consistently and that treatment provides the client-offender with a sense of self-worth.

Such goals may make it necessary to adjust the environment and change attitudes of therapeutic staff (Wanberg & Milkman, 1998). Treatment professionals should be willing to look at the treatment settings to make the physical environment more appealing to clients and project an atmosphere of respect. Similarly, staff attitudes and behaviours should convey respect for client-offenders. For example, the manner in which clients are addressed should convey respect; clients should be asked rather than told what their needs are and how they will be met (Wanberg & Milkman, 1998). In this way, the client-offender and the treatment provider are more likely to function as a team to promote the client's recovery.

## Treatment as Punishment

Treatment for the offender is usually ordered within the context of a criminal proceeding, and, in the case of intermediate sanctions, within a sentencing proceeding. Thus, the justice system usually communicates to the offender that treatment is punishment. Indeed, in this context treatment is not voluntary and is part of a sanction that is intended to benefit the offender. This creates confusion in the mind of the offender and a major therapeutic challenge to the treatment system is to address the offender's likely resentment that treatment has been imposed on them.

Client-offenders need assistance to clarify and resolve this conflict between the criminal justice sanction and AOD treatment. Once the client-offender is involved in AOD treatment, therapeutic staff, with support from corrections staff, should help the client re-focus on the goals of treatment and recovery. To benefit from treatment, the offender needs to move beyond the fact that it is involuntary and to understand that treatment represents an opportunity to help him or herself.

The goals of treatment and recovery are likely to vary among groups of client-offenders. In general, treatment providers need to not only help the client-offender develop the motivation to create an AOD and crime-free lifestyle, but also assist in addressing some of the ancillary problems that are associated with AOD abuse, such as psychosocial, medical, financial, and entitlement problems.

Forging a relationship with a client is also critical in enhancing the therapeutic process and provides the client-offender with the opportunity of participating in the process of their recovery (Springer, McNeece & Arnold, 2002). Research suggests several key strategies for inviting the client-offender into a partnership role:

• fully inform clients and disclose to them the expectations of treatment providers and the criminal justice system (setting out very clearly what treatment is and is not) and the repercussions if these are not met;

• create and develop a partnership role with clients to help set recovery goals that are realistic and meaningful to them;

• provide immediate and appropriate responses to positive and negative behaviour;

• follow through on commitments to clients;

• empower clients to participate in the recovery process;

• treat clients with respect;

• acknowledge and attempt to address clients' other problems that may or may not be causally related to their AOD or criminal behaviour (non-criminogenic needs);

• work closely with criminal justice organisations and ensure that representatives of both systems speak with a single voice on critical issues and responses are jointly supported; and

• create positive and negative incentives for clients.

## Manipulation of the System

Addicted individuals typically manipulate the people and institutions that surround them (Springer, McNeece & Arnold, 2002). The treatment and criminal justice systems must be vigilant that they are not permitting or facilitating manipulation, either within their own system or through giving different or opposing signals to client-offenders. Good cross-system case management as well as consistent and uniform messages by both systems is critical to dealing with manipulation.

For similar reasons, it is crucial to establish and enforce effective sanctions for infractions in treatment so that client-offenders know that their behaviour will have consequences. Research has reported that offenders usually communicate among themselves, and if the word is out that a treatment program does not deal seriously with rule-breaking, the program will be faced with endless efforts to manipulate its rules (Dowden & Brown, 2002).

For client-offenders it is important that the consequences for failure to comply be provided within the treatment continuum before the criminal justice system responds (e.g., increased frequency of attendance and drug-testing). Every treatment problem encountered should not engender a response from the criminal justice system and protocols should be developed which would aid in determining when such interventions are appropriate (Hubbard et al, 1988). In many jurisdictions in Australia Community Corrections Officers have substantial discretion in making decisions about violations. Such discretion can cause problems if the officers apply different standards and the treatment program is working with the clients of many different officers. In such situations it may be helpful to develop basic guidelines that orient both treatment staff and corrections staff to the range of responses to each category of behaviour, thereby providing consistency in responding.

# TRAINING PROFESSIONALS TO PROVIDE AOD TREATMENT IN A FORENSIC CONTEXT

## Introduction

It is evident in the growing body of research literature regarding outcome of therapeutic interventions, which while clinical approaches must be responsive to client needs, a wide variety of communication skills and cognitive behavioural training appear to be quite effective with criminal justice-involved AOD clients (Monti et al, 1995; Wanberg & Milkman, 1998; Springer, McNeece & Arnold, 2002). Interestingly, therapist style and particularly therapist empathy have been implicated as having significant impact on treatment outcome (Luborsky et al, 1985; Miller & Rollnick, 1991). As much as two-thirds of the variance in six-month outcome data could be attributed to the degree of empathy shown by therapists during treatment and therapist empathy accounted for one-half the variance in outcome after one-year and one-fourth of the variance in outcome at 24 months (Miller, Taylor & West, 1980). Other research has found that the most desirable characteristics that clients found in AOD professionals were sensitivity, honesty and gentleness (Lazarus, 1971). Additional research has also looked at the effective counsellor relationship with the offender, and established that these relationships emphasise the core characteristics of caring, genuineness and empathy.

Although having core counsellor characteristics are an advantage in promoting treatment gains, research strongly recommends that staff who deliver drug and alcohol treatment should receive adequate training and supervision in order to develop the skills set that is necessary to work with this population (Andrews et al, 1990; Miller & Rollnick, 1991; Wanberg & Milkman, 1998, Springer, McNeece & Arnold, 2002). To this end, it has been argued that therapist skills should be matched with the type of treatment program and therapists who have a concrete problem-solving style function best in highly structured programs (Andrews et al, 1990). Others have suggested that therapists should have at least an undergraduate degree or equivalent, and receive three to six months formal on-the-job training in the application of interventions (Gendreau, 1996).

Staff competencies are critical to the effective implementation of rehabilitation initiatives in the forensic setting (The Forensic Psychology Research Group, 2003), and this includes training to promote commitment to rehabilitation, and specific skills training in both assessment and program delivery. In the late 1990s, research considered that recent literature had indicated that improved systematic education and training of key AOD professionals was required if the

helping services were to be more effective in reducing the personal and social harm associated with drug and alcohol misuse (Roche, 1998). Similarly, the Task Force on Drug Abuse in Western Australia (1995) identified that invariably professionals needed specific education and training to develop appropriate skills in drug-related problems and argued that meeting this need was essential to maximise the effectiveness of any strategy to deal with this.

## The training impetus

Although in recent years greater emphasis has been placed on the need for AOD professionals to develop proficiency in areas such as behaviour change techniques, there still remains little published information about the effectiveness of various training programs undertaken to achieve this end (Roche, 2001). In fact, until very recently, much of the literature provided little more than a rationale and description of the training program offered (Sallis et al, 1990; Ockene et al, 1990).

With increasing evidence that well trained AOD professionals can identify problems at an earlier stage and intervene more effectively (Wanberg & Milkman, 1998; Springer, McNeece & Arnold, 2002), efforts to train health and human services professionals in the complex area of illicit AOD abuse and corresponding forensic involvement have been largely underdeveloped, or sporadic at best (Roche, 2001). Some authors have argued that training of health care professionals, and other human service workers have not kept pace with the advances experienced in the field over the past ten to fifteen years (Roche, 1998; Keller & Dermatis, 1999). While clearly there has been some considerable progress in this area, critics maintain that the advancements achieved fall far short of what is required to make substantial in roads. Moreover, it is further argued that for significant change to occur in the AOD and related fields involved in addressing alcohol and drug problems, vastly more complex and diverse strategies than merely the provision of training courses are required. It has also been suggested that at one level a major conceptual shift away from the traditional and narrow confines of 'education and training' to a broader more widely encompassing notion of 'workforce development' is needed (Roche & Cormack, 2000).

## The proliferation of courses and training options

Quite recently, Australia has developed important structural changes that have brought about significant shifts in thinking about education and training, particularly in relation to AOD abuse (Roche, 2001). Some hold that the turning point in Australia can be attributed to the activities of the employers at the National Training Levy and the results they saw from their training (Roche, 1995; Laing, 2001). It has also been stated that the tide has now turned and that there is increasing recognition on the part of employers of the importance of training and that if individuals do not participate they run the risk of becoming unemployable (Laing, 2001). It is within this context that Australia has witnessed an expansion in the nature and quantity of AOD education and training opportunities which have taken various forms (Roche, 2001):

1. AOD Minimum Qualification Strategy – This is a Victorian strategy that recognises the need for AOD workers to have accredited credentials in the field of alcohol and other drugs and ensures the development and maintenance of a consistently competent and professional AOD workforce. All the competencies contained in the Certificate IV in Alcohol and Other Drugs Work is nationally recognised and delivered through the Community Services Training Package by the sector's own Registered Training Organisations (The Victorian Alcohol and Other Drugs Workforce Development Strategy – Minimum Qualification Strategy).

2. University graduate level training – Most states now offer some form of university level specialised training in AOD. Such courses are usually intended for those currently engaged in the field in some capacity or other, i.e. they are in the form of ongoing professional training, and not usually offered as basic (pre-registration) training.

3. TAFE sector training – Developed around specified competencies designated for various levels of performance, and often then used as an entry point to the above courses.

4. Short courses – These can vary from a semester in length (and be either accredited or not) through to very short courses (i.e. one-half to two to three days in duration). These can be offered by a wide variety of educational providers.

5. In-house, on-site training – This is increasingly common in areas such as police, correctional services and perhaps to a lesser extent teacher training.

The array of training providers has also changed considerably. No longer are universities the principal providers at the tertiary level. The Australian National Training Authority (ANTA) has initiated a number of reforms and a structure known as the National Training Framework (Roche, 2001). Three key features of the National Training Framework are the:

• development of training packages;

• national assessment arrangements; and

• Australian recognition framework.

The training packages are the most tangible and practical of the products. They are intended to be developed by industry and to incorporate standards and assessment guidelines endorsed within the Australian Qualification Framework. They provide a model for the assessment of workers against competency standards and the granting of a qualification at the appropriate level of skill.

For some, the overly heavy emphasis on training packages is also not the most appropriate way to tackle education and training. While attempting to standardise content, reflect industry needs and ensure minimum competencies, there is the problem that a package is only as good as the writer and the trainer who finally delivers it (Roche, 2001). Moreover, difficulties have been reported in the conversion of curricula concepts into the final packages (Williams, 1995; Velleman, Mistral, & Sanderling, 1999). A critical review of this approach is required to determine whether this is a satisfactory way to develop and deliver training.

In reviewing the advances made in AOD training and education in Australia, it is pertinent to highlight that it is not only the professional role or disciplines that need to be considered (Roche, 1998). Training needs are also determined by the level of specialised or generalist interest of a given individual. For example, workers can be categorised as:

• Non-AOD health professionals;

• AOD-specialist health professionals;

• alcohol and drug workers;

• non-health professionals;

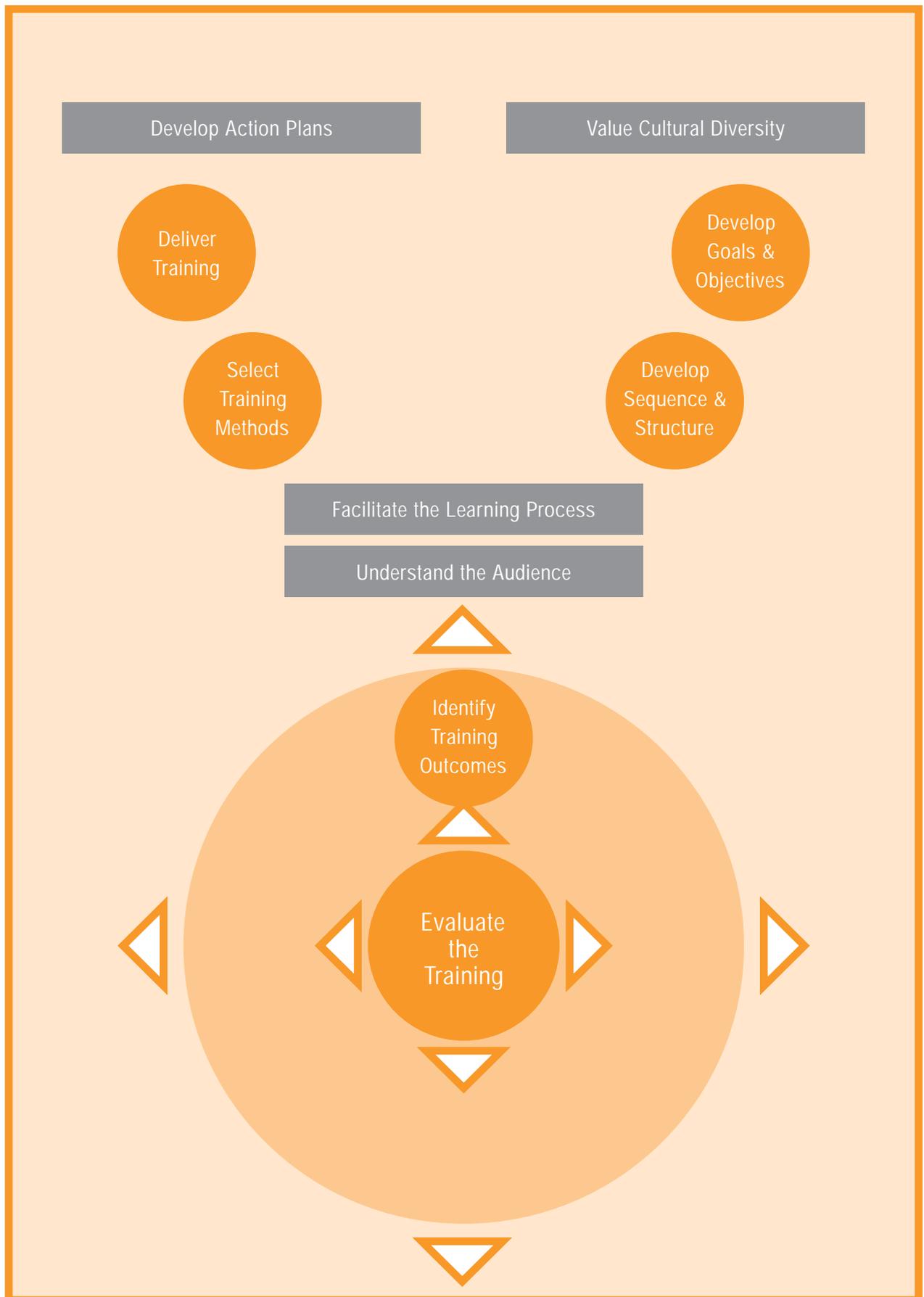• non-health AOD specialists; and

• volunteers.

Hence, the training responses required to appropriately cater for the above range of groups, and contexts within which they work, are diverse. Similarly, the forensic training needs of such AOD professionals will vary given the context in which they work. Unfortunately, there has been a tendency towards the production of training programs and packages that are generic in nature and lack the specialist content that are necessary for more specific training needs (Roche, 2001). As a result, while many of these generic training programs have wide scale suitability and applicability, they are not readily transferable to other settings (Velleman, Mistral, & Sanderling, 1999). The emergence of frontline training initiatives such as those supported by the Commonwealth Department of Health and Ageing Care and the Victorian Department of Human Services provides a much needed alternative to generic training.

In terms of educational methods, there has only been limited critical review of the educational methodologies that are of known efficacy and that are best suited to different groups and different work settings (Roche, 2001). It is argued that this is an area of major deficit and warrants close attention (Kent, 1993; Roche, 2001). Even then, well evaluated materials and programs are not always immediately transferable to other contexts and settings. It is therefore essential to determine the compatibility of efficacious products with the setting(s) for which they are intended.

## Purpose of training: Transfer of learning

The literature indicates that there is some confusion as to whether AOD-related training in Britain aims to provide training for practitioners, education about the field of substance use or opportunities for professionals to gain an accreditation or academic qualification (Kent, 1993). Other research argues that although the terms 'training' and 'education' are commonly used interchangeably, they have very different meanings (Roche, 1998). 'Training' is essentially about the transfer and acquisition of skills, while 'education' is about theoretical underpinnings. This is illustrated by maintaining that training is about teaching someone to drive a car, while education is about how a car works (Saunders, 1993).

Although effective application of technical skill is often dependent upon a secure knowledge base, clarification of these terms assists in the identification of priorities and strategies. Evaluation of the effectiveness of training needs to be carried out in terms of pre-established goals and, often, these have been found to be insufficiently articulated or so broad as to be meaningless (Roche, 1998). Greater clarity about the purpose or expected outcomes of training activity is needed. In 1992, The Centre for Substance Abuse Prevention (CSAP) inaugurated a radical new approach to training and learning. The approach focused on targeting it's trainees through a comprehensive Training Needs Analysis coupled with the development of a curriculum design and delivery, specific to the needs of the trainees. Having also built in an elaborate evaluation mechanism, CSAP successfully, analysed and monitored the sustainability of its training programs. Figure 1 illustrates the process involved in designing, and delivering a pertinent training program (Adapted from CSAP 2005).

Develop Action Plans

Value Cultural Diversity

Deliver Training

Develop Goals & Objectives

Select Training Methods

Develop Sequence & Structure

Facilitate the Learning Process

Understand the Audience

Identify Training Outcomes

Evaluate the Training

While the objective of a training program, such as the one illustrated above, is to enhance professional skills, the transferability of learning is a key outcome aspired to by most trainers. Many trainers, however, assume that transfer is both a possible and probable outcome of their training efforts (Hall, 1994). Transfer of information from training to the job is meaningless unless an individual learns effectively. Establishing conditions for effective transfer is therefore fundamental. Three critical areas have been defined in the literature to be investigated by the trainer in relation to the learning environment (Goldstein and Ford, 2002). They concern 'instructional design' (which looks at the objectives, instruction plans and learning principles); 'trainee factors' (including a readiness and motivation to learn); and, 'work characteristics' (including the opportunity for practice, organisational climate that values the training and supervisor support to ensure trainees can access resources and strategies that will facilitate transfer of learning to work practice).

While these factors provide an overview of key strategies relevant to learning and training transfer, identifying and developing strategies for responding to barriers to training transfer (for example, dealing with unsupportive colleagues, obtaining supervisor support to enhance transfer) must also be addressed (Shoobridge, 2003). The message is clear. In order to develop effective training transfer, trainers must set aside training time for teaching these concepts and measure the outcomes at various post-training points.

The effectiveness of transfer strategies has received varying degrees of support. On one hand, it has been reported that trainees taught relapse prevention and self-management strategies tend to achieve better outcomes when compared with groups who are just taught goal setting methods (Shoobridge, 2003). To this end, a range of workplace and organisational factors have also been identified as central to the effective transfer of training into work practice. On the other hand, there are indications that training teams have experienced difficulties in following-up trainees after training courses ended, and that employing agencies did not give sufficient attention to providing opportunities for their trained staff to utilise newly acquired knowledge and skills (Williams, 1995). As such, it would seem that without commitment from employing agencies much of the value of training is likely dissipated. The degree to which an organisation supports training transfer has been found to impact employee's ability and motivation to translate learning into job performance (Huczynski, 1980; Rouiller, 1993, Tracey, 1995).

The overview provided above highlights the complexity of factors likely to influence a trainee's capacity to effectively transfer training outcomes into everyday work practice. It is clear that the responsibility for effective training extends beyond the trainer and educator alone. It is also increasingly evident, however, that AOD trainers may need to extend their role beyond training provision and evaluation, and include supporting organisations to identify and respond to the range of factors that may influence work practice. These factors may include issues such as strategic alignment of learning strategies, developing strategies for enhancing training transfer and encouraging management to support staff in the implementation of acquired skills. It is also crucial that managers, supervisors and organisations as a whole recognise the key role they play in providing opportunity, support, recognition and incentives to trainees to ensure sustainability of training skills.

## Training needs assessment

A report aiming to provide guidance on good practice in drugs prevention training notes that those who conduct training had difficulty in assessing training needs in any systematic way in advance of the commencement of a course (Williams, 1995). This was found to be partly a function of time and partly of different levels of need. Williams argues, nevertheless, that a thorough assessment of need is crucially important before training begins. Other research has examined a multi-project evaluation of training programs for drug prevention, which highlighted varying approaches to the assessment of training needs, and illustrated the complexity contained in conducting assessments of training deficits and needs (Velleman, Mistral, & Sanderling, 1999). This research outlined a number of approaches that were employed by the training programs, some of which are detailed below:

1. In-depth interviews and questionnaires with a wide variety of agency representatives;
2. induction meetings for a new trainer with agency representatives;
3. discussion evening with youth workers, followed by 'taster' training and evaluation, and personal visits at work to complete a questionnaire;
4. consultation questionnaire, followed by pilot training courses with DRG members and volunteer workers in social services, to test a training resource pack;
5. evaluation of feedback from previous training and discussion with steering group;

6. revision, by a working-group of experienced trainers, of an existing training course;

7. discussion with key persons associated with drugs education and consideration of relevant literature; and

8. using a university training department to assess the need for post-qualifying training for social workers.

Based on the evaluation of these projects the authors (Velleman, Mistral, & Sanderling, 1999) have identified key areas that make a training needs analysis (TNA) successful in contributing to the development of targeted training programs:

1. TNA at trainee level – Assessing training needs of individual professionals proved useful where those individuals went on to attend the training. Trainers who conducted focused discussions, either with individuals or groups, found these were an effective way of eliciting needs where individual professionals had a variety of tasks and responsibilities. These discussions encouraged cross-fertilisation of ideas, and facilitated development of sessions that met the expressed needs of participants.

2. TNA at agency level – Semi-structured discussion seemed an effective method of clarifying needs at an agency level. The evaluation found that the majority of managers as well as practitioners were initially unable to voice training needs (because of unfamiliarity with what training was available and how training might aid professionals to work more effectively and efficiently) and very few agencies had a system for discovering whether employees had adequate knowledge and skills to carry out drug prevention work. Agency-level TNAs were also beneficial in guiding the format for delivery of training, with a one-day multi-disciplinary format being the most popular. One-day training was found to be the most resource-friendly, reducing loss of staff time, and multi-disciplinary training was seen as the best way to spread a little training as far as possible throughout an organisation via experience based dissemination of learning.

3. TNA at locality level – A need at a locality level for TNAs was identified in order to provide a networking opportunity for training organisations as well as professionals, and this helped to maximise co-ordination and avoid duplication, as well as providing information to pass to trainees regarding further training opportunities.

4. TNA as an aid to recruitment – Trainers who involved managers and practitioners in a TNA reported positive effects on recruitment to training courses. The establishment of a database containing key agency representatives and professionals coupled with on-going personal contact with trainees and management, where needs could be discussed informally, appeared to make a positive contribution to recruitment for training programs. A second factor believed to have a positive effect on both recruitment and continued interest was a sense of 'ownership' derived from having input into the development of training structure and content.

## Accreditation

There has now been a notable push towards providing recognised credentials and accreditation for AOD professionals (Easthope, 1992), whereby it is predicted that as drug work gains greater professional recognition, accredited qualifications will become essential for workers' career development. It is also argued that there will be a pressure for comparability between a range of qualifications, and that increasing demand for places on accredited courses will result in an increasing homogeneity of approach and less recognition of the idiosyncratic experiences of trainees (Easthope, 1992). In addition to the consistency that accredited training programs provide in the delivery of AOD abuse treatment, independent evaluation studies have shown that accreditation of AOD professional training is a major contributory factor towards sustainability of training, both with trainees and within AOD agencies (Velleman, Mistral, & Sanderling, 1999; Centre for Substance Abuse Prevention, 2005). In fact, the most effective contribution to sustainability of training, was the validation and award of the accreditation locally, but its' recognition nationally.

## Multi-disciplinary / multi-service training

It has been noted that a common thread encompassing reports from three training teams highlights the importance of inter-disciplinary and inter-service networking (Williams, 1995). The prevention of drugs misuse and associated problems clearly involves professionals from many different fields and training must, to be fully effective, engage professionals from a broad range of disciplines and agencies. The World Health Organisation (1989) argues in support of a multi-disciplinary approach to training, and that such an approach has been demonstrated to be effective (Mason, 1992). A comprehensive British study evaluated the effectiveness of 13 training projects ranging from single agency to multi-agency/multi-disciplinary participation with a range of professionals and found that training had a lasting effect on skill development if it met the needs of the trainees (Velleman, Mistral & Sanderling, 1999). The Centre for Substance Abuse Treatment in America has been involved in and has developed a number of training programs for working with substance abuse in the criminal justice setting (CSAT, 2004).

These cross training efforts, however, are not without its problems: groups might encounter difficulties accommodating conflicting perspectives held by professionals used to working in very different situations (Selwyn, 1996). That being said, it is difficult to determine the effectiveness (or lack thereof) of these cross training programs in working with substance abusing offenders as there is a paucity of systematically evaluated training program in this regard. The Forensic Psychology Research Group (2003), in a review of substance abuse treatment in Victorian corrections, have stated not being aware of any universally recognised training pathways for those involved in program delivery within the forensic context and note that many current substance use services are offered by a combination of prison staff, community drug agencies and volunteer groups. It is their recommendation that good practice in the area of AOD treatment in the criminal justice system involves an understanding of the theory underpinning a particular program, training in model of intervention, counselling or group-work and familiarity with the offender rehabilitation literature.

## Evaluating training programs

The effectiveness of a range of treatment approaches in the AOD field and its translation into practice has been facilitated by the development of training programs designed to train professionals in the recognition and treatment of AOD abuse (O'Donovan & Dawe, 2002). The effectiveness of training programs themselves has been, however, the subject of limited research studies (Berman & Norton, 1985). In drawing from studies evaluating psychotherapeutically oriented training programs, other researchers propose that an understanding of the interplay of a range of factors that influence training effectiveness needs to be considered (O'Donovan & Dawe, 2002):

- The first of these, pre-existing trainee characteristics, include professional training, experience and personal characteristics that are associated with enhanced therapeutic outcome such as empathy, genuineness and warmth;

- next, the mode of training delivery needs to be considered and the relative effectiveness of different teaching models need to be assessed; and

- finally, in determining whether training is effective, both immediate outcomes such as trainees' satisfaction and increase in knowledge and more distal outcomes such as improvements in client outcomes needs to be operationalised clearly and measured precisely.

The most frequent measure of training effectiveness is the assessment of the increase in content knowledge following training, and this is true for both the clinical psychology field and the AOD field where there are many studies demonstrating an increase in knowledge following training (Miller, 2001; Tori, 1989). In the AOD field an increase in knowledge has also been accompanied by a more positive attitude towards people with substance abuse problems (Henry et al, 1993). However, does increasing content knowledge per se improve clinical practice? This question has not been directly addressed but should be considered when evaluating training-effectiveness in the AOD field (O'Donovan & Dawe, 2002).

Some authors suggest that while basic behavioural skills in treating clients can be learned quickly through instruction and do not require modelling, feedback or rehearsal, inter-personal skills training and more complex skills such as case conceptualisations, development of appropriately tailored treatments and case management require more extensive instruction (Lambert & Ogles, 1997). These more complex tasks are taught more effectively when trainees receive

immediate feedback and an opportunity to correct their errors and the repeated opportunity to practice newly acquired skills (Singley & Anderson, 1989). When evaluating the effectiveness of these training gains, an emphasis should be placed on the assessment of these discrete tasks so that different components of the training program can be assessed and re-structured if required. Finally, previous content knowledge of micro skills, assessed via written assessment, is also associated with greater training gains in micro skills (O'Donovan & Dawe, 2002). Thus, an assessment of prior knowledge should be included routinely in any evaluation of the impact of training on miro-skill development (Daniels et al, 1997).

The importance of evaluating training program effectiveness has been highlighted in a series of studies (Velleman, Mistral & Sanderling, 1999; O'Donovan & Dawe, 2002; Centre for Substance Abuse Prevention, 2005). Evaluation not only addresses the achievement of outcomes expected from the training, but also provides information on the processes and outputs that contribute to these outcomes (e.g., the guide to evaluating drug prevention projects in Victoria, 2002). This understanding makes it possible to provide ideas and strategies to better manage and improve current and future training programs.

Thus, the literature on evaluation of training programs suggests that evaluation should fulfil two key aims:

1. Provide a performance measurement framework to:
   a. improve the training program;
   b. measure processes, outputs, impacts and outcomes, such as:
      i. Content, method and format of Training;
      ii. training focus;
      iii. trainee satisfaction and outcomes;
      iv. client outcomes and transferability of skills;
   c. make necessary changes to the training plan; and
   d. support the subsequent project work.
2. Provide good management of project initiatives:
   a. defining the expected outputs, impacts and outcomes;
   b. measuring performance regularly and objectively; and
   c. learning and adapting in order to improve effectiveness and efficiencies.

# UNDERPINNING PRECEPTS OF EFFECTIVE TRAINING PROGRAMS

## Principles of evidence-based practice

The course content, as with the program overall, should be based on the principles of evidence-based practice. That is, aetiology, assessment and intervention strategies reflect current state-of-the-art knowledge and best practice.

## Adult learning principles

Education and training principles appropriate for experienced professionals. Key factors which define quality programs and which facilitate the transfer of knowledge and skills into practice include:

- basing methods on adult learning principles;

- the use of experiential and participative learning strategies;

- linking course content with trainee's previous experience, with their usual work role and existing skills;

- ensuring practice is underpinned by theory;

- using methods which encourage trainees to be responsible for their own learning and which will enable them to translate new knowledge and skills into practice;

- providing post-training support, supervision and practice as workplace support is widely recognised as having a positive impact on sustaining the effects of training;

- linking education to support in the form of leadership which legitimises the practice of new knowledge and skills in the work setting and where employing agencies and funding bodies make a fundamental commitment to providing opportunities for the utilisation of newly acquired skills;

- rewarding course participation (e.g., accreditation that is recognised nationally but provided locally);

- high quality and well resourced programs which have experienced training staff and up to date equipment and materials;

- relating the program to accepted standards;

- making program content relevant to the job roles of participants; and

- providing flexible delivery strategies to enhance access;

## Skills development and orientation

Training programs should be oriented towards skills development. An important criticism levelled against much AOD education and training is insufficient attention directed towards skills development.

## Mode of delivery

The model and length of training has an impact on its appropriateness, attractiveness and skills sustainability for trainees. There is some evidence to suggest that longer programs have more difficulty with recruitment, whereas one or two-day programs have greater success in recruiting professionals. Evidence also supports use of several different delivery modes packaged in a variety of formats. The three main delivery formats are:

- face-to-face delivery;

- self-directed learning using paper based instructional modules and optional tutors; and

- electronic delivery using a web based package.

## Training tailored by specialty and context

Training programs that have been the most effective have assessed training needs of participants at trainee, agency and locality levels. The advantages of doing so are:

- trainers are provided with vital information about trainees to enable them to plan relevant training programs;

- managers are offered an opportunity to consider the needs of their organisation;

- it acts as an aid to recruit course participants; and

- it encourages a sense of involvement with training.

Trainee needs vary. For trainees with much more experience, some programs fail to provide the appropriate level of practical skills training or information relevant to their professional activity. Pre-program contact with trainees would appear to be essential to ensure participants and training are matched. This could be via telephone, a pre-program questionnaire (e.g., a TNA) or a pre-training event (e.g., focus group/workshop) where levels of awareness and basic knowledge could be standardised. This is particularly important as time increases between any analysis of training needs and the resulting delivery of training).

Multi-disciplinary training is critical to enhancing trainee skills and provides AOD professionals with the opportunity to network and share the perspectives of others. This is further enhanced by assessing which professions or agencies might most benefit from working together.

Training programs need to be flexibly structured so that different components of a program can be tailored to groups' needs.

## Tiered options

For purposes of flexibility, training packages often comprise of a series of modules. Modules form self contained and independent learning units, which can be related with other modules in the package. Modules are often categorised as:

- core;
- optional; or
- technical specialty.

## Ongoing education and training

It is an accepted educational principle that one-off or short-term training experiences that lack options for reinforcement, consolidation of learning and options for ongoing training and support are likely to be less successful than more integrated training experiences. In order to be effective, training packages need to be backed up with access to consultancy/supervision as trainees are putting their knowledge into action. Strategies to maximise the impact of the short training courses include:

- ongoing support systems;
- consultancy service;
- further integrated training experiences;
- establishment of networks and mentoring schemes; and
- network newsletters and updates.

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