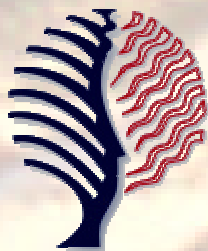


# **Evaluation of the Lismore MERIT Pilot Program**

## **Final Report**



**NORTHERN RIVERS**

**University Department of Rural Health**



# **Evaluation of the Lismore MERIT Pilot Program**

**Final Report**

## ***Editor***

Megan Passey

## ***Contributing Authors***

Megan Passey  
Stella Patete  
Greta Bird  
Steve Bolt  
Lyndon Brooks  
Kate Lavender  
Don Scott  
Keith Sloan  
Catherine Spooner  
John Vail



Published by the NSW Attorney General's Department, October 2003  
ISBN 0 7347 2819 0

Northern Rivers University Department of Rural Health  
P.O. Box 3074  
Lismore, NSW 2480

Phone +61 2 6620 7570  
Fax +61 2 6620 7270  
[nrudrh@med.usyd.edu.au](mailto:nrudrh@med.usyd.edu.au)

The Northern Rivers University Department of Rural Health is a joint venture of the University of Sydney and Southern Cross University, and incorporates the former Southern Cross Institute of Health Research. It is supported by the Australian Government Department of Health and Ageing and the Northern Rivers Area Health Service.

## **Acknowledgements**

We extend our thanks to all the participants of the Lismore MERIT Pilot Program, who assisted with interviews for the evaluation and shared their experiences. We are also grateful to all the other interviewees who kindly gave their time and insights.

We would particularly like to thank the Lismore MERIT Pilot Program Team for their assistance and patience with the evaluation. The support of John Scantleton, the Manager, and Peter Didcott, the Research and Quality Officer were invaluable.

The evaluation steering committee, Greta Bird, Steve Bolt, Lyndon Brooks, Peter Didcott, Bruce Flaherty, David Reilly and Keith Sloan, provided valuable guidance and assistance to the design and implementation of the evaluation, as well as feedback on earlier versions of this report. Bruce Flaherty, from the Crime Prevention Division of the Attorney General's Department was especially helpful in this regard.

The NSW Bureau of Crime Statistics and Research kindly provided us with data on both court outcomes and reoffending. We are grateful to all those involved, and particularly Bronwyn Lind, for the considerable effort they made in attempting to meet all our requests.

We would like to thank the original investigators, John Beard and Tim Sladden, and Christine Hunter, the first project officer.

We would also like to thank Shianne Ford for administrative support and data entry.

The evaluation was undertaken with funding from the New South Wales Attorney General's Department with a contribution from the Commonwealth Government under the Illicit Drug Diversion Initiative.



# Table of Contents

<b>Executive Summary .....</b>	<b>ix</b>
<b>Chapter 1 - Introduction and Literature Review .....</b>	<b>1</b>
Initiation of an 'Court Early Intervention Pilot Program' .....	1
Lismore MERIT Pilot Program .....	1
Comparable diversion programs for drug offenders .....	4
<b>Chapter 2 - Methodological Approach to the Evaluation.....</b>	<b>7</b>
Introduction .....	7
Overall Approach.....	7
Program and Participant Profiles .....	8
Implementation Review.....	8
Outcomes Studies .....	8
Economic Assessment.....	9
Legal Issues Review .....	10
The Report Structure .....	10
<b>Chapter 3 - Program and Participant Profiles.....</b>	<b>11</b>
Introduction .....	11
Methods .....	11
Findings .....	11
Participant Profiles.....	11
Operational Processes .....	15
Characteristics Associated with Completion of the Program.....	19
Discussion.....	21
<b>Chapter 4 - Court Outcomes and Recidivism .....</b>	<b>25</b>
Introduction .....	25
Methods .....	26
Court Outcomes .....	26
Indicative Sentences .....	27
Recidivism.....	27
Findings .....	29
Description of the Sample .....	29
Court Outcomes .....	30
Indicative Sentences .....	31
Recidivism.....	31
Discussion.....	34
<b>Chapter 5 - Health and Social Functioning Outcomes.....</b>	<b>37</b>
Introduction .....	37
Methods .....	38

Overall Design .....	38
Data Collection Instruments.....	38
Schedule and Procedures .....	39
Data Processing and Analysis .....	40
Findings .....	41
Sample Recruited .....	41
Drug Usage and Treatment .....	42
Changes in scores on the Opiate Treatment Index .....	44
Changes in SF-36 Scores .....	47
Discussion.....	49
<b>Chapter 6 - Participant Perspectives of the Lismore MERIT Pilot Program.....</b>	<b>51</b>
Introduction .....	51
Methods .....	51
Findings .....	51
Sample Interviewed .....	51
Reasons for Joining the LMPP.....	52
Understanding and Choice .....	52
Satisfaction .....	52
Usefulness and Challenges .....	53
Impact.....	54
Comments, Suggestions and Recommendations .....	55
Discussion.....	57
<b>Chapter 7 - Stakeholder Views of the Lismore MERIT Pilot Program.....</b>	<b>59</b>
Introduction .....	59
Methods .....	59
Findings .....	60
Program Design Issues .....	60
Development of policies and procedures .....	65
Impact on services .....	66
Resource requirements .....	67
Overall views .....	68
Critical Success Factors .....	69
Discussion.....	70
<b>Chapter 8 - An Economic Assessment of the Lismore MERIT Pilot Program .....</b>	<b>73</b>
Introduction .....	73
Economic Assessment Methods .....	74
The LMPP Costs and Benefits .....	74
Assessable LMPP Costs and Benefits.....	75
Comparison of Costs and Benefits .....	78
Non-assessed Potential LMPP Costs and Benefits .....	79



Discussion.....	80
<b>Chapter 9 - Review of Legal Issues from the MERIT Program.....</b>	<b>82</b>
Legal Basis of the MERIT Program .....	82
Methodology.....	82
Comparison with Other Diversion Schemes .....	83
Legislative Base .....	83
Bail Act .....	86
Eligibility Criteria.....	87
Sentencing.....	89
Therapeutic Jurisprudence .....	90
Restriction on Use of Therapeutic Information.....	91
Is Coercion Justified?.....	92
Duration of the MERIT Program.....	92
Conclusion .....	92
<b>Chapter 10 – Final Discussion and Conclusions .....</b>	<b>95</b>
Evaluation Challenges .....	95
Conclusions .....	96
Is the program acceptable to potential participants and other key stakeholders? .....	96
Has the program reduced drug-related crime? .....	97
Has the program improved the health and social functioning of participants? .....	97
Did the program work better for some participants than others? .....	97
Are the costs of the LMPP adequately offset by the benefits? .....	98
What are the key legal issues? .....	98
What were the critical success factors? .....	100
How could the program be improved? .....	101
What are the outstanding challenges for the LMPP? .....	103
Final Remarks .....	103
<b>References.....</b>	<b>105</b>
<b>Appendix A – Review of Literature on Diversion Schemes.....</b>	<b>111</b>
<b>Appendix C – Comparison of Indicative and Actual Offences.....</b>	<b>118</b>
<b>Appendix D - Proportional hazards models for time to first offence .....</b>	<b>119</b>
<b>Appendix E - OTI and SF-36 Scores Results.....</b>	<b>121</b>
<b>Appendix F – List of stakeholders interviewed.....</b>	<b>122</b>
<b>Appendix G – Local Court Practice Note .....</b>	<b>123</b>
<b>Appendix H – Case Studies of Participants .....</b>	<b>127</b>

## List of Tables

Table 1.1	Comparison of MERIT with CREDIT and the NSW Drug Court .....	6
Table 3.1	Demographic characteristics of participants.....	12
Table 3.2	Drug use on entry, among participants .....	13
Table 3.3	Recency of injecting .....	14
Table 3.4	Type of previous treatment accessed .....	14
Table 3.5	Other health problems reported .....	14
Table 3.6	Prior conviction and imprisonment .....	15
Table 3.7	Type of current charges .....	15
Table 3.8	Reasons for being classified as ineligible.....	16
Table 3.9	Referral source by program entry status .....	17
Table 3.10	Main service provided to participants .....	17
Table 3.11	Other AOD services used by participants .....	18
Table 3.12	Time on the program.....	18
Table 3.13	Exit status .....	19
Table 3.14	Other AOD services referred to on exit.....	19
Table 3.15	Univariate analysis of characteristics associated with program completion.....	20
Table 3.16	Multivariate analysis of characteristics associated with program completion.....	21
Table 4.1	Demographic characteristics of participants.....	30
Table 4.2	Sentences of participants .....	31
Table 4.3	Charge for new offences .....	32
Table 5.1	Eligibility for interviews .....	39
Table 5.2	Statistical Analysis of SF-36 and OTI Variables .....	40
Table 5.3	Comparative data for all participants accepted and for each interview group .....	41
Table 6.1	Level of understanding .....	52
Table 6.2	Satisfaction with treatment plan and with caseworker support .....	53
Table 8.1.	Assessable potential LMPP costs and benefits .....	75
Table 8.2.	Comparison of costs and benefits .....	78
Table 8.3.	Potential LMPP costs and benefits not assessed .....	79
Table A.2.	Diversion options .....	112
Table D.1.	Proportional hazards model - elapsed time to first offence of any kind, .....	119
Table D.2.	Proportional hazards model - elapsed time to first drug, theft or robbery offence ..	119
Table D.3.	Proportional hazards model - free time to first offence of any kind .....	119
Table D.4.	Proportional hazards model - free time to first drug, theft or robbery offence.....	119
Table D.5.	Proportional hazards model - elapsed time to first offence of any kind .....	120
Table D.6.	Proportional hazards model - elapsed time to first drug, theft or robbery offence ..	120
Table D.7.	Proportional hazards model - free time to first offence of any kind .....	120
Table D.8.	Proportional hazards model - free time to first drug, theft or robbery offence.....	120

## List of Figures

Figure 3.1	Referral and assessment outcomes .....	16
Figure 4.1	Survival function of 'elapsed time' to first offence .....	33
Figure 4.2	Survival function of 'free time' to first offence .....	33
Figure 5.1	Main reported drug of choice .....	43
Figure 5.2	Reported respondents' associates use of illicit drugs .....	43
Figure 5.3	Reported type of drugs most frequently used by respondents' associates.....	44
Figure 5.4	Mean Scores for Polydrug Use on the OTI.....	44
Figure 5.5	Mean Scores for HIV Risk-taking Behaviour associated with injecting drug use.....	45
Figure 5.6	Mean Scores for Social Functioning on the OTI .....	45
Figure 5.7	Mean Scores for Criminal Activity on the OTI.....	46
Figure 5.8	Mean Scores on the GHQ .....	47
Figure 5.9	Mean Scores on the SF-36 Bodily Pain scale .....	47
Figure 5.10	Mean Scores on the SF-36 General Health scale.....	48
Figure 5.11	Mean Scores on the SF-36 Vitality scale .....	48
Figure 5.12	Mean Scores on the SF-36 Social Functioning scale .....	48
Figure A.1.	Model of diversion options .....	114

## Glossary

Aboriginal	Refers to Aboriginal and Torres Strait Islander
AIC	Australian Institute of Criminology
AGD	Attorney General's Department
AOD	Alcohol and Other Drugs
BBV	Blood Borne Viruses
CPD	Crime Prevention Division
DAAP	Drug Assessment and Aid Panel
DoCS	Department of Community Services
DoH	Department of Health
LMPP	Lismore MERIT Pilot Program
MERIT	Magistrates Early Referral Into Treatment
MIMS	MERIT Information Management System
MMT	Methadone Maintenance Treatment
NRAHS	Northern Rivers Area Health Service
NSW	New South Wales
OTI	Opiate Treatment Index
SF-36	Short Form 36

## Executive Summary

The Lismore Magistrates Early Referral into Treatment (MERIT) Pilot Program, a pre-plea early court intervention, was planned by the NSW Government in response to recommendations from the Drug Summit held at the NSW Parliament House in May 1999. It was run as a pilot program for two years from July 2000, with an evaluation commissioned by the Attorney General's Department. This report is the final report from that evaluation.

The target population of the Lismore MERIT Pilot Program (LMPP) was adult defendants at Lismore and surrounding Local Courts, who had a demonstrable drug problem, were eligible for bail, and who were motivated to engage in treatment for their illicit drug problems.

The intended outcomes of the program were:

- Decreased drug-related crime by participants, during the program and following completion
- Decreased illicit drug use by participants, during the program and following completion
- Improved health and social functioning among participants, during the program and following completion
- Reduced sentences due to better rehabilitation prospects.

### *The Evaluation*

The aim of the research project was to formally evaluate the impact and effectiveness of the LMPP. A number of studies were developed:

- **Program and participant profiles** – routine data collected by the LMPP were analysed by the evaluation team to develop detailed participant profiles, describe treatment provided to participants, and to assess factors associated with retention in the program.
- **Court outcomes and recidivism** – the impact on court outcomes was assessed by comparing outcomes for program completers with those for non-completers. A second analysis compared actual sentences to 'indicative' sentences provided by the Magistrate, (the sentence he is likely to have given the successful program completers in the absence of the LMPP). To assess recidivism, re-arrest data from the Police database were used, and completers were compared with non-completers. Reoffending within 3 months and 12 months, as well as time to first offence were compared.
- **Health and social functioning outcomes** – program participants were interviewed on entry, at exit and several months after program exit. Standardised interview schedules incorporating the Opiate Treatment Index (OTI), the General Health Questionnaire (GHQ) and the SF-36, were used to assess changes in health and social functioning between entry and the subsequent interviews.
- **Economic assessment** – an assessment of costs and benefits was undertaken for the first year of operation. The actual costs incurred were used. The benefits were estimated from savings associated with lower levels of incarceration, police crime investigation, hospitalisation and reduced criminal activity costs. The data on court outcomes and 'indicative' sentences from the court outcomes and recidivism study (above) were used to estimate the savings from lower levels of incarceration.
- **Review of legal issues** – an assessment of the legal basis of the program and of the key legal issues raised by it, was undertaken using a literature review, interviews with stakeholders and analysis of relevant quantitative data compiled by LMPP staff.
- **Implementation review** – using two rounds of interviews with key stakeholders and analysis of routinely collected data, this study identified those aspects of the program which worked particularly well, critical success factors, and areas for improvement.
- **Participant perspectives and satisfaction** – the perspectives of the participants were sought to determine their satisfaction with, and experience of, the program and the impact it had on their lives. Standardised interviews were conducted in conjunction with those for the health and social functioning study.

## ***Program and participant profiles***

During the first two years of operation the LMPP recruited 238 participants for 266 program episodes, with the majority (72%) of those referred accepted to the program, and half of those entering the program successfully completing it.

The overall picture of the participants is one of a group of people with complex social and health problems, and many with substantial prior criminal histories. The participants were predominantly male, unemployed, and users of multiple different classes of illicit drugs. Heroin (54%) was the most common principal drug of concern, with amphetamines (18%) and cannabis (23%) also common. The median age was 29 years, and 16% were Aboriginal. Most participants had a long history of drug abuse, with only 14% never having injected, and nearly half reporting infection with Hepatitis B or Hepatitis C viruses. They also reported extremely high rates of chronic physical and mental health problems. The participants were mostly recidivist offenders, with 61% having previously been imprisoned, and 85% having at least one prior conviction. Many had multiple charges current on referral to the LMPP, with 55% being charged with theft offences; 46% with drug offences; and 22% with driving offences.

The LMPP was designed as an early intervention program, with the expectation that many participants would be referred by the Police shortly after arrest. However, the data show that only 11% of participants were referred by Police, with the majority (64%) referred by the Magistrate. As there may be delays of up to four weeks between a person being charged and their first court appearance, this creates delays in assessment and treatment.

A distinguishing feature of the LMPP is that the caseworkers act as both the primary treatment provider, and the caseworker. They must be skilled clinicians, and also have expertise in reporting to the court. It is therefore crucial that there are adequate external Alcohol and Other Drug (AOD) services to refer participants to, and that the caseworkers are themselves well supported. External AOD services frequently used by the current program were residential detoxification and rehabilitation services and methadone maintenance treatment.

Half of the participants who started the program completed it. Although some participants were able to do so within the three months initially planned, some needed longer, with an average time on the program of 116 days for program completers. The program allows some flexibility in the time allowed for completion, at the discretion of the Magistrate.

An analysis of characteristics associated with program completion found that those for whom the principal drug of concern was heroin or amphetamines were less likely to complete the program; as were Aboriginal people. Those living in privately owned accommodation were more likely to be successful. There were no differences in completion among those who had previously been imprisoned, and those who had not.

## ***Court outcomes and recidivism***

Participants who completed the program received less severe sentences than non-completers, with only one completer receiving a custodial sentence, compared to 38% of those who were breached or removed from the program. Similarly, in the comparison of the actual sentences received with the 'indicative' sentences provided by the Magistrate, the actual sentences were lighter. The reduced severity of sentences is consistent with the completers' improved prospects for rehabilitation.

Using Police charges as the indicator of reoffending shows that those who complete the program are significantly less likely to reoffend, and take longer to reoffend than those who do not complete the program. At any point in time, the non-completers are twice as likely to have reoffended as the program completers. This holds true for both 'drug, theft and robbery offences' and for 'all offences' and applies to both 'free time' and 'elapsed time' analyses. The reduction in reoffending is significantly associated with program completion, even when other factors associated with recidivism are controlled for, including previous incarceration.

## **Health and social functioning**

The findings from the health and social functioning study suggest that:

- Health and social functioning on entry were generally very poor, consistent with the participant profiles
- For program completers, there were significant improvements in health and social functioning, with greater impact on psychological health than physical health.

There were significant improvements on the Social Functioning scores of both the OTI and the SF-36, and on the Criminal Activity score of the OTI. Improvements in psychological function, were significant on three of the four scales of the GHQ, as were improvements on the Vitality, Bodily Pain and General Health scales of the SF-36.

Program completers had a significant reduction in the numbers of classes of drugs used between the entry and exit interviews, which was maintained at the follow-up interview. There was a reduction in the use of heroin, with an increase in cannabis as the drug of choice. This may reflect substitution of heroin with cannabis, or continued use of cannabis in the absence of heroin.

From the qualitative data, both the participants and key stakeholders believed that there were substantial improvements in health and social functioning of program completers. Participants reported reduction in, or complete abstinence from drug use; improved life skills; improved relationships with family, especially children; more positive attitudes and greater self-esteem. Key stakeholders interviewed, particularly AOD staff and Police, agreed with these claims.

## **Economic assessment**

The assessment of the costs and benefits of the LMPP for the financial year 2000-2001 indicated considerable savings from implementation of the program. Three cases were examined to allow for a possible range of costs for police crime investigation and criminal activity. A potential ratio of benefits to costs of between 2.41 and 5.54 to the \$1 was determined, with a conservative estimate of an annual net benefit of \$914,214 for a yearly average of 55 LMPP completers, or \$16,622 per completer.

Additionally, a number of indirect and intangible benefits could have accrued as a result of the program. Values could not be determined for these potential benefits, which were therefore not included in the current assessment.

## **Legal issues**

The legal review undertaken as part of this evaluation identified a number of legal issues which could be addressed.

The MERIT program operates within the legal framework of the *Bail Act, 1978*, and in particular section 36A, which allows bail to be granted on the condition that the defendant enters treatment to address their drug use.

There are no legislated guidelines for the program. The Chief Magistrate issued a (non-binding) Practice Note on MERIT on 20 August 2002. The question of whether specific legislation should be introduced was raised, with the judgement that separate legislation to underpin MERIT is not essential.

Eligibility for bail is a criterion for entry to MERIT. However, there is one sentence in the Practice Note which could be construed as implying that suitability for MERIT could influence the decision to grant bail. The Chief Magistrate could be asked to consider a review of the Practice Note for the purpose of clarifying that the decision making on eligibility for bail should precede consideration of eligibility for MERIT.

The Practice Note excludes from eligibility for MERIT, defendants charged with offences involving allegations of "significant violence". In practice, the determination of whether a particular charge involves "significant violence" is made with regard to the particular circumstances, with recognition that there are degrees of violent conduct. Such decision making on MERIT eligibility echoes the

very similar issues raised in determining bail where violence is involved. Section 32 (1) (c) of the *Bail Act* requires courts to take account of the “nature and seriousness of the offence, in particular whether the offence is of a sexual or violent nature” when determining bail. Continuation of the present arrangements where the magistrate determines, for MERIT eligibility purposes, whether an offence involves “significant violence” on the basis of all relevant material before the Court, is supported.

Another eligibility issue concerns defendants charged with the offence of “ongoing supply” under section 25A of the *Drug Misuse and Trafficking Act 1985*. Defendants facing this charge are not eligible for MERIT as the offence is wholly indictable. However, it is likely that these people and society would benefit from their participation. Consideration could be given to extending the eligibility criteria of the MERIT scheme to include people charged under section 25A of the *Drug Misuse and Trafficking Act 1985*. Alternatively, this offence could be re-classified as not wholly indictable.

A number of stakeholders would support the eligibility criteria being extended to include juveniles. Several possible solutions were considered. Young offenders could be deemed eligible persons for the purposes of the MERIT program. Alternatively, a variation of MERIT could be specifically designed for dealing with juvenile defendants. If MERIT is to be regulated as an “intervention program” under the *Criminal Procedure Act*, amendments would be necessary to allow participation by juvenile defendants.

### ***Critical success factors***

A number of critical success factors were identified, including:

- The close professional relationship between senior staff of the critical players
- The professionalism of the LMPP case workers and manager in dealing with the Court and the Police, in particular, their prompt and competent reporting to the Court, and notification of breaches to the Court and Police
- The adequate resourcing of the program, including reasonable case loads and brokerage of residential AOD services
- The professionalism and dedication of the LMPP team in working with participants
- The program intensity, structure and flexibility

### ***Opportunities for improvement***

While it appears that overall the LMPP has been successful, there is scope for improvement by:

- Improving partnerships and communication by more formalised arrangements including Memoranda of Understanding; together with improved liaison, sharing of information and joint case planning
- Encouraging police referrals at the time of arrest by training in drug dependency and diversion programs, use of a carbonised referral pad, and development of prompts in the Police database
- Providing post-program support to completers
- Implementing strategies to better meet the needs of Aboriginal participants including: employment of an Aboriginal caseworker; liaising more closely with Aboriginal agencies and communities; development of culturally appropriate resources; and relevant staff training
- Providing staff training in managing participants with mental health problems

### ***Concluding remarks***

The LMPP appears to have been successfully implemented, with the evaluation findings suggesting that it has achieved its intended outcomes. The participants were mostly recidivist drug-dependent offenders, and given the short-term nature of the intervention, the achievements to date are impressive.



# Chapter 1 - Introduction and Literature Review

Catherine Spooner‡ and Megan Passey\*

‡ Catherine Spooner Consulting, conjoint at National Drug & Alcohol Research Centre, UNSW

\* Northern Rivers University Department of Rural Health & Northern Rivers Area Health Service

## Initiation of an 'Early Court Intervention Pilot Program'

In May 1999, the New South Wales Parliament conducted a Drug Summit at Parliament House, involving Members of both Houses of Parliament and invited community representatives, to consider problems relating to the use of drugs in the community and how these problems should be addressed.<sup>1</sup> As part of the NSW Government response to the Drug Summit, a range of diversion schemes were planned.<sup>2</sup> One of these was a Early Court Intervention Pilot program at the Lismore Local Court. This was based on the CREDIT scheme in Victoria and was to be trialled over twelve months from July 2000.

Early court intervention was designed to complement other diversion programs operating or planned for NSW. In particular, while the Adult Drug Court targeted serious offenders facing prison sentences, the early court intervention targeted a wider range of minor offenders appearing at Local Court level.

Lismore Local Court had a number of particular advantages. Firstly, it is positioned in an area known for high levels of illicit drug use, (Swift *et al*, 1998; Darke *et al*, 2000; Reilly *et al*, 1998) so the court was likely to be exposed to drug offenders. Secondly, the area had some existing drug treatment facilities, such as The Buttery, to which offenders could be referred. Third, being based in a rural area, the pilot was able to provide information about the feasibility and effectiveness of diversion programs in a rural area. This complemented other diversion programs such as the Adult Drug Court and the Youth Drug Court, which were based in urban Sydney. The program subsequently became known as the Lismore MERIT Pilot Program, where MERIT is an acronym for Magistrates' Early Referral Into Treatment.

Although originally planned as a 12 month pilot program in the Lismore, Kyogle and Casino Local Courts, the geographic spread were subsequently extended to cover Byron Bay, Mullumbimby and Ballina Courts. The time period was also extended for an additional 12 months, giving a total of 24 months from July 2000 to June 2002. Following early promising results (Linden 2001; Reilly *et al*, 2002), the MERIT Program is now being rolled out across NSW.

In this chapter we describe the Lismore MERIT Pilot Program (LMPP) and place it in the context of other drug diversion programs operating in Australia. A brief review of the literature related to the development and design of the LMPP is provided in **Appendix A**. The methodological approach of the evaluation is presented in Chapter 2.

## Lismore MERIT Pilot Program

The NSW Attorney General's Department had the responsibility of lead agency in the development of the LMPP as a demonstration project. Following the adoption of the Drug Summit Plan of Action, an interagency group was formed to plan and oversee the conduct of the trial project. Membership of this group included a range of key stakeholders, including Police, Health Department, Office of Drug Policy, Legal Aid Commission, Chief Magistrate, Office of the Director

<sup>1</sup> <http://203.147.254.2/NSWDS/NSWDrugSummit.nsf/Content/Outcomes>

<sup>2</sup> [http://drugsummit.socialchange.net.au/action\\_plan/index.html#six](http://drugsummit.socialchange.net.au/action_plan/index.html#six)

of Public Prosecution and the Premier's Department. Additional individual experts or agency representatives were also recruited as required.

The following description of the LMPP is based upon a program plan prepared by the Crime Prevention Division (CPD) of the NSW Attorney General's Department in 2000. (NSW Attorney General's Department - Crime Prevention Division, 2000).

### ***Program Outcomes***

The intended outcomes of the LMPP were:

- Decreased drug-related crime by participating offenders for the duration of their program
- Decreased drug-related crime by participating offenders following program completion
- Decreased illicit drug use by participating offenders for the duration of the program and in the post program period
- Improved health and social functioning for the duration of the program and in the post program period
- Reduced sentences due to better rehabilitation prospects

The possible unintended program outcomes anticipated by the CPD were:

- Increased remand numbers if offenders fail to comply with bail conditions
- Displacement of voluntary clients by MERIT participants in drug treatment services
- Disruption to drug treatment services by MERIT participants
- Potential 'net-widening'.

### ***Target Population***

The target population of the LMPP was adult defendants at Lismore and surrounding Local Courts with a demonstrable drug problem who were eligible and suitable for release on bail and who were motivated to engage in treatment and rehabilitation for their illicit drug problems.

An estimation of demand for the LMPP was calculated. In the CREDIT pilot project in Melbourne, about 50% of eligible offenders were attracted to enrolment. Therefore, based on a consideration of the likely throughput in the participating courts and the capacity of drug treatment services in the area and a 50% take up rate, it was estimated that the number of offenders who could be managed by the LMPP would be in the range of 120-150 persons over the twelve months of the pilot project.

### ***Inclusion Criteria***

The inclusion criteria for the scheme were as follows:

- Restricted to adult offenders
- Defendant had a treatable illicit drug use problem
- A suitable treatment place was available
- Defendant gave informed consent to participate

Exclusion criteria from the scheme were as follows:

- Defendants charged with violent or sexual offences, or with violent or sexual offences still pending
- Defendants charged with wholly indictable offences (including indictable drug offences)
- Defendants on other court ordered treatment programs
- People who lived outside a defined catchment area

### ***Referral and Assessment***

Potential clients were referred by NSW Police in the Richmond Local Area Command, the Legal Aid Commission solicitors, private legal practitioners and magistrates operating in the participating courts, which were Lismore, Kyogle and Casino.

The catchment area during the LMPP covered those persons arrested by Richmond LAC police and who appeared before the Local Courts of Lismore, Casino and Kyogle. Defendants appearing at Ballina Mullumbimby and Byron Bay courts could have had their cases transferred to Lismore in order to participate in the LMPP.

To maximise program integrity, a detailed Program Operational Procedure Manual was developed, which included standard referral forms and the assessment questions.

Defendants, after being screened by the police and/or their defence lawyer as potential candidates for the LMPP and giving informed consent, were bailed to the next court date at Lismore Court to attend an interview with the drug assessment (LMPP) team. Alternatively, magistrates could refer defendants appearing before them who appeared suitable. Assessments took place in the office of the LMPP team or at Lismore Court.

When the LMPP team was informed that a Bail Brief for entry into the Program had been received, they conducted a thorough assessment of the defendant. This included drug use behaviours, drug use problems, family relationships and family drug history, social situation, legal issues, medical problems associated with drug use, mental health, motivation for change, and potential to engage in treatment for drug use problems.

At the bail hearing, the LMPP team provided a written report to the Magistrate, including a recommendation of whether the defendant should be entered into the LMPP and the type of drug treatment services that were appropriate. The Magistrate had discretion to determine whether the defendant was an appropriate candidate to be bailed with conditions. If the defendant was accepted into the Program, the LMPP team received a copy of the bail order from the Clerk of the Court.

Because of a typical four-week period between the charging of a person and the initial court appearance, it was foreseen that the defendant might agree to participate in a drug treatment program after assessment but before formally being enrolled in the LMPP. Consequently, the LMPP team was to maintain contact with the defendant throughout the period of the bail order to provide support, structure and/or supervision as necessary.

The LMPP team was not to monitor bail conditions that were not specifically drug treatment related. This was a function of the Probation and Parole Service or the Police, depending on the specific bail conditions.

### ***Treatment and Supervision***

A full range of health and welfare services were provided, to meet offenders' complex needs ranging from drug dependence, mental health disorders, disabilities, unemployment, financial difficulties, housing problems, poverty, family dysfunction, children at risk, and health problems, as well as their legal problems. Offenders were matched to appropriate treatments, including detoxification, pharmacotherapies (eg. methadone, naltrexone), residential rehabilitation, community outpatient services, and case management. In addition to specialised drug treatment services, ancillary services were used, as appropriate, such as medical and primary health care services, accommodation and housing, employment and vocational services, education and training, family counselling, and psychiatric and psychological interventions.

The Magistrate was encouraged to undertake an increased level of judicial supervision as a core element of the program. For the LMPP, this judicial supervision usually involved one or two additional "mentions" to establish how a defendant was progressing and to offer encouragement, as appropriate. On the other hand, if a defendant was not going well, judicial supervision could play a salutary role in emphasizing the consequences of non-compliance with the program.

Where possible, the same Magistrate dealt with the defendant throughout the bail order. It was anticipated that greater involvement of the judiciary - and a consistent voice - would add an important element to the management of offenders and the success of the Program.

Breaches were defined as commission of further offences, non-compliance with bail conditions, or failure to appear. The consequences were that the magistrate could withdraw bail or final sentence could be affected.

The completion of the LMPP program usually coincided with the final hearing and sentencing of the person. Wherever possible, the LMPP case manager contacted the defendant by telephone to attend a personal appointment for a review prior to the sentencing hearing. The Magistrate hearing the case was provided with a comprehensive report from the LMPP team, containing information on the defendant's participation in drug treatment and any further treatment recommendations.

A representative of the LMPP team could attend the sentencing hearing, if requested by the Magistrate or the defendant. As far as possible, the sentencing hearing was held by the same Magistrate who considered the initial bail hearing. The relevance of compliance or non-compliance with the LMPP program to the determination of final sentence was at the discretion of the Magistrate.

## **Comparable diversion programs for drug offenders**

Court-based diversion is one of many possible diversion options, and MERIT is one of many court-based diversion programs in Australia. Other court-based diversion programs being trialed around Australia include the Adelaide Drug Court, (Adelaide Magistrates Court, 2002); drug courts in the Perth Children's Court, the Perth Court of Petty Sessions and the Perth District Court, (W.A. Department of Justice, 2002); a sentencing option called an Intensive Drug Rehabilitation Order in Queensland Magistrates Courts, (Queensland Department of Justice and Attorney-General, 2002) and Victoria's Drug Court, (Magistrates Court of Victoria, 2002a). Rather than describe all relevant programs, a brief description of the two programs with which MERIT is most often compared is provided: the CREDIT program in Victoria (upon which MERIT was based) and the NSW Drug Court in Parramatta (which MERIT was intended to complement).

### ***CREDIT (Court Referral Education, Drug Intervention and Treatment)***

The MERIT model was based on a pilot program conducted in the Melbourne Magistrates Court, Victoria called CREDIT (Court Referral & Evaluation for Drug Intervention Treatment). (Magistrates Court of Victoria, 2002b; Magistrates Court of Victoria, 2002c) The CREDIT program is offered to offenders with substance abuse issues as part of bail proceedings after initial arrest. Persons charged with a non-violent offence who have a drug problem are referred by police for assessment by a Drug Clinician based at the court. Where appropriate, the alleged offender is diverted into a recommended treatment regime by the magistrate as a condition of bail. This option is only available at Magistrates Courts where there is a court appointed drug clinician.

CREDIT commenced as a nine-month pilot program in November 1998. A process evaluation of CREDIT has been published (Heale *et al*, 2001). The evaluation aimed to:

- assess CREDIT according to its key performance indicators of client uptake, treatment completion and re-offending while on bail
- identify factors that contributed to success or failure
- identify possible improvements to the program
- assess the value of expanding the program to other Magistrates Courts

The evaluation included the use of data supplied by police, discussions with key informants (Magistrates, clinicians, treatment staff, police and government representatives) and interviews with clients who had completed treatment. The client sample was not representative, so Heale and Lang did not report the results of those interviews.

Results reported by Heale and Lang included the following:

- Client uptake: 399 people were referred to CREDIT, 50% of these were subsequently placed on the program

- Treatment completion: 52% of CREDIT participants completed their treatment conditions
- Reoffending while on bail: 25% of CREDIT clients reoffended while on bail. There was no statistical difference in rates of re-offending between CREDIT clients and comparable offenders who did not participate in CREDIT.
- Factors that contributed to success or failure: there was a slow take-up rate of CREDIT, which appeared to be due to the need for improved training of police and others involved in program implementation.
- Benefits of CREDIT identified by the key informants included:
  - better understanding and improved relationships between organisations (health, police, justice)
  - earlier access to treatment for CREDIT participants – one third had no previous treatment history
  - reduced burden on courts and prisons
  - Magistrate access to professional advice regarding defendants with drug problems

The positive views by key informants suggested that there was strong support for continuing CREDIT. However, Heale and Lang noted that improved data monitoring and evaluation systems were needed to truly assess the programs worth in terms of reoffending rates.

In sum, the initial evaluation of CREDIT indicated that it was possible to engage a number of illicit drug dependent persons in drug treatment. However, there was no substantial impact on the level of reoffending whilst on bail. Nevertheless, the scheme has since been expanded in Victoria and the results were regarded as sufficiently promising for there to be a trial of a similar approach in New South Wales.

### ***NSW Drug Court***

The NSW Drug Court, which is the first such court to be introduced in Australia, is located in the Parramatta Court complex and is accessible only to residents in Greater Western Sydney. Drug-dependent adult offenders are offered the opportunity to undertake intensively supervised drug treatment programs as an alternative to incarceration. The Drug Court was officially opened on 8 February 1999 (NSW Drugs Program Bureau, 2002).

The Drug Court has both Local and District Court jurisdiction. A Local or District Court may refer persons to the Drug Court in the catchment area if they appear to meet the eligibility criteria. Offenders must successfully complete detoxification and comprehensive health assessments before being accepted onto the program. The treatment program and supervision conditions vary across participants. However, all offenders are required to report to the Court at regular intervals so that their progress on the program can be assessed. At the outset of the Drug Court trial, programs were designed to take 12 months to complete, but in practice, programs are sometimes taking longer to complete (Briscoe and Coumarelos, 2000).

The NSW Drug Court adopts a team approach to the management of offenders. The team includes the senior Judge, the senior Judge's Associate, a Magistrate, the Drug Court Registrar, Probation and Parole Coordinator, Legal Aid solicitors, Director of Public Prosecutions solicitors, a nurse from Corrections Health, and an Inspector of Police. The team meets to discuss the participant's progress before each report-back appearance to the Court. The judge then discusses with the participant the issues raised at the team meeting.

The NSW Bureau of Crime Statistics and Research conducted the evaluation of the NSW Drug Court. The evaluation included monitoring (Briscoe and Coumarelos 2000; Briscoe and Doak, 2000), description of participants (Freeman *et al* 2000), process evaluation (Taplin 2002), assessment of health, well-being and participant satisfaction (Freeman 2001; Freeman 2002), and cost-effectiveness (Lind *et al* 2002).

Interviews with participants revealed that those who remained on the Drug Court program showed clear and sustained evidence of improvement in their health and social functioning (Freeman 2002). Participants on the program were generally very satisfied with it. Interviews with those directly involved in managing or providing services to the Drug Court also indicated general

satisfaction with the program (Taplin 2002). Two areas highlighted for reform were the need for clarification of the legal provisions prohibiting violent offenders from entering the program and the need for improved services for women, Aboriginal offenders and those with a concurrent psychiatric problem.

The cost-effectiveness study included identified that, despite the high drop-out rate (approximately 40%), the NSW Drug Court program has proved more cost-effective than imprisonment in reducing the number of drug offences and equally cost-effective in delaying the onset of further offending. This evaluation also highlighted several ways in which the cost-effectiveness of the Drug Court could be improved. These include improving the Court's ability to identify offenders who will benefit from the program, earlier termination of those unsuited to the program, improving the match between offenders and treatment regimes and improving the level of coordination between agencies involved in the program (Lind *et al* 2002).

MERIT was planned as a complement to the Drug Court at Parramatta. Differences to the Drug Court are that MERIT:

- targets a wider range of less serious offenders
- does not require the defendant to enter a plea of guilty in order to participate in the program
- does not require a determination of guilt be made prior to the opportunity of entry to MERIT being extended to the defendants
- participants are not necessarily facing custodial sentences
- participants are not required to be drug dependent

### **Comparison summary**

A comparison of MERIT with CREDIT and the NSW Drug Court is summarised in Table 1.1

**Table 1.1 Comparison of MERIT with CREDIT and the NSW Drug Court**

<b>Feature</b>	<b>CREDIT</b>	<b>MERIT</b>	<b>Drug Court</b>
Target group	Less serious offenders	Less serious offenders	More serious offenders
Program length	Approx. 10 weeks	Approx. 12 weeks	12 months
Location	Statewide	Rural	Urban
Guilty plea required	No	No	Yes
Evaluation	Process	Process Impact Outcome	Process Impact Outcome
Court	Local	Local	Local/District

## Chapter 2 – Methodological Approach to the Evaluation

Megan Passey

Northern Rivers University Department of Rural Health & Northern Rivers Area Health Service

### Introduction

In line with the commitment to rigorously evaluate the innovative programs under the Drug Summit, the NSW Attorney General's Department (AGD) commissioned a monitoring and evaluation project. An evaluation framework was developed, with aims, objectives and questions for the evaluation (NSW Attorney General's Department, 2000).

### *Aims and objectives of the evaluation*

The overall aim of the monitoring and evaluation project was to provide regular data and information on the implementation of the Lismore MERIT Pilot Program (LMPP) and to formally evaluate its impact and effectiveness.

More specific objectives set by the Reference Committee were:

- to determine the level of attractiveness of the scheme to eligible offenders
- to determine the health and social impacts of the early court intervention approach
- to determine criminal justice system impacts of the early court intervention approach, particularly on the level of reoffending amongst the project participants
- to identify the critical success factors and any barriers to effective program operation
- to recommend on the future development and expansion of the early court intervention scheme in this State.

### Overall Approach

In line with the evaluation framework developed by the Reference Committee (NSW Attorney General's Department, 2000), a number of different studies were developed for the evaluation:

1. Program and Participant Profiles
2. Implementation Review
3. Outcomes Study – which had several elements – court outcomes and recidivism among participants; health and social functioning outcomes; participant satisfaction and perspectives of the program
4. Economic Assessment
5. Legal Issues Review

The evaluation was undertaken by the Southern Cross Institute of Health Research, a collaborative research initiative between Southern Cross University (SCU) and the Northern Rivers Area Health Service (NRAHS). An Evaluation Steering Committee was formed to guide the evaluation process. The Evaluation Steering Committee was composed of a representative from the Attorney General's Department, the Manager of Drug and Alcohol Services (NRAHS), the Data Quality Officer for the LMPP, a solicitor from the Northern Rivers Community Legal Centre, a statistician from SCU, and the researchers themselves – economists and lawyers from SCU, the epidemiologist and research officer from NRAHS. The members of the Steering Committee are listed in **Appendix B**.

Below is a description of the studies undertaken for the evaluation of the LMPP. The various different components of the evaluation are described with an overview of the methods used for each. More detailed descriptions of the methods used for each component are provided in the relevant chapters.

### ***Program and Participant Profiles***

It was decided that the LMPP itself was best placed to perform the ongoing collection of data and monitoring of activity. The program undertook to collect data on participants, court processes, treatment provided and exit status of participants, as part of their management and quality activities. They developed standardised forms for data recording, and an electronic database – the MERIT Information Management System (MIMS), in which data from the standard program forms was entered. The LMPP produced routine quarterly reports on program activities, using these data. The Evaluation Steering Committee routinely reviewed these reports and suggested a number of additions and clarifications.

Data from the MIMS has been analysed for this report. These data were used to develop detailed participant profiles, describe treatment provided to participants, and to assess factors associated with retention in the program. The results of this process are provided in Chapter 3 – Program and Participant Profiles.

### ***Implementation Review***

The purpose of this component was to identify critical features of the LMPP which work well, as well as those which do not, and require modification. Two series of interviews were undertaken with key informants – one in February and March 2001, and the second in July and August 2002. Key informants interviewed included LMPP staff, the Magistrates, Court Administrative staff, Police officers, Probation and Parole officers, Legal Aid solicitors, health staff working in detoxification and rehabilitation units, Mental Health staff, Aboriginal support workers, and participants themselves.

A summary of issues identified in these interviews was provided to the Attorney General's Department. Key issues relevant to the ongoing management and roll-out of the MERIT Program across NSW are discussed in Chapter 7 – Stakeholder Views of the Lismore MERIT Pilot Program.

### ***Outcomes Studies***

The outcomes study had a number of elements:

#### ***a. Court Outcomes and Recidivism***

As the intended outcomes of the LMPP included a reduction in drug-related crime by participating offenders; as well as a reduction in the severity of sentences due to better rehabilitation prospects, we assessed both the court outcomes of the participants for the offences which brought them to the LMPP, and reoffending after the date of referral to the program.

Data on court outcomes were obtained from the NSW Bureau of Crime Statistics and Research (BOCSAR), which maintains databases on court proceedings and police arrests. Some of the information on court outcomes was not available from the BOCSAR and was obtained from the LMPP database. Additionally, in order to assess the impact of the program on court outcomes, the Magistrate presiding at the Lismore Local Court during this period was asked to indicate the sentence he would have given the program completers, had there been no LMPP available to refer them to. The actual sentences received were compared to these 'indicative' sentences.

For the analysis of recidivism, program completers were compared to non-completers. Data on the Police database for charges for alleged offences occurring after the date of referral to the program were provided by the BOCSAR. These were used to assess reoffending within



three months, and within 12 months of referral to the program, as well as time to first offence. An attempt was also made to develop an external comparison group, but this proved unsuccessful.

The findings from this study are presented in Chapter 4 – Court Outcomes and Recidivism.

**b. Health and Social Functioning Outcomes**

One of the intended outcomes for participants of the LMPP was improved health and social functioning, both for the duration of the program and in the post program period. The aim of this component of the evaluation was to determine to what extent the improvements in health and social functioning were achieved.

The study was designed as a prospective cohort study, with participants interviewed at program entry, exit and a follow-up interview several months after program exit. All people accepted onto the program were eligible to be included in the evaluation, including the exit and follow-up interviews, regardless of exit status. The study was designed to be analysed on an intention-to-treat basis, and thus outcomes of all those accepted onto the program were of interest.

Participants health and social functioning were measured by interviews using standardised interview schedules. The SF-36 (Ware *et al*, 1993) and the Opiate Treatment Index (OTI) (Darke *et al*, 1991) were included at each interview, together with demographic data, and questions regarding drug treatment and criminal history. The SF-36 is an instrument developed to measure health and well-being, while the OTI is an Australian instrument incorporating a set of measures designed to evaluate outcomes among people receiving treatment for opiate use. Changes in health and social functioning were assessed by comparing the entry interview and subsequent interviews.

The findings from this study are presented in Chapter 5 – Health and Social Functioning Outcomes.

**c. Participant Satisfaction**

The perspectives of the participants in the program were sought to answer a number of the evaluation questions and to determine their views of the program. We were interested in assessing their satisfaction with the program; which aspects of the program they found most useful, and which aspects most challenging; the positive and negative effects they had experienced from the program; and how confident they were of maintaining any changes they had made on the program. We were also interested in their suggestions for ways to improve the program.

Participants were interviewed at program entry, exit and a follow-up interview several months after program exit, in conjunction with the interviews for the Health and Social Functioning Outcomes study. Both program completers and non-completers were interviewed.

The findings from this study are presented in Chapter 6 – Participant Perspectives of the Lismore MERIT Pilot Program.

**Economic Assessment**

One of the rationales for undertaking drug diversion programs is that they are more cost effective than traditional criminal justice processes. This study assessed both the costs and the financial benefits of the LMPP.

The assessment of costs and benefits was undertaken for the first year of operation of the program – the 2000/2001 financial year. The actual costs incurred were obtained from the LMPP, and were adjusted for start-up costs. The financial benefits were estimated from savings associated with lower levels of incarceration, police crime investigation, hospitalization and reduced criminal activity costs. The data on court outcomes and indicative sentences obtained for the Court Outcomes and Recidivism Study described above were used to

estimate cost savings from lower levels of incarceration. Other costs and savings were estimated based on reviews of the relevant literature. Three different cases were examined to allow for a possible range of costs for police crime investigation and criminal activity.

The findings from this study are presented in Chapter 8 – Economic Assessment of the LMPP.

### ***Legal Issues Review***

The Legal Issues Review was undertaken to assess the conceptual and legal basis of the program and to review the key legal issues raised.

The review utilized a combination of methods including a literature review, qualitative data drawn from semi-structured interviews with key stakeholders and analysis of relevant quantitative data compiled by the LMPP staff.

The findings from this review are presented in Chapter 9 – Review of Legal Issues from the MERIT Program.

## **The Report Structure**

The findings from these studies are presented in the next seven chapters. Most chapters contains a brief literature review relevant to that study, a detailed description of the methods used, the findings, and a discussion. The relevant references, and appendices are included at the end of the full report. The findings and issues identified in these chapters are then brought together in the final chapter of the report, with overall conclusions drawn. As a final appendix to the report, the staff of the LMPP have provided a number of case studies of participants.

## Chapter 3 – Program and Participant Profiles

Megan Passey

Northern Rivers University Department of Rural Health & Northern Rivers Area Health Service

### Introduction

This chapter will describe the key processes and participants accepted into the Lismore MERIT Pilot Program (LMPP) during the first two years of operation. It will address some key evaluation questions including:

- What is the descriptive profile of offenders who enter the program?
- Is the Lismore Early Intervention Drug Court capturing drug offenders *early* in their involvement with the criminal justice system?
- What are the reasons for non-compliance and failure to fully complete?

### Methods

The LMPP established standardised assessment and treatment processes and forms to ensure program integrity. These are described in the MERIT Program Operational Manual (NSW Health, 2002a). A database – the Merit Information Management System (MIMS) was developed for electronic recording and storage of this information. This database was developed and maintained by the LMPP team for ongoing management, monitoring of operations and reporting purposes<sup>3</sup>. The evaluation team was provided with access to the data for all people referred to the program during the evaluation period – 1<sup>st</sup> July 2000 to 30<sup>th</sup> June 2002. The data used for analysis for this report were extracted on 1<sup>st</sup> October 2002 and thus includes information on program participation and completion up to this date.

The MIMS database was developed in Microsoft Access. The data was analysed using a variety of methods, including Access queries, and analysis in statistical software – Epi-Info 6 (version 6.04a) and SAS (version 8).

### Findings

#### *Participant Profiles*

Between 1<sup>st</sup> July 2000 and 30<sup>th</sup> June 2002, there were 238 people accepted into the LMPP a total of 266 times. It was possible for people to be accepted to the program more than once during this period, and several people had more than one episode of care. A breakdown reveals that 213 had only one acceptance, 23 had two, one had three and one had four acceptances during this period. Data in the rest of this chapter will be presented for episodes of care, not for each person, as the information may change for different episodes.

---

<sup>3</sup> The data used in this chapter were provided to the evaluation team by the Lismore MERIT Pilot Program Team. We are particularly grateful to Peter Didcott, the Research and Quality Officer of the MERIT Program Team for his assistance and support.

**Table 3.1 Demographic characteristics of 266 participants accepted onto the LMPP 1<sup>st</sup> July 2000 to 30<sup>th</sup> June 2002**

	Number	Percent
<b>Gender</b>		
Male	202	75.9
Female	64	24.1
<b>Age at entry</b>		
< 20	28	10.5
20-24	56	21.1
25-29	64	24.1
30-34	54	20.3
35-39	27	10.2
40 +	37	13.9
<b>Aboriginality *</b>		
Aboriginal	42	16.1
Not Aboriginal	219	83.9
<b>Country of birth *</b>		
Australia	239	90.9
New Zealand	7	2.7
Great Britain	5	1.9
Other European	6	2.3
Other	6	2.3
<b>Marital status *</b>		
Single	153	58.0
Married/defacto	77	29.2
Divorced/Separated	34	12.9
<b>Children *</b>		
Yes	139	53.7
No	120	46.3
<b>Main source of income</b>		
Full-time employment	11	4.1
Part-time employment	8	3.0
Temporary benefit	157	59.0
Pension	72	27.1
Other income source	10	3.8
No income	8	3.0
<b>Accommodation *</b>		
Rented house/flat	144	54.3
Privately owned house/flat	57	21.5
Caravan on serviced site	34	12.8
Homeless	14	5.3
Other	16	6.0
<b>Highest level of education attained *</b>		
Year 10 or less	167	65.0
Year 11 or 12	42	16.3
TAFE/Trade	31	12.1
Tertiary	17	6.6

\* Missing data: Aboriginality – 5 missing; Country of birth – 3 missing; Marital status – 2 missing; Children – 7 missing; Accommodation – 1 missing; Education – 9 missing

## Demographic Profiles

The demographic profile of all those accepted onto the program is shown in Table 3.1. As can be seen, the majority of participants were male (75.9%), which is similar to both the NSW Adult Drug Court (Briscoe *et al*, 2000) and the Victorian CREDIT program (Heale *et al*, 2001). There was a spread of age on entry to the program, with a mean of 29.9 years (median 28.8 years). the oldest participant was 54 years old.

Aboriginal and Torres Strait Islander people (referred to as Aboriginals in this report) made up 16.1% of the people accepted onto the program, compared with 3.1% of the NRAHS population<sup>4</sup>. The majority of participants were born in Australia and there were none from Asia. Most of the participants (58%) described themselves as single, with 29% married or living in a de facto relationship, and 13% of them divorced or separated. A slight majority reported having children (53%), but only 23% claimed to have any dependents (not shown in table). There were no differences between men and women in reporting that they had children, or in reporting dependents.

The majority of the participants (59%) were dependent on temporary benefits for their main (legal) source of income, with a further 27% on a pension. There were 19 people (7%) in either part-time or full-time employment. Eight people reported no source of income.

While the majority reported that they lived in a rented house or flat, one fifth reported living in a privately owned house or flat (not necessarily their own). There were a significant number living in caravan parks (12.8%), and 14 (5.3%) reporting that they had no fixed address. Education levels of the participants were generally low, with nearly two-thirds having Year 10 education or less<sup>5</sup>. This is similar to the NRAHS adult population, where 63% have Year 10 education or less<sup>5</sup>. Nearly one fifth had some sort of post-secondary school education.

## Drug Use and Treatment History

Drug use by the participants at the time of entry into the program was recorded. Participants were asked about their principal drug of concern as well as other drugs used. For drugs not considered their principal drug of concern, clients were asked whether they considered their use of that drug to be a "problem" (other drug of concern). These data are shown in Table 3.2 below.

**Table 3.2 Drug use on entry, among 266 participants accepted onto the LMPP 1<sup>st</sup> July 2000 to 30<sup>th</sup> June 2002**

	Principal drug		Problem Use	
	Number	Percent	Number	Percent
Heroin	144	54.1	163	61.3
Cannabis	60	22.6	167	62.8
Amphetamines	49	18.4	96	36.1
Alcohol	1	<1.0	63	23.7
Benzodiazepines	5	1.9	49	18.4
Other opiates	2	<1.0	16	6.0
Other	5	1.9	-	

Over half the participants nominated heroin as their principal drug of concern, with 19 more indicating that they considered their use of it a "problem". Although less than a quarter nominated cannabis as their principal drug of concern, nearly two thirds identified cannabis, as a problem drug. The other common principal drug of concern was amphetamines, with nearly 20% identifying them as their principal drug of concern and slightly more than one third identifying them as a problem drug. It is also clear from the "Problem Use" column, that many of the participants used more than one class of drug with a substantial number (23.7%) identifying alcohol as a problem drug.

<sup>4</sup> Source: Australian Bureau of Statistics 2001 Census, Usual Residents Profile – Cdata2001

<sup>5</sup> Source: Australian Bureau of Statistics 2001 Census, Usual Residents Profile – Cdata2001

Participants were also asked how recently they had injected drugs. These results are summarised in Table 3.3.

**Table 3.3 Recency of injecting, among 266 participants accepted onto the LMPP 1<sup>st</sup> July 2000 to 30<sup>th</sup> June 2002**

	Number	Percent
<b>Last Injected</b>		
< 3 months ago	191	72.6
> 3 but < 12 months ago	17	6.5
> 12 months ago	17	6.5
Never injected	38	14.4

\* Missing data: Method of use – 1 missing; Last injected – 3 missing

Consistent with the data on principal drug of concern, nearly two thirds of the participants usually injected their drugs. An even greater proportion had injected at least once in the last 3 months, with only 14.4% having never injected drugs.

Many of the participants reported that they had accessed treatment for their drug problems in the past. The types of treatment previously accessed are shown in Table 3.4, with the number of people who had used that particular treatment type. Data were not available on the total number of times each person had used a particular type of treatment, or on current treatment.

**Table 3.4 Type of previous treatment accessed, for 266 participants accepted onto the LMPP 1<sup>st</sup> July 2000 to 30<sup>th</sup> June 2002**

	Number	Percent
Counselling	142	53.4
Inpatient withdrawal management	89	33.5
Outpatient withdrawal management	37	13.9
Residential rehabilitation	77	28.9
Day program rehabilitation activities	19	7.1
Methadone	102	38.3
Other pharmacotherapies	23	8.6
Other	21	7.9
No previous treatment	56	21.1

Only 21% had not previously accessed any treatment, with many participants having accessed a range of treatment modalities in the past. The most common of these were counselling, detoxification (withdrawal management) either as an outpatient or inpatient, methadone, and residential rehabilitation.

### **Other Health Issues**

As part of the assessment, participants were asked about health problems other than their drug use.

**Table 3.5 Other health problems reported by 266 participants accepted onto the LMPP 1<sup>st</sup> July 2000 to 30<sup>th</sup> June 2002**

	Number	Percent
Chronic physical disease	199	74.8
Mental health problem	104	39.1
Previous attempted suicide	70	26.3
Previous overdose	92	34.6

As shown in Table 3.5, 75% of the participants suffered from at least one chronic physical health problem, and 39% suffered from a mental health problem. Additionally over one quarter had previously attempted suicide, and one third had experienced at least one previous

overdose. Hepatitis B and Hepatitis C infections were common among this group, with 122 (45.9%) of the 266 participants reported to be infected. Clearly, this is a group of people suffering from chronic and complex health problems, in addition to their drug use and other social needs.

### **Prior Convictions and Current Charges**

Data on prior convictions and imprisonment are presented in Table 3.6. Nearly two thirds of the participants had previously spent time in gaol. Despite missing data on prior convictions, it is also clear that the majority of the participants had multiple prior convictions, with a mean number of prior convictions of 10.5 (median 7). Of the 68 participants for whom no data on number of prior convictions was recorded, 56 had data on prior imprisonment. Of these, 34 (60%) had previously been sentenced to gaol, indicating at least one prior conviction. Thus at least 215 of the 254 (84.6%) participants for whom information is available, had at least one prior conviction.

**Table 3.6 Prior conviction and imprisonment, for 266 participants accepted onto the LMPP 1<sup>st</sup> July 2000 to 30<sup>th</sup> June 2002**

	Number	Percent
<b>Prior Imprisonment *</b>		
Yes	154	60.9
No	99	39.1
<b>Number of prior conviction episodes *</b>		
None	17	8.6
1-5	65	32.8
6-10	42	21.2
11-15	26	13.1
16-20	22	11.1
>20	26	13.1

\* Missing data: Prior imprisonment – 13 missing; Prior conviction episodes – 68 missing

Data on current charges were also recorded, and are shown in Table 3.7. Just over half of those accepted onto the program were charged with a theft offence, with nearly half charged with drug offences. Many participants had multiple charges.

**Table 3.7 Type of current charges \* against the 266 participants accepted onto the LMPP 1<sup>st</sup> July 2000 to 30<sup>th</sup> June 2002**

	Number	Percent
Theft	142	54.8
Drug offences	119	45.9
Driving offences	57	22.0
Offences against justice procedures	44	17.0
Offences against good order	42	16.2
Offences against the person	37	14.3
Property damage	16	6.2
Robbery and extortion	9	3.5
Other offences	31	12.0

\* Missing data: Current charges – 7 missing

## **Operational Processes**

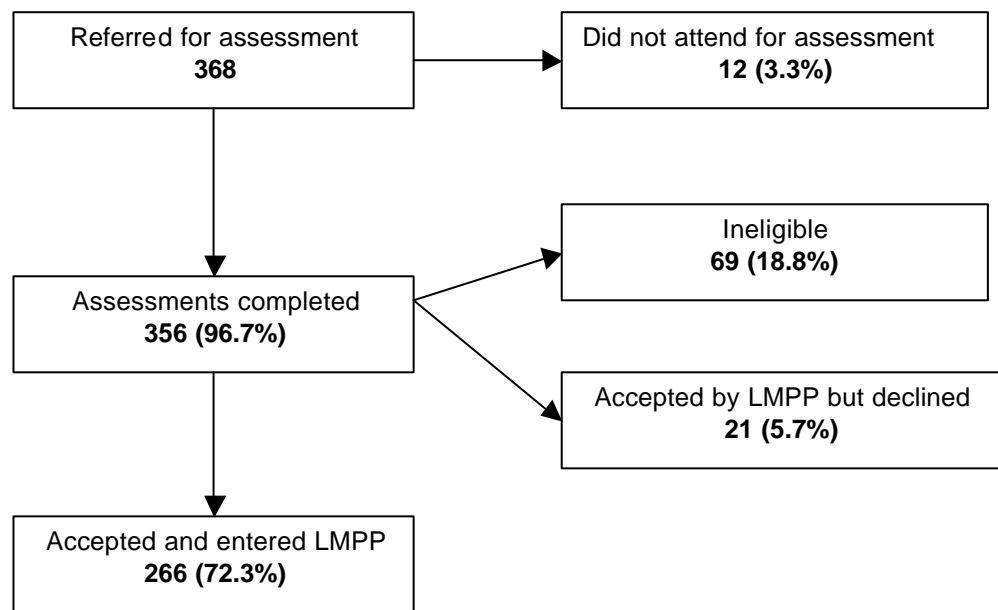
### **Referrals and Assessment**

The eligibility criteria for the LMPP were described in the introductory chapter of this report. Essentially, adults charged with an offence must have a demonstrable drug problem, be eligible for bail, have no current or outstanding charges for violent or sexual offences, live in

the catchment area, not be charged with an indictable offence and must give informed consent. If considered eligible, they may be referred for assessment by the Police, solicitors, the Magistrate, the Probation and Parole Service, or by the person themselves.

Figure 3.1 shows the number of people referred to the LMPP for assessment, and the outcomes of that process. Of the 368 referrals to the LMPP, 266 entered the program. Those who were considered ineligible were more likely to be male (91%) than those accepted onto the program. There were no differences in Aboriginality between those accepted and those who either did not attend, were considered ineligible, or declined the program.

**Figure 3.1 Referral and assessment outcomes for 368 referrals to the LMPP, 1<sup>st</sup> July 2000 to 30<sup>th</sup> June 2002**



Note: percentages are calculated as the percentage of all people referred for assessment (ie % of 368)

The reasons for being considered ineligible are shown in Table 3.8. The most common reason people were assessed as being ineligible for participation in the LMPP was because they had no demonstrable drug problem.

**Table 3.8 Reasons for being classified as ineligible<sup>\*</sup>, for referrals to the LMPP between 1<sup>st</sup> July 2000 to 30<sup>th</sup> June 2002**

	Number	Percent
Not eligible for bail	8	12
No demonstrable drug problem	25	37
Current violent or sexual offence	11	16
Unwilling to participate	9	13
Mental health problem	4	6
Already in treatment	3	4
Indictable offence	6	9
Program entry not endorsed by Magistrate	1	1

\* Missing data for 2 participants classified as ineligible

The source of referrals is shown in Table 3.9. As can be seen, nearly two-thirds of the referrals were from the magistrate and/or solicitor on the day of court, with the police being the second most common source of referrals. Interestingly, there were 33 self-referrals to the program. Only 21 of the 287 accepted (7.3%) declined the opportunity, with a further 9



classified as ineligible as they were unwilling to participate. This suggests a high level of acceptability of the program among potential participants.

**Table 3.9 Referral source by program entry status, for all referrals to the LMPP 1<sup>st</sup> July 2000 to 30<sup>th</sup> June 2002**

Referral source	Program Entry Status				Total	
	Entered		Didn't enter			
	No.	%	No.	%	No.	%
Police	30	11.3	10	9.8	40	10.9
Magistrate/Solicitor day of court	171	64.3	60	58.8	231	62.8
Solicitor prior to court	14	5.3	6	5.9	20	5.4
Probation and Parole	7	2.6	5	4.9	12	3.3
Self	23	8.6	10	9.8	33	8.9
Other	21	7.9	11	10.8	32	8.7
Total	266	100.0	102	100.0	368	100.0

The assessment involves a comprehensive review of drug use, problems associated with drug use, previous treatment, family relationships and family drug history, social situation, medical problems, mental health and psychological well-being, motivation for change and legal issues. At the bail hearing, the LMPP team provide a written report to the magistrate recommending whether or not the defendant is suitable for the program and the type of treatment recommended. The magistrate then makes the final determination as to whether the person should be bailed to the LMPP.

For those referred for assessment prior to their initial court appearance, there may be a short delay (up to four weeks) before they can be bailed to the program. For this reason, those assessed as being suitable for the program are encouraged to participate in drug treatment on a voluntary basis before being officially bailed to it. Of the 266 people who entered the program in the evaluation period, 65 (24.4%) had an assessment date prior to the first court date.

### ***Treatment Program***

Each participant is assigned a caseworker, who manages their treatment for the duration of their time on the program. The caseworker works closely with the participant to develop a suitable treatment program. Urinalysis is used for therapeutic purposes to monitor compliance with treatment and the results are not automatically reported to the court.

As identified in the first section of this chapter, most of the participants have chronic and complex social and health problems and are often in need of a range of health and welfare services. A distinguishing feature of the MERIT program is that much of the treatment is provided by the caseworkers, rather than through referrals to external services. The main treatment provided to participants by the caseworkers is shown in Table 3.10.

**Table 3.10 Main service provided to participants on the LMPP by caseworkers, for all participants accepted onto the program 1<sup>st</sup> July 2000 to 30<sup>th</sup> June 2002**

	Number	Percent
Counselling	226	87.9
Day program rehabilitation	1	<1
Information and education	11	4.3
Assessment only	19	7.4
Total	257	100.0

\* Missing data: Main service provided - 9 missing

The vast majority (88%) of the participants received individual counselling as their main intervention, with most participants requiring intensive supervision and counselling, particularly in the first few weeks when daily contact is often required. All participants are also required to

attend group sessions which are run weekly by the caseworkers. These sessions focus on giving the participants greater insight into their drug problem and its consequences, as well as developing a range of skills to deal with their drug problem and to improve their social functioning.

The participants are also referred to external alcohol and other drug (AOD) treatment services. Many were referred to more than one external service. As can be seen in Table 3.11, the most common services referred to were residential rehabilitation and residential detoxification. There were 45 participants recorded as being referred to a variety of other services mainly medical practitioners and non-residential AOD services for methadone maintenance treatment (MMT), and a number of participants were already receiving MMT. One fifth of the participants were not referred to any external services.

**Table 3.11 Other AOD services<sup>\*</sup> used by LMPP participants accepted onto the program 1<sup>st</sup> July 2000 to 30<sup>th</sup> June 2002**

	Number	Percent
Residential detoxification	72	22.1
Residential rehabilitation	57	17.5
Non-residential AOD services	38	11.7
Medical practitioner	48	14.7
Other	43	13.2
No referral	68	20.9

\* Missing data: Other AOD services referred to – no data for 45 participants

It was originally envisaged that participants would complete the program in approximately 3 months. This however proved too short a time for many of the participants. For all participants, the mean time on the program was 86.5 days, (median 91), measured from the day of referral. However, the duration on the program was longer for those who completed than for those who did not, as shown in Table 3.12.

**Table 3.12 Time on the program, for LMPP participants<sup>\*</sup> accepted 1<sup>st</sup> July 2000 to 30<sup>th</sup> June 2002**

Duration (days)	Completers n=134	Non-completers N=128
Mean	116.3	55.3
Median	103.5	42
Maximum	245	207
Minimum	70	1

\* does not include the 4 people still on the program on 1<sup>st</sup> October 2002

### ***Exit from the Program***

Participants may exit the program in a variety of ways:

- Complete the program
- Be breached by the LMPP<sup>6</sup>
- Be removed by the Court
- Voluntarily withdraw
- Other – eg those found to be not eligible after more detailed assessment

The exit status of the 266 participants accepted between 1<sup>st</sup> July 2000 and 30<sup>th</sup> June 2002 is shown in Table 3.13. As can be seen, half the participants entering the program completed it. Characteristics associated with completion are discussed in the next section.

<sup>6</sup> Refers to a breach of program conditions, not a breach of bail. Only the Magistrate determines a breach of bail.

**Table 3.13 Exit status for LMPP participants accepted 1<sup>st</sup> July 2000 to 30<sup>th</sup> June 2002**

	Number	Percent
Completed	134	50.4
Breached by the LMPP <sup>b</sup>	69	25.9
Removed by the Court	30	11.3
Withdrew voluntarily	22	8.3
Other	7	2.6
Current on program <sup>*</sup>	4	1.5
Total	266	100.0

<sup>\*</sup> 4 participants were still on the program on 1<sup>st</sup> October 2002.

Some of the participants were continued in treatment when they exited the program, but data is not available to present. Some were also referred to new services for further treatment when they exited the program. These are shown in Table 3.14. In these data, residential detoxification and residential rehabilitation are combined into one category. There is only one type of service recorded for each participant.

**Table 3.14 Other AOD services <sup>\*</sup> participants were referred to on exiting the LMPP, for all participants accepted 1<sup>st</sup> July 2000 to 30<sup>th</sup> June 2002**

	Number	Percent
Residential AOD services (rehabilitation)	61	23.8
Non-residential AOD services	28	10.9
Medical practitioner	30	11.7
Other	19	7.4
No referral	118	46.1
Total	256	100.0

<sup>\*</sup> Missing data: Other AOD services referred to on exit – no data for 10 participants

### ***Characteristics Associated with Completion of the Program***

It was considered important to look at characteristics associated with completion of the program for two main reasons. Firstly, concerns regarding effectiveness, and efficiency of resource allocation, mean that it is important to understand which participants or potential participants are most likely to complete the program. In this case, identification of characteristics of participants who do well in the program may help with future targeting and refinement of the assessment of potential cases. Secondly, concerns regarding equity and quality make it imperative that when resources are scarce they are allocated in an equitable manner, so that as many as possible of those in need benefit from the resources available. Thus, identification of those who do well, or do poorly, may help identify areas where the program could be improved to better meet the needs of these subgroups.

### ***Methodological Approach***

Data from the MIMS database was used. Participants on the program were classified as completers or non-completers. Non-completers included all those with exit status classified as breached, removed, withdrawn or other. The four people still on the program were not included in this analysis. Initial analysis involved cross-tabulations, using Chi-square tests to assess differences in proportions of completers, for a range of variables. After review of the preliminary results, some categories were collapsed due to small numbers, and to reduce the overall numbers of categories for each variable. All variables where the Chi-square test gave a p-value  $\leq 0.1$  in the univariate analyses were then entered into a multivariate logistic regression model. Two different approaches to model building were taken: backwards elimination, and stepwise selection. Both approaches yielded the same final model. Because of *a priori* concerns that Aboriginals and female participants may do less well in the program

(see chapter on Stakeholder Perspectives), these two variables were forced to stay in the model.

### Results - Characteristics Associated with Program Completion

Results of the univariate analysis for all variables where the Chi-square test gave a p-value of  $\leq 0.1$  are presented in Table 3.15. Other variables tested but found to be not significant at this level were: age at entry; marital status; source of income; education; chronic physical disease; mental health problem; previous attempted suicide; previous overdose; and prior imprisonment. The results for gender are also included in Table 3.15, although they do not meet the significance criteria.

**Table 3.15 Univariate analysis of characteristics associated with program completion, for 262 participants accepted onto the LMPP 1<sup>st</sup> July 2000 to 30<sup>th</sup> June 2002, and exited by 30<sup>th</sup> September 2002**

	Completers n=134		Non-completers n=128		Chi-square test p
	No.	%	No.	%	
<b>Gender</b>					
Male	105	78.4	95	74.2	0.431
Female	29	21.6	33	25.8	
<b>Aboriginality *</b>					
Aboriginal	15	11.4	27	21.3	0.031
Not Aboriginal	117	88.6	100	78.7	
<b>Accommodation *</b>					
Rented house/flat	64	48.1	78	60.9	0.015
Privately owned house/flat	38	28.6	18	14.1	
Other	31	23.3	32	25.0	
<b>Principal Drug of Concern</b>					
Heroin	69	51.5	71	55.5	0.023
Amphetamines	18	13.4	31	24.2	
Cannabis	38	28.4	22	17.2	
Other	9	6.7	4	3.1	

\* Missing data: Aboriginality – 3 missing; Accommodation – 1 missing

From Table 3.15 it can be seen that Aboriginals were less likely to complete the program. Those living in privately owned accommodation were also more likely to complete than those living in either rented house/flat or other situations. The privately owned accommodation was not necessarily owned by the participant, but may belong to parents, other relatives or friends. For the multivariate analysis, this variable was further collapsed to privately owned versus all others. Principal drug of concern was highly significant as a predictor of completion, with users of heroin and amphetamines less likely to complete than users of cannabis or other drugs. This variable was also further collapsed for the multivariate analysis into heroin/amphetamines versus cannabis/others. This was considered appropriate as, during the heroin drought many local heroin users substituted amphetamines for heroin, and if they presented to the LMPP during this period, may have identified amphetamines as their principal drug of concern.

Results of the multivariate logistic regression are shown in Table 3.16. The likelihood ratio for the overall model had a p-value of 0.0003. Addition of other variables did not improve the model. It can be seen that all the variables found to be significant in the univariate analysis, are significant in the multivariate model.

**Table 3.16 Results of multivariate logistic regression of characteristics associated with program completion, for 262 participants accepted onto the LMPP 1<sup>st</sup> July 2000 to 30<sup>th</sup> June 2002, and exited by 30<sup>th</sup> September 2002**

	Odds Ratio	95% Confidence Intervals		p
		lower	upper	
Gender (male vs female)	1.121	0.615	2.044	0.7098
Aboriginality (Aboriginal vs not)	0.449	0.220	0.917	0.0280
Accommodation (privately owned vs other)	2.452	1.288	4.667	0.0063
Principal drug (heroin/amphetamines vs other)	0.415	0.230	0.746	0.0033

## Discussion

### Participant Profiles

The profiles of the participants presented in this chapter indicate that, as with other drug diversion programs, the majority of participants are male, unemployed, have low levels of education and are single. There was a considerable spread of ages, with the group as a whole, slightly older than those involved in the Parramatta Drug Court (Briscoe *et al*, 2000).

Although over half reported having children, only one quarter had dependents, and the majority (58%) were single. However, the high proportion of participants with children does raise the issue of the implications of parental drug use on children, and the need for parenting skills to be addressed within the program, or by referral.

Aboriginals made up 16% of the participants. Given that the 2001 census found that Aboriginals made up 3.1% of the NRAHS population, they are clearly over-represented in the LMPP group<sup>7</sup>. This is not surprising however, as Aboriginals are over-represented in the criminal justice system. Additionally, there is emerging evidence that illicit drug use is a significant problem among Aboriginal peoples, particularly in NSW. In a national study of injecting drug users, 13% of the NSW sample were Aboriginal or Torres Strait Islander, compared to 5% of the national sample (Rutler *et al*, 2001).

The majority of participants lived in rental accommodation, although there were a few living in privately owned accommodation. Nearly one quarter of the participants were living in caravan parks or hostels, or were homeless, suggesting a fairly mobile population.

Heroin was the most common principal drug of concern reported, with amphetamines and cannabis also common. There was considerable poly-drug use among participants, and nearly three quarters of participants had injected drugs within the last 3 months. Only 14% had never injected drugs. The majority (80%) had also had at least one episode of treatment for their drug problem in the past, with counselling, detoxification, rehabilitation and methadone the most common treatments. Although there were no data available on duration of illicit drug use, these data combined with the high levels of infection with Hepatitis B and Hepatitis C viruses, suggest that the majority of the participants had long-term and severe drug problems.

The data on chronic physical disease, and mental health problems also indicate a considerable burden of disease. Many of the problems identified by participants were a result of drug use (e.g. hepatitis infections), and the dual diagnosis of drug dependence and mental health problems create an additional challenge for treatment.

The data on prior imprisonment and prior convictions indicate that the majority of the participants had a long history of criminal behaviour. In other words, the program is *not* capturing drug offenders *early* in their involvement with the criminal justice system.

<sup>7</sup> Source: Australian Bureau of Statistics 2001 Census, Usual Residents Profile – Cdata2001

Interestingly, charges for drug offences were more common than in the Parramatta Drug Court (46% of LMPP participants compared with 24% of Parramatta Drug Court participants), but charges for theft (55% of LMPP, 94% of Parramatta), driving offences (22% vs 32%) and offences against good order (16% vs 30%) were all less common (Briscoe *et al*, 2000).

The overall picture of the LMPP participants is one of a group of people with complex social and health problems, some of which derive from their drug dependence, and with substantial prior criminal histories. This picture is consistent with the picture emerging from other drug courts both in Australia (Briscoe *et al*, 2000; Freeman 2002; Heale *et al*, 2001) and in the United States (Belenko 1998; Belenko 2001; Turner *et al*, 2002). Providing suitable drug treatment, and referral to other services to meet these needs is challenging, and requires access to a range of other AOD, health and social services.

## ***Operational Processes***

The majority of referrals to the program were from the Magistrate on the day of their initial court appearance. As there can be a delay of up to four weeks between a person being charged, and their first court appearance, this implies that there are also delays in the potential client being referred for assessment and treatment. Other factors may also influence the police referral rates including the uptake of police referrals, given the difficult dynamics of the arrest process. Although the LMPP has established a close working relationship with the local police service, these data suggest that more work needs to be done to encourage referrals by police officers at the time of arrest.

The majority of people (72.3%) who were referred were accepted onto the program. The low numbers of those considered eligible who then declined the program, combined with a small but significant number of self-referrals suggests that the program is perceived as acceptable to participants.

The LMPP is unusual in that the caseworkers not only develop case management plans and refer participants to other services, but they also act as the primary treatment provider, giving counselling (often on a daily basis in the early stages of the program), and running group sessions. Additionally the caseworkers have to report to the court on participant progress. Thus, caseworkers must be highly skilled clinicians, as well as have considerable expertise in reporting to the court. This is a demanding role, requiring diverse skills. It is therefore crucial that there are adequate external AOD services to refer the participants to, and that the caseworkers are themselves well supported. External AOD services frequently used by the current program were detoxification and rehabilitation services and methadone maintenance treatment.

The LMPP has achieved a reasonable rate of completion with half of the participants who started the program completing it. This is similar to the 55% retention on the Parramatta Drug Court at four months (Freeman 2002), and the 52% retention in the CREDIT program (Heale *et al*, 2001). It is also apparent that although some participants are able to complete the program within the three months initially planned, some participants need considerably longer. Thus it is important that there is flexibility in the time allowed for completion, at the discretion of the Magistrate. When compared with other programs, three months is quite a brief intervention time, for example, the drug treatment component of the Parramatta Drug Court runs for a minimum of 12 months, and is not even initiated until the participant has undergone detoxification (Briscoe *et al*, 2000).

## ***Characteristics Associated with Successful Completion***

Although there is a high rate of completion of the program for non-Aboriginal participants, the rate for Aboriginal participants is relatively low. This may be due to a range of factors, and requires further investigation. The high rate of acceptance of Aboriginal participants suggests that the referral and assessment process is reasonable. It is particularly important that the needs of this group are met, as they are over-represented among participants, relative to the general population, and they are generally disadvantaged.

The higher completion rate for people living in privately owned accommodation may reflect greater stability in the lives of these participants, particularly compared to those living in hostels, caravan parks or those who are homeless. The higher completion rate may also reflect exposure to parental supervision among this group. These factors may make it easier for them to comply with the program requirements. LMPP staff identified housing problems as one of the key challenges in their work, particularly finding crisis accommodation for those living in inappropriate situations (see Chapter 7 – Stakeholder Views of the LMPP, in this report).

The lower completion rate among those using heroin or amphetamines, compared to those with other drugs as their principal drug of concern, may reflect a more serious drug problem in this group. Heroin and amphetamine users may have greater drug dependency, and more severe social and health consequences of their drug use. However, as 46% of those whose principal drug of concern was heroin or amphetamines, did successfully complete the program, it appears that the program is still reasonably effective with this group.





## Chapter 4 – Court Outcomes and Recidivism

Megan Passey \* and John Vail ‡

\* Northern Rivers University Department of Rural Health & Northern Rivers Area Health Service

‡ John Vail Consulting

### Introduction

This chapter will look at both the court outcomes for the charges current when the participants entered the Lismore MERIT Pilot Program (LMPP), and at recidivism among the participants from the date of referral. Drug diversion programs aim to reduce recidivism by addressing an important risk factor for offending, namely drug abuse and dependence (Sinha *et al*, 1999). For the LMPP, the intended outcomes included:

- Decreased drug-related crime by participants, during the program and following completion
- Reduced sentences due to better rehabilitation prospects.

One of the objectives of the evaluation was to determine the criminal justice system impacts of the early court intervention approach, particularly on the level of reoffending amongst the project participants.

### *Drug Diversion Programs and Recidivism*

There is good reason to expect that a program such as the LMPP would reduce recidivism among participants, at least while on the program. In reviewing the role of legal coercion in the treatment of offenders, Hall concluded that there was reasonable evidence that community-based treatment for heroin dependence was effective in reducing heroin use and crime, regardless of whether it is legally coerced or not (Hall 1997). It is recognised that coercion into treatment is associated with increased entry into treatment (Hser *et al*, 1998) and retention in treatment, relative to voluntary treatment (Loneck *et al*, 1996; Young *et al*, 2002).

The majority of evidence relating to recidivism and drug diversion programs comes from the United States. In a review of American drug courts, Belenko concluded that drug use and criminal behaviour are substantially reduced while offenders are participating in drug courts (Belenko 1998; Belenko 2001), but that the post-program impact on recidivism was less clear (Belenko 2001).

The evaluation of the CREDIT program in Victoria, was less conclusive about the impact on recidivism. In evaluating this program, Heale and Lang (2001) used police arrest data to assess recidivism. They found that there was little difference in reoffending between CREDIT clients and those who were referred to CREDIT but whom, for whatever reason, did not participate in the CREDIT program. They assessed both recidivism during the full follow-up period and recidivism during a proxy bail period of 12 weeks, and found no significant difference in either, although the participants did reoffend slightly less frequently. They also noted that 30% of reoffending for each group occurred within 7 days of bail being set. It is worth noting that they did not consider the non-participants to be an ideal comparison group as most of these had been assessed by the CREDIT clinicians and had either elected not to go on the program or were considered unsuitable. The evaluators recognised that the two groups may differ in terms of their motivation to address both their drug use and their legal issues.

The evaluation of the NSW Drug Court demonstrated a reduction in recidivism among participants as measured by 'free time' to first offence (Lind *et al*, 2002). This study involved random assignment of potential participants to the intervention or a control group. The investigators measured time to first drug-related offence dealt with in court, assessing both 'elapsed time' and 'free time'. In the 'free time' analysis, drug court participants were found to take significantly longer than the control subjects to commit their first shop stealing or their first drug offence. In the 'elapsed time' analysis, there were no significant differences in the time to first offence, although the participants had longer 'elapsed time' to their first drug offence.

A comparison of those who were not terminated from the program with participants who were terminated and with the control group was also undertaken, controlling for various other factors considered likely to have an impact on recidivism. In this analysis, the non-terminated participants performed better than the other two groups in terms of 'free time' to first offence and offending frequency for shop stealing, other larceny and unlawful possession. They also performed better than terminated participants in terms of 'free time' to first break, enter and steal offence, and in terms of 'elapsed time' to first theft or drug offence.

The evidence to date suggests that drug diversion programs may have a moderate impact on re-offending. They may be a means to encourage people into treatment, and for those who remain in treatment there may be reductions in recidivism. It is clear however, that expectations should be realistic.

## **Methods**

### ***Court Outcomes***

#### ***Subjects Included***

All participants who entered the LMPP in the first 18 months of operation (referred between 1<sup>st</sup> July 2000 and 31<sup>st</sup> December 2001) were included. During this period 13 people were accepted onto the program more than once. Data on all episodes are included.

#### ***Data Sources***

Data on participants was obtained from the MERIT Information Management System (MIMS) database maintained by the LMPP. For each episode, data was extracted on name, date of birth, sex, Aboriginality, police identifier (CNI), date of alleged offence, date charged, date of referral to the LMPP, and date of finalisation of the matter in court. These data were provided to the NSW Bureau of Crime Statistics and Research (BOCSAR), which maintains databases on court proceedings and police arrests.

The BOCSAR<sup>8</sup> identified those participants who had at least one record on their database of matters dealt with by the NSW Local Court. For these participants, they extracted data on all matters finalised in Local Courts between 1<sup>st</sup> January 2000 and 30<sup>th</sup> September 2002. We used these data to identify convictions and sentencing outcomes.

Not all participants had a record on the BOCSAR Local Court database. For these participants, as well as any for whom the relevant record was missing, convictions and sentencing outcomes were sought in the MIMS database.

#### ***Data Processing***

The MIMS database records only one offence date for each participant. However, many participants had more than one charge, and these may have allegedly been committed on different dates.

---

<sup>8</sup> The NSW Bureau of Crime Statistics and Research kindly provided the evaluation team with data on both court outcomes and recidivism. We are grateful to all those involved, and particularly Dr Bronwyn Lind, for the considerable effort they made in attempting to meet all our requests.

The date of the alleged offence and the date the matter was finalised in court, recorded on the MIMS database, were matched to the corresponding data on the BOCSAR Local Court database in order to identify the relevant 'index' charges recorded on the BOCSAR Local Court database. Where dates on either database were missing, other information was used to attempt to identify the 'index' charges. This included data on types of alleged offences, date charged, dates of other court appearances, and any relevant information recorded in the "remarks" field of the MIMS database. Once the 'index' charges were identified, data on all other charges for offences allegedly committed before the date of referral to the LMPP, and finalised in court on the same day as the 'index' charges, were identified. For each participant, these charges were considered to be the 'bundle' of charges outstanding at the time of referral. The court outcomes for these charges (findings and sentences) were extracted.

For those participants for whom no 'index' offence could be found in the BOCSAR Local Court database, data on the court outcomes was taken from the MIMS database if recorded.

Data on program exit status (completers versus non-completers of the program) was taken from the MIMS database. Results are presented for the two groups separately.

### ***Indicative Sentences***

In order to assess the impact of the program on court outcomes, the Magistrate presiding at the Lismore Local Court during this period was asked to indicate the sentence he would probably have given the program completers, had there been no LMPP available to refer them to. For this process, 50 completers were randomly selected from all 93 completers referred in the first 18 months of the program. The Magistrate was provided with information on the current charges, prior criminal history, the sentence given, and other information contained in the court records and was asked to objectively assess them. Using this information, he provided 'indicative' sentences for 39 of the 50 completers. Of the remaining 11, four were finalised in the District Court or other jurisdictions, one had not yet been finalised, and the remaining six were not able to be completed in the time available. Unfortunately he was relocated to another area during this process and was unable to complete the review of papers for the final six.

These data were used to compare the actual sentences with the 'indicative' sentences, to give an indication of the impact of the LMPP on court outcomes. These data are also used in the cost-benefit analysis described later in this report.

### ***Recidivism***

#### ***Attempt to Build a Comparison Group***

An attempt was made to build a suitable comparison group for the assessment of the impact of the program on recidivism. Although this process was eventually abandoned, it is described briefly here as it involved considerable effort by the evaluation team, staff at the BOCSAR, and the steering committee. The reasons for abandoning the process may be relevant to other drug court evaluations.

Data were obtained from the BOCSAR on all offences finalised in Grafton, Coffs Harbour and Tweed Heads Local Courts during the period 1<sup>st</sup> January 2000 to 30<sup>th</sup> June 2002. These data contained fields for the BOCSAR identifier (mspd), police identifier (CNI), date of birth, sex, Aboriginality, type of charge, date of offence, date of final court hearing, court finding and sentence.

From these data, four comparison subjects were selected for each LMPP participant. As the selection required data on the LMPP participants from the Local Courts database, only those for whom the finalised offence had been found in the BOCSAR Local Court data could be used. Matching criteria used were sex, nature of the current most serious charge, 5-year age-group, Aboriginality and date of alleged offence (by three month groups). The majority of comparison subjects selected were matched on at least the first four of these criteria.

The identified LMPP participants and their matched comparison subjects were provided to the BOCSAR, who extracted data on charges for both groups from their Police database. For the LMPP participants, charges for offences allegedly committed between the date of referral to the program and the 31<sup>st</sup> December 2002 were identified. For the comparison group, charges for alleged offences between the referral date for the matched LMPP participant, and the 31<sup>st</sup> December 2002 were identified.

At this point, it was recognised that the comparison group was unacceptably flawed. From the outset, it had been realised that we would be unable to determine whether or not the comparison subjects had a drug problem, or if so, the severity of drug dependence. However, the importance of the subjects criminal history had not previously been recognised. The majority of LMPP participants have substantial criminal histories (see the chapter on Program and Participant Profiles in this report), and as prior convictions and prior imprisonment are both likely to be risk factors for recidivism, this became a major concern for the evaluation. When the indicative sentences provided by the Magistrate for the LMPP graduates were compared to the sentences given to their selected comparison subjects, it became clear that the comparison group was inappropriate and the process was abandoned.

Thus, only recidivism among LMPP participants, comparing completers with non-completers is assessed. The methods used for this are described below.

### ***Subjects Included***

Participants entering the LMPP in the first 18 months of operation (referred between 1<sup>st</sup> July 2000 and 31<sup>st</sup> December 2001) were included. During this period 13 people were accepted onto the program more than once. For the analysis of recidivism, data on only the first episode on the program is included.

### ***Data Sources***

Data on charges for the LMPP participants were provided by the BOCSAR from their Police database. All charges for offences allegedly committed between the date of referral to the program and the 31<sup>st</sup> December 2002 were identified. Police charges were used rather than finalised offences, because court processes can sometimes be protracted, and data recording, cleaning and processing require additional time. Thus data on offences committed may sometimes not be available for a year or more. For our purposes, it was decided that an acceptable proxy for offences committed was a Police charge for an offence. It is also recognised that only detected offences are measured in this way.

### ***Data Processing***

As non-completers were more likely to receive custodial sentences than completers, and as time spent in prison reduced the opportunity for reoffending, we measured recidivism in terms of both 'elapsed time' and 'free time'. Using the LMPP referral date, the finalisation date and sentencing outcome for the offences current on entry into the LMPP, these times were calculated:

- *Elapsed time* – time from date of referral to the date of first offence, or censored at the end of the follow-up period (31<sup>st</sup> December 2002)
- *Free time* – time from date of referral to the date of first offence, subtracting time spent in custody between these dates and censoring at the end of the follow-up period. In calculating 'free time' it was assumed that sentences were served in full, and commenced on the date of sentencing. Those for whom no court outcome data were available on the Local Courts database were excluded from 'free time' analyses

Two different types of charges were assessed:

- *Any offence* – all charges for alleged offences recorded on the Police database, excluding offences against justice procedures
- *Drug, theft and robbery offences* – charges for any alleged drug, theft or robbery offences recorded

For each offence category we calculated the proportion reoffending within 3 months and within 12 months of the date of referral (elapsed time), comparing those who completed the program with those who did not.

We also looked at the time to first offence for each offence category and each type of time calculation, comparing completers to non-completers. For these analyses we used survival analysis, a statistical technique that measures time to an event. Survival analysis allows for different follow-up periods, and for censoring of cases where follow-up ceases before a failure is recorded i.e. ceasing follow-up when a person has not (yet) reoffended.

We used Cox Proportional Hazards models to allow incorporation of other variables which may affect recidivism. The variables used in the models included those traditionally considered likely to affect recidivism and those associated with retention in the program (see chapter on Program and Participant Profiles earlier in this report).

- Completion (coded as 1 for those who completed the program, and 0 for all others who started the program but did not complete)
- Gender (males coded as 1 and females as 2)
- Age (in years, using age at time of referral to the program, as a continuous variable)
- Prior Imprisonment (coded as 1 if previously imprisoned, 0 if not)
- Drug of concern (coded as 1 if principal drug of concern was reported as heroin or amphetamines, and 2 for all other drugs)
- Aboriginality (coded as 1 if person identified as being Aboriginal and/or Torres Strait Islander, and 0 for all others)
- Accommodation type (coded as 1 for those living in privately owned accommodation, and 2 for all others)

Finally, we plotted the Kaplan-Meier survival functions for completers and non-completers.

## **Findings**

### ***Description of the Sample***

There were 178 people accepted to the program a total of 193 times between the start of the program (1<sup>st</sup> July 2000) and the 31<sup>st</sup> December 2001. Of these people, 12 commenced the program twice, one person 4 times, and the remaining 165, only once. Table 4.1 shows the characteristics of the group included in this analysis. The mean age of the 193 participants was 29.9 years. Over half the participants (100/193) completed the program. This group is similar on all characteristics to the larger group of 266 participants entering the program in the first two full years of operation, and described in more detail in Chapter 3 of this report.

**Table 4.1 Demographic characteristics of 193 participants accepted onto the LMPP, 1<sup>st</sup> July 2000 to 31<sup>st</sup> December 2001**

	Number	Percent
<b>Gender</b>		
Male	147	76
Female	46	24
<b>Aboriginality *</b>		
Aboriginal	28	15
Not Aboriginal	164	85
<b>Accommodation</b>		
Rented house/flat	108	56
Privately owned house/flat	41	21
Other	44	23
<b>Principal drug of concern</b>		
Heroin/Amphetamines	144	75
Cannabis	44	23
Other	5	3
<b>Prior imprisonment *</b>		
Yes	107	58
No	78	42
<b>Exit Status</b>		
Completed	100	52
Breached	48	25
Removed	27	14
Withdrew	17	9
Other	1	<1

\* Missing data: Aboriginality – 1 missing; Prior imprisonment – 8 missing

## ***Court Outcomes***

Data on court outcomes for the index offences were available from the Local Court database for 157 of the 193 program episodes. Additional data contained in the MIMS database were available for a further 25 participants, giving a total of 182 with some data available. There were no data available on the court outcomes of the remaining 11.

The Magistrates' finding in relation to the charges was available for all of these 182 participants. All of the completers with data available (94 of 94) were found guilty on at least one charge. All but one of the non-completers was found guilty (87 of 88) on at least one charge. The one person found 'not guilty' had withdrawn from the program.

The most severe sentence given to each participant is shown in Table 4.2. The sentences are presented separately for program completers, those who were breached or removed, and those who withdrew or whose exit status was "Other". Data on sentences was missing for 7 of the completers, 19 of those breached or removed, and 4 of those whose exit status was "Withdrew" or "Other".

**Table 4.2 Sentences of participants accepted onto the LMPP 1<sup>st</sup> July 2000 to 31<sup>st</sup> December 2001**

	Completers		Breached/Removed		Withdrew/Other	
	No.	%	No.	%	No.	%
Imprisonment	1	1	21	38	-	
Suspended sentence	31	33	9	16	4	29
Community service order	5	5	2	4	1	7
Bond with supervision	15	16	6	11	2	14
Bond without supervision	13	14	3	5	1	7
Bond without conviction	9	10	-		-	
Fine	6	6	12	21	4	29
Licence disqualification	-		1	2	-	
Nominal sentence	3	3	-		1	7
No conviction recorded	6	6	1	2	-	
No action taken	3	3	-		-	
Migration order	1	1	1	2	-	
Not guilty	-		-		1	7
Total	93	98	56	101	14	100

Note: Missing data: completers – 7 missing; breached/removed – 19 missing; withdrew/other – 4 missing  
 \* Percentage totals may not equal 100 due to rounding error

As can be seen, the completers generally received less severe sentences than the non-completers, with only one (1%) of the completers being sentenced to gaol, compared with 38% for the non-completers. Six of the completers had no conviction recorded, compared to only one of those who were breached or removed.

### ***Indicative Sentences***

The indicative sentences provided by the Magistrate together with the actual sentences received are shown in **Appendix C** for each of the selected completers. Where a person was found guilty of more than one charge, or was given more than one penalty for a particular offence, the most severe penalty was selected. Only the most severe sentence actually received, and the most severe indicative sentence is shown.

It is clear that successful participation in the Program had an enormous impact on the sentencing outcomes, as the sentences actually given to these program completers were lighter than the ones they would probably have received in the absence of the program. The severity of the indicative sentences is reflective of the prior criminal history of these people. The more lenient actual sentences reflect the more positive outlook given their response to treatment and their rehabilitation prospects.

### ***Recidivism***

For the analysis of recidivism we used data for 175 acceptances to the program during the first 18 months of operation. Although there were 193 acceptances, some were accepted more than once; for these people only the first episode was included, leaving 178. Additionally, three people had no record at all on the Local Courts database and were excluded from the analysis. A total of 175 were included, of whom 91 completed and 84 did not.

### ***Proportion reoffending***

Using data for charges for alleged offences recorded on the Police database, we looked at the proportion of completers and of non-completers allegedly reoffending in the first 3 months, and the first 12 months from the date of referral to the LMPP. Three months was chosen to reflect the time participants were on the program, as this was the intended program duration. We were also interested in reduction in recidivism following the program, and as all participants were followed-up for at least 12 months, this time period was selected. These analyses used 'elapsed time'. Offences against justice procedures were excluded. The data are presented in

two categories – any offences; and drug, theft and robbery offences. The results are shown in Table 4.3.

**Table 4.3 Numbers of LMPP participants charged with new offences with the alleged offence date within 3 months and 12 months of referral, for those accepted between 1<sup>st</sup> July 2000 and 31<sup>st</sup> December 2001**

	Completers (n=91)		Non-completers (n=84)		RR	p-value
	No.	%	No.	%		
<b>Any offence</b>						
3 months	23	25	42	50	0.51	<0.001
12 months	48	53	58	69	0.76	0.027
<b>Drug, theft and robbery offences</b>						
3 months	15	16	25	30	0.55	0.037
12 months	28	31	45	54	0.57	0.002

\* The relative risk of reoffending within the specified period, for completers versus non-completers, with the p-value for the Chi-square test for differences in proportions.

As can be seen, the non-completers were more likely to have reoffended in each period than the completers. The difference in proportion reoffending within each period was tested using the Chi-square test. This was found to be significant for both any offence and for drug, theft and robbery offences, for both time periods. The relative risk of completers being charged with another drug, theft or robbery offence was just over half for both the 3 month and the 12 month period, compared to non-completers. For any offence, the relative risk of completers reoffending was 0.5 within 3 months, and 0.76 within 12 months, compared to non-completers. These data suggest there is a greater impact on drug, theft and robbery offences than other types of offences, as would be expected for a drug diversion program.

### **Time to first offence**

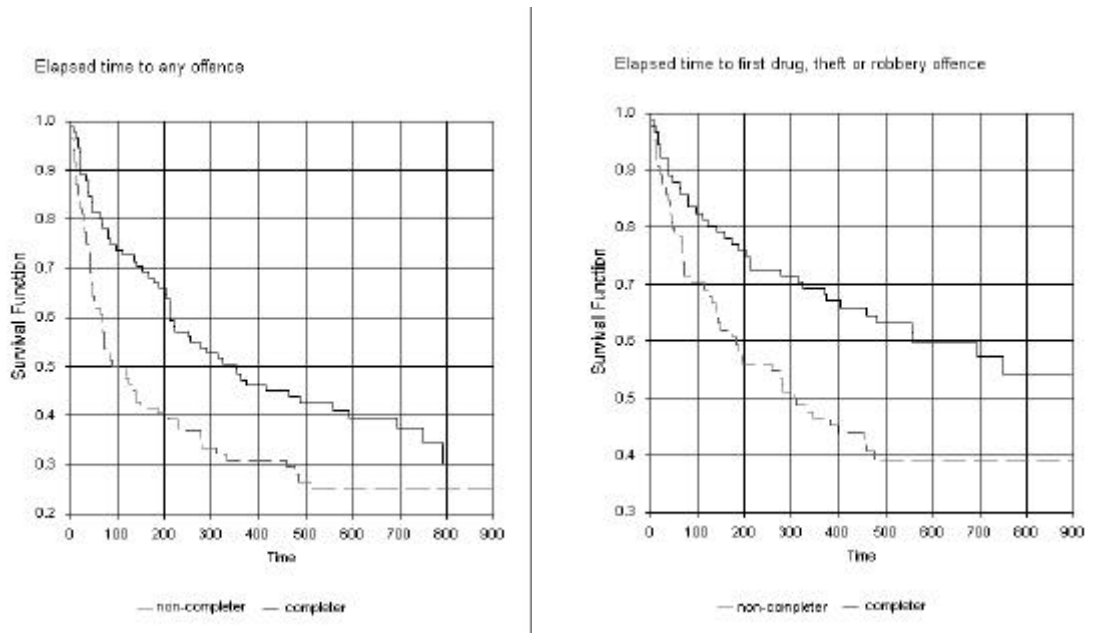
The time to first offence was calculated using both 'elapsed time' and 'free time', for both offence categories. Follow-up for the study ceased on 31<sup>st</sup> December 2002. Duration of follow-up for an individual varied, depending on whether or not a person reoffended, with follow-up ceasing on the date of the alleged offence. The average duration of follow-up (using 'elapsed time') for completers and non-completers was:

	<i>Follow-up for any offence</i>	<i>Follow-up for drug, theft or robbery offence</i>
Completers:	375 days	462 days
Non-completers:	247 days	330 days

The Kaplan-Meier survival functions are plots showing time to first offence. In the current study, they show the proportion 'surviving' ie not reoffending at any point in time. Thus, at the beginning of the follow-up period, 100% of people have not offended. As time passes, and some people commit further offences, the curve drops. The Kaplan-Meier survival functions for 'elapsed time' to first offence are shown below. Figure 4.1 shows the 'elapsed time' to first offence of any kind (excluding offences against justice procedures) on the left, and 'elapsed time' to the first drug, theft or robbery offence on the right.



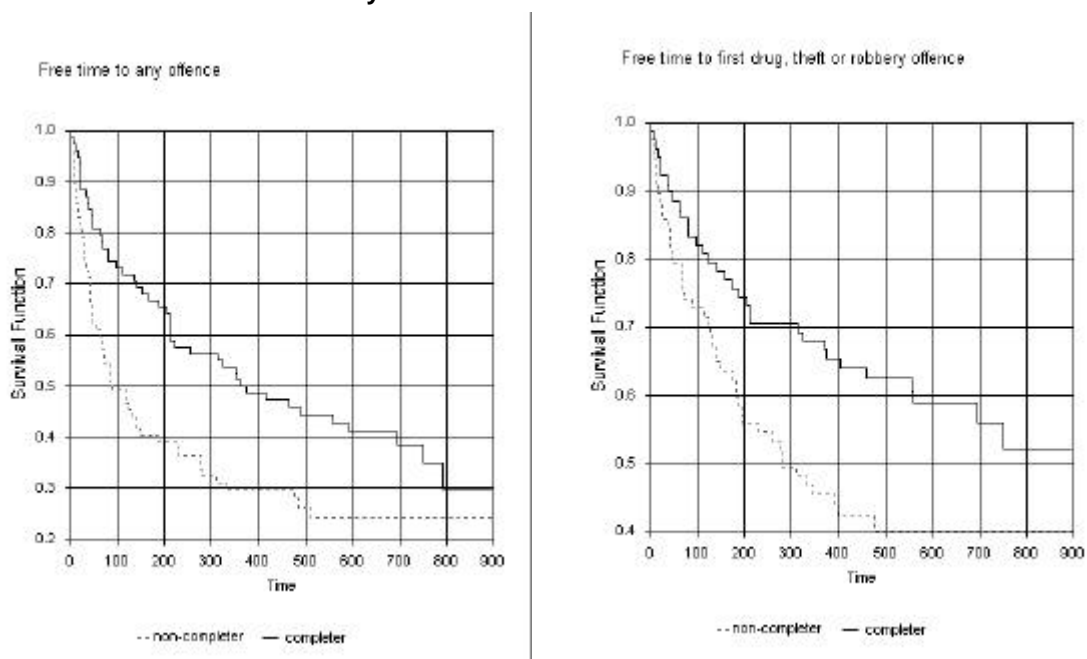
**Figure 4.1** Survival function of 'elapsed time' to first offence of any kind (left) and to first drug, theft or robbery offence (right) for LMPP participants accepted between 1<sup>st</sup> July 2000 and 31<sup>st</sup> December 2001



It is clear from these graphs that fewer Program completers reoffended and they were slower to reoffend than non-completers. At 100 days of 'elapsed time', approximately 73% of program completers had not reoffended, compared with just over 50% of non-completers.

The Kaplan-Meier survival function for 'free time' to first offence of any kind (excluding those against justice procedures) is shown on the left in Figure 4.2, and the 'free time' to the first drug, theft or robbery offence on the right. As for the 'elapsed time' to first offence graphs, these graphs both indicate that more non-completers reoffended and they were quicker to reoffend than completers.

**Figure 4.2** Survival function of 'free time' to first offence of any kind (left), and to first drug, theft or robbery offence (right) for LMPP participants accepted between 1<sup>st</sup> July 2000 and 31<sup>st</sup> December 2001



We used survival analysis to test whether these differences in time to first offence were statistically significant. In order to allow for the possible impact of other factors on reoffending, we fitted Cox Proportional Hazards models incorporating completion, gender, age, prior imprisonment, drug of concern, Aboriginality and type of accommodation.

Data on prior imprisonment was missing for eight participants, and consequently only 167 of the 175 participants were able to be included in the analyses involving 'elapsed time'. For analyses involving 'free time' only those where the relevant record was found on the Local Court database were included, as data from this database was needed to calculate 'free time'. Thus only 151 of the 175 participants are included in the 'free time' analyses.

For both 'elapsed time' and 'free time', and for both offence categories (any offence and drug, theft and robbery offences), the only variable which was significant was program completion. Completing the program was highly significant for all models. Adding other variables to these models did not result in any improvement in the models, as measured by reductions in the deviance. The detailed models are presented in **Appendix D**.

For both the 'elapsed time' and the 'free time' models, the program completers are just over half as likely to reoffend at any point in time as the non-completers. Conversely, the non-completers are approximately twice as likely to commit further offences as program completers. This applies to both 'any offence' and to 'drug, theft and robbery' offences. This is consistent with the earlier analysis of proportion reoffending within three or 12 months, except that the difference between the offence categories is not apparent.

## Discussion

In this study we have attempted to assess the impact of the LMPP on the criminal justice system, in terms of both court outcomes for the offences current on program entry and in terms of recidivism following referral to the program. In undertaking this study we have faced a number of methodological challenges, and the limitations of the study must be borne in mind when interpreting the results.

The study design led to some difficulties in developing a suitable comparison group for the assessment of the program's impact on recidivism. As the evaluation was not designed as a randomised-controlled trial, we attempted to build a *post-hoc* comparison group. Unfortunately we were unable to build an acceptable comparison group in this manner. Evaluations of drug-diversion programs have rarely had the luxury of a randomised control group. In reviews of methodological challenges facing drug court evaluations, both Belenko (2002) and Mahoney *et al* (1998), cited difficulty identifying appropriate comparison groups as one of the main problems. The evaluation of the CREDIT program in Victoria also encountered difficulties in developing a suitable comparison group (Heale *et al*, 2001).

We have undertaken comparisons between program completers and those who did not complete the program. This may have introduced some bias into the results, as program completers may be people who would have done relatively well regardless of the program. However, we have attempted to control for this by including a number of other factors in multivariate models testing for differences in recidivism between completers and non-completers. Factors included were those traditionally associated with recidivism and those found to be associated with program completion (see chapter on Program and Participant Profiles). Once these factors were controlled for, program completion remained a significant factor for both 'free time' and 'elapsed time' to first offence. Additionally, it must be recognised that many of those who completed the program had a long history of criminal activity, and it is therefore unlikely that they would have spontaneously changed without the program.

In the absence of a control group, another option may have been to use individual's prior criminal history as a baseline for comparison. Unfortunately, sufficiently detailed information on prior convictions was not available. We consider that our approach is an acceptable one for assessing the impact of the program on recidivism.

Another limitation of this study was that the measure of reoffending used was Police charges for alleged offences. Although ideally we would have measured actual re-offending, this was not possible. One possibility would have been to rely on self-report of offences. However, the validity of such an approach is also limited, as participants may not accurately report their behaviour. Additionally, this would have added the risk of bias due to loss to follow-up and was not logistically feasible, as it would have required follow-up interviews with every participant over at least a 12 month period. Another possibility would have been to use convictions from the Local Court database. However, as previously mentioned, court processes can sometimes be protracted, and data recording, cleaning and processing require additional time. We believe that the use of Police charges for alleged offences was an appropriate and acceptable indicator of recidivism.

The comparison of actual court outcomes with the 'indicative' sentences provided by the Magistrate is also less than ideal. In the evaluation of post-sentencing drug-diversion programs, it is possible to compare the final sentence with the sentence given at the outset of the program. However, in a pre-plea program such as the LMPP, it is clearly not possible to know exactly what sentence the participant would have received. We attempted to overcome this problem by asking the Magistrate involved in the program to provide 'indicative' sentences for a randomly selected group of program completers – i.e. indicate the sentence he is likely to have given the person in the absence of the LMPP. As the actual and the indicative sentence were both provided by the same, highly experienced Senior Coordinating Magistrate, we consider this to be an acceptable approximation of the sentence the participants are likely to have received.

The analysis may also be biased by potential "net-widening" if non-completers are "punished" for not completing and given more severe sentences than they would have received had they not started the program. It was not possible to exclude this possibility in the evaluation, but it is worth noting that there were no complaints related to this from participants or solicitors.

We have found that, compared to those who did not complete the program, completers received less severe sentences. This analysis does not control for the type of offences committed. However comparing the actual sentences received with the 'indicative' sentences provided by the Magistrate also showed that program completion was associated with lighter sentences. The reduced severity of sentences actually given is consistent with one of the purposes of sentencing, as the completers had improved prospects for rehabilitation. Only one of the program completers received a custodial sentence, compared to 38% of those who were breached or removed from the program. Additionally, a greater proportion of program completers had 'No conviction recorded', than non-completers. Thus, we conclude that the program has resulted in reduced sentences for those who complete it, meeting one of its objectives.

In assessing recidivism among program participants, we have been able to follow all participants for a minimum of 12 months from the date of referral to the program. This includes some post-program time for all participants, and for some includes over a year of follow-up after leaving the program. Thus, the results are able to reflect both the impact on recidivism for the duration of the program, and the impact following program completion. We have found that those who complete the program are significantly less likely to reoffend either within 3 months of referral to the program, or within 12 months of referral. The reduction in reoffending applies both to 'all offences' and to a subgroup of offences – drug, theft and robbery offences.

In a more sophisticated analysis, looking at time to first offence, and controlling for gender, age, Aboriginality, drug of choice and prior imprisonment, the completion of the program is significantly associated with a reduction in recidivism, both using 'elapsed time' and 'free time' to first offence. Again, this applies to both 'all offences' and to drug, theft and robbery offences. The data indicate that, at any point in time, the non-completers are approximately twice as likely to have reoffended as the completers. Thus, we conclude that the program does reduce recidivism among those who complete it, both for the duration of the program and following program completion. The observed reduction in recidivism continues for at least the first 12 months from referral to the program.



## **Chapter 5 – Health and Social Functioning Outcomes**

Megan Passey\*, Stella Patete‡ and Lyndon Brooks #

\* Northern Rivers University Department of Rural Health & Northern Rivers Area Health Service

‡ Southern Cross University & Northern Rivers Area Health Service

#Southern Cross University

### **Introduction**

This chapter focuses on the impact of the Lismore MERIT Pilot Program (LMPP) on the health and social functioning of the program participants. One of the explicit intended outcomes for participants of the LMPP was improved health and social functioning, both for the duration of the program and in the post program period. In order to achieve this, it was intended that a full range of health and welfare services would be provided to participants according to individual need (see introductory chapter of this report). The aim of this component of the evaluation is to determine to what extent the improvements in health and social functioning were achieved.

### ***Diversion into Treatment and Participant Well-being***

The majority of evaluations of drug diversion courts have been undertaken in the United States. These evaluations have largely concentrated on the impact on the criminal justice system, with little attention paid to the health and social outcomes of participants. The most common health outcome included has been illicit drug use. Hall (1997) reviewed the available literature on legal coercion of offenders with alcohol and heroin problems, and concluded that legally coerced treatment is at least as effective as imprisonment in reducing offending and drug use. Belenko, in reviewing the research on drug courts, has also concluded that they are effective in reducing illicit drug use while participants are on a drug court program (Belenko 1998; Belenko 2001). However, there is little information available on use of illicit drugs once participants leave drug court programs.

The comprehensive evaluation of the NSW Drug Court reported poor health and social functioning of the Drug Court participants on entry (Freeman 2002). In this evaluation, Drug Court participants were interviewed at entry, and every four months for the first year, while remaining on the program. Their health and social functioning were assessed using the SF-36 Health Survey and the Opiate Treatment Index (OTI), while illicit drug use was assessed using a proxy measure of weekly spending. Baseline data collected on entry to the program indicated that participants were in poor health on most of the physical and emotional dimensions of the SF-36, when compared to the general Australian population. Moreover participants had very poor social functioning, as measured by the social functioning scale of the OTI, and a large proportion suffered from a chronic illness.

Freeman reported significant improvements in health, social functioning and drug use for the 51 participants who completed all four scheduled interviews. These improvements were demonstrated within four months, and were sustained for the full 12 months the participants were on the program. For male participants, the SF-36 scores at 12 months were as high or higher than the Australian population norms. Importantly, the reduction in drug use (as measured by the proxy measure of median weekly spending) occurred while the participants were living in the community, and thus had access to illicit drugs. There is no information available on those who exited the program before the 12-month interview.

## ***The Health and Social Functioning Outcomes Study***

The aim of this component of the evaluation was to determine to what extent the intended improvements in health and social functioning were achieved. Specific objectives were to:

- Determine if participants' drug use declined during the program
- Determine if participants' health improved during the program
- Determine if participants' social functioning improved during the program
- Determine if these changes were sustained in the post-program period.

## **Methods**

### ***Overall Design***

The study was designed as a prospective cohort study, with participants interviewed at program entry, exit and a follow-up interview several months after program exit. All people accepted onto the program were eligible to be included in the evaluation, including the exit and follow-up interviews, regardless of exit status. The study was designed to be analysed on an intention-to-treat basis. Thus outcomes of all those accepted were of interest, whether or not they completed the program.

The health outcomes component of the LMPP evaluation began after the program had been running for more than nine months. Following pilot-testing of the interview instruments, the health outcomes study commenced in April 2001. Interviews were conducted between 23<sup>rd</sup> April 2001 and 30<sup>th</sup> August 2002.

Participants health and social functioning were measured using standardised interview schedules. Changes in health and social functioning were assessed by comparing the entry interview and subsequent interviews.

### ***Data Collection Instruments***

A standard interview schedule was developed for each interview time, taking into account data routinely collected by the LMPP and available to the research team. The SF-36 (Ware *et al*, 1993) and the Opiate Treatment Index (OTI) (Darke *et al*, 1991) were included at each interview, together with demographic data, and questions regarding drug treatment and criminal history.

The SF-36 is an instrument developed to measure health and well-being. It has been widely used in Australia and population standards have been developed (Australian Bureau of Statistics, 1995). It has eight dimensions:

- physical functioning
- role limitations due to physical functioning
- bodily pain
- general health
- vitality
- social functioning
- role limitations due to emotional functioning
- mental health

The OTI is an Australian instrument incorporating a set of measures designed to evaluate outcomes among people receiving treatment for opiate use. It is multi-dimensional, incorporating scales measuring:

- drug use (for several classes of drugs)
- HIV risk-taking behaviour (injecting drug use and sexual)
- social functioning

- criminality
- health status
- psychological adjustment

This latter dimension is measured using the General Health Questionnaire-28 (GHQ-28) (Goldberg and Hillier, 1979), which provides a global score of psychological adjustment as well as four sub-scores: somatic symptoms; anxiety; social dysfunction; and depression.

At the entry interview, participants were also asked questions relating to their drug use. In the follow-up interview, participants were asked more detailed questions about drug use and criminal activity since exiting the program.

Data routinely collected by the LMPP and recorded on the electronic MERIT Information Management System (MIMS) for monitoring purposes, were used to assess the representativeness of the sample recruited to the evaluation.

## Schedule and Procedures

Initially it was planned to conduct interviews with LMPP participants at entry, three and 12 months after acceptance. However, as many participants were still on the program at three months, the timing for interviews was revised to entry, exit and between three and nine months after exit (see Table 5.1).

**Table 5.1 Eligibility for interviews**

Interview	Program Dates	Timing of interview
Entry Interview	Accepted to LMPP Referred between 15/05/01 & 30/06/02	Interviewed within one month of joining
Exit Interview	Accepted to LMPP Referred before 30/06/02 Exited between 1/05/01 & 30/08/02	Interviewed within 14 days of exit
Follow-up Interview	Accepted to LMPP Exited before 1/05/02	Interviewed between 3 and 9 months after exiting

LMPP participants were not required to participate in the study as part of their program. With the participants' permission, the LMPP staff notified the research officer of the name and contact details of those accepted. The research officer then attempted to contact the participants by telephone, and by letter to invite them to participate in the study. If no contact was made by these means, the research officer then tried to contact the person through the caseworker. The research officer also frequently attended groups at the LMPP office, introducing herself to the participants and explaining the study. As participants could be referred to the program from a range of sources including three different courts, and as there were no facilities for the study at the courts, it was not possible to interview participants at the court at the time they were accepted to the LMPP.

Initially there were often considerable delays in notifying the research officer of participants accepted onto the program. By December 2001, the process was streamlined, and the researchers were well informed of new participants. However, as the participants were free in the community, and many still had very chaotic lives early in the program, contact and recruitment to the health outcomes study for the entry interview was difficult. Participants were considered eligible for an entry interview for the first month of being on the program.

Contacting participants for the exit and follow-up interviews followed similar procedures. When a participant left the program, the LMPP staff notified the researchers. If the exit was unplanned (eg breach of bail conditions or withdrawal), there were frequently delays in notifying the research team, and the participants were difficult to contact. Even among completers, many chose to leave the area immediately after completing the Program, posing

further problems for follow-up. Despite a system for the participants to notify the research team of changes in contact details, many of the exited participants were lost to follow-up, particularly non-completers. Because of these difficulties it was decided to limit the attempts to contact non-completers, but make repeated attempts to contact completers.

All those willing to participate provided written informed consent. They were interviewed at a convenient place, including the LMPP offices, coffee shops, parks, and other public places where confidentiality could be achieved and where both the participant and the interviewer felt comfortable. A few interviews were conducted by telephone. Respondents were initially paid \$15 to cover expenses associated with the interview. This was increased to \$20 in February 2002.

## Data Processing and Analysis

All data were entered into an Access database. Data from open-ended questions were collated and coded for key themes and responses. Where quantitative data were categorical, differences in proportions between the different times were tested using Chi-square tests.

Both the OTI and the SF36 provide measures on continuous scales, however the distributions were in many cases far from normal. Where the distributions were of a form such that normal inference could be employed through the central limit theorem, multilevel models were fitted to compare mean scores over the three interviews (entry, exit and follow-up). Multiple comparisons following overall significant results are reported unadjusted for their number.

Multilevel models are designed for use with clustered data, as arises in repeated measures data where scores over time are more similar within than between subjects. Standard repeated measures models are not appropriate for the present data because the same subjects were not in all interview samples. However, some subjects were present in two or more samples. The multilevel model adjusts the standard error estimates for the dependency between samples due to their inclusion of some of the same individuals.

Where the distributions were distinctly non-normal but where means were considered meaningful summaries, Kruskal-Wallis tests were used to compare the data from the three interviews with Mann-Whitney tests used for subsequent pairwise comparisons. The results of the Mann-Whitney tests are reported unadjusted for their number.

In some cases both kinds of analyses were performed. Where the substantive conclusions did not differ between the two models, the normal inference results are reported. Where substantive conclusions did differ, the more conservative results are reported.

**Table 5.2 Statistical Analysis of SF-36 and OTI Variables**

Instrument	Multi-level models	Kruskal-Wallis tests
SF-36	Bodily Pain	Physical Functioning
	General Health	Role – Physical
	Vitality	Role – Emotional
	Social Functioning	
	Mental Health	
OTI	Polydrug Use	Drug Use HIV Risk-taking
	Social Functioning	Sexual HIV Risk-taking
	General Health	Criminal Behaviour
	Health Total	
	GHQ scores	



The extent to which the sample could be seen to be representative of MERIT participants was assessed using data from the MIMS database. A range of factors were assessed comparing the distribution of the variable among the people interviewed at each time, to the distribution among all those admitted between 1<sup>st</sup> July 2000 and 30<sup>th</sup> June 2002. For categorical variables, Chi-square tests were used to test for differences in proportions between those interviewed and those not interviewed. For continuous variables, Student's t-test was used to test for differences in the mean.

## Findings

### Sample Recruited

There were a total of 266 acceptances to the LMPP during the period 1<sup>st</sup> July 2000 to 30<sup>th</sup> June 2002. Of these 156 were referred after 15<sup>th</sup> May 2001, and were eligible for recruitment for an entry interview; 180 exited between 1<sup>st</sup> May 2001 and 30<sup>th</sup> August 2002, and were eligible for recruitment for an exit interview; and 205 exited before 1<sup>st</sup> May 2002 and were eligible for a follow-up interview. Actual numbers recruited were 69 (44% of those eligible) for an entry interview, 50 (28% of those eligible) for an exit interview and 55 (27% of those eligible) for a follow-up interview.

Descriptive data for the respondents and for the 266 accepted, are presented in Table 5.3.

**Table 5.3 Demographic, programmatic and health data for all participants accepted and for each interview group**

	Overall ‡ n=266	Entry n=69	Exit n=50	Follow-up n=55
<b>Demographic</b>				
Mean Age (years)	29.9	28.8	30.4	30.1
Male	76%	74%	74%	67%
Aboriginal	16%	12%	12%	8%
Single	58%	65%	49%	61%
School = year 10	65%	67%	67%	75%
Employed on entry	7%	7%	6%	9%
Living in privately owned house/flat	22%	31%*	24%	36%*
<b>Health</b>				
Heroin principal drug of concern on entry	54%	49%	50%	57%
Chronic physical health problem	75%	75%	80%	78%
Mental health problem	39%	49%*	50%	38%
<b>Programmatic</b>				
Referred by magistrate	64%	59%	64%	47%*
Previous gaol	58%	58%	65%	57%
Completed	51%	70%**	82%**	76%**

‡ Overall = all participants accepted to the LMPP between 1<sup>st</sup> July 2000 and 30<sup>th</sup> June 2002

\* and \*\*: Statistically significant difference in distribution of the variable between respondents in each group and those not interviewed; \* p = 0.05; \*\* p = 0.001

Missing data: marital status 2; accommodation 1; education 6; previous gaol 13. Four participants were still on the program

The recruitment rate to the study was low, particularly for the exit and follow-up interviews. Nevertheless, the groups have a similar profile on most of the variables available for assessment. The most striking difference is that completers were much more likely to participate in all the interviews than non-completers. The lower rate of interviewing at entry for non-completers is not surprising given that many exited fairly early. Of the 86 non-completers eligible for the entry interview, 17 (20%) had exited within 14 days, and 32 (37%) within 28 days, the cut-off for interviewing. These people may also have had more complex drug-dependency and other problems which may have made them both less likely to succeed on the LMPP and less likely to be willing to participate in the study. The low rate of recruitment to the exit and follow-up interviews among non-completers may also be because some of them had breached bail conditions and were wanted by the police.

Respondents were also more likely to live in privately owned accommodation than those not interviewed. However, as shown in Chapter 3 – Program and Participant Profiles, those living in privately owned accommodation were also more likely to complete the program, and their over-representation in the interviewed sample is due to the over-representation of completers. The proportion of Aboriginal respondents was low, but not significantly so.

In light of the bias in recruitment towards completers, the results presented below should be interpreted as more representative of completers of the Program, than of all those accepted.

### ***Drug Usage and Treatment***

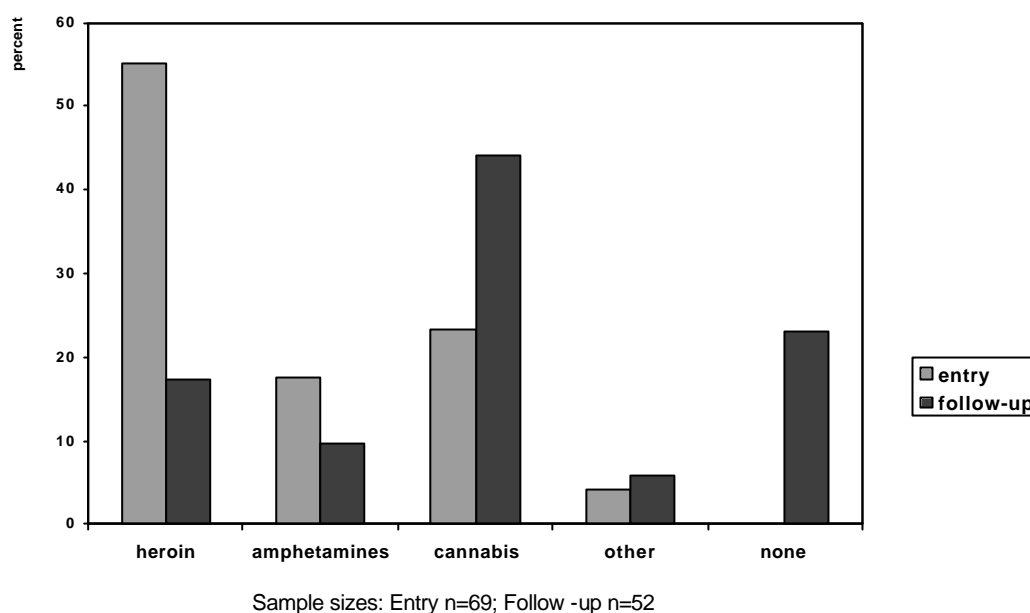
At all three interviews, participants were asked if they were currently in any type of drug treatment (the entry interview asked about treatment prior to entering the LMPP). At entry, 30 participants (44%) reported being in treatment. This increased to 70% shortly after exit, (statistically significant:  $p=0.004$ ) but was not sustained at that level, dropping to 53% at the follow-up interview. Although a greater proportion were in treatment at follow-up, than on coming into the Program, the difference is not significant.

At both the entry and follow-up interviews participants were asked questions related to their drug of choice and use of drugs by their friends. The questions asked were:

- What was your main drug of choice (coming into MERIT/ since your exit from MERIT)?
- (In the past six months / since you left MERIT) how many of the people you have been hanging round with would you say are regular illicit drug users?
- What is the main drug used by the people you have been hanging around with (in the past six months / since you left MERIT)?

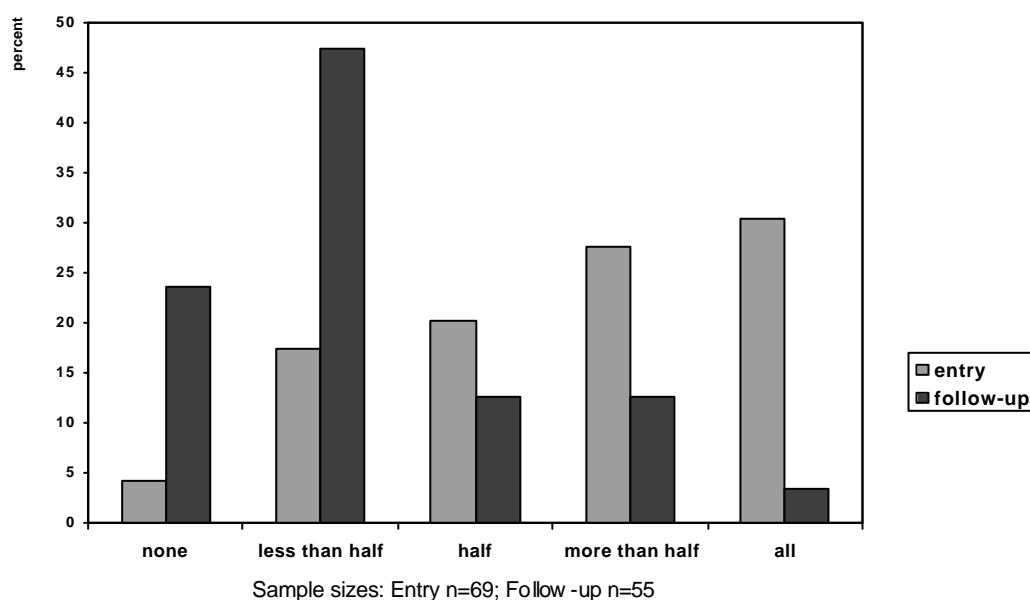
At entry, 55% of respondents reported that their main drug of choice was heroin or other narcotics. This had fallen to only 17% of respondents at the follow-up interview, despite a slightly higher percentage of those interviewed at follow-up having identified heroin as their main drug of choice on entry into the program (57% versus 49% - see Table 5.3). The percentage reporting amphetamines as their main drug of choice had fallen from 17% to 10%, while those reporting cannabis as their main drug of choice increased from 23% at entry to 44% at follow-up. At follow-up 23% reported no illicit drug use. These changes are shown in Figure 5.1 below. The change in main drug of choice was highly significant ( $p<0.0001$ ).

**Figure 5.1 Main reported drug of choice for LMPP participants at the entry and follow-up interviews**



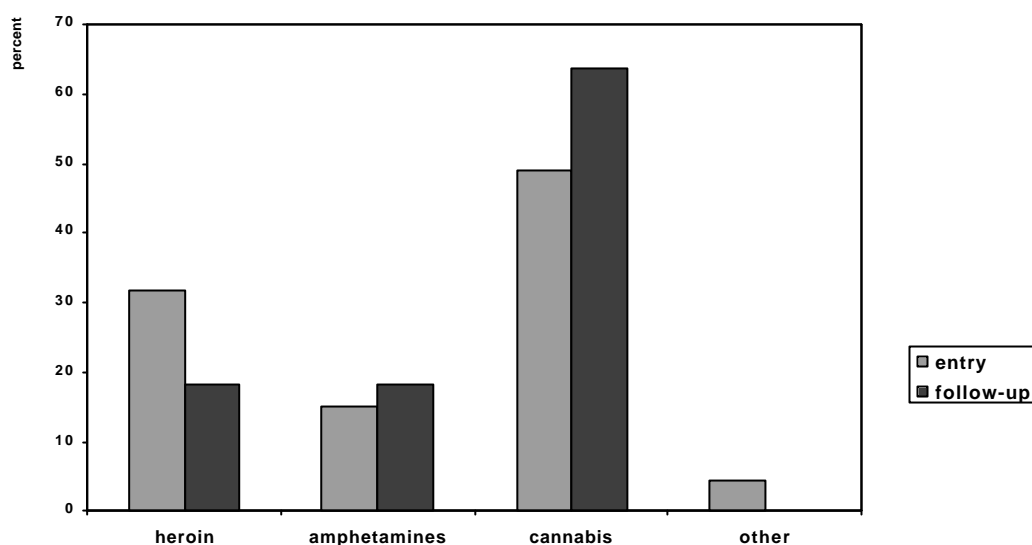
There were also highly significant shifts in the reported proportion of the respondents' associates who were illicit drug users ( $p < 0.0001$ ), with 71% of respondents interviewed at follow-up reporting that none, or less than half of the people they associated with were regular users of illicit drugs. This is shown in Figure 5.2.

**Figure 5.2 Reported proportion of LMPP respondents' associates who are regular users of illicit drugs**



The types of drugs that the respondents' associates used also changed, although this was not statistically significant. Among those reporting spending any time at all with people who regularly used illicit drugs, there was a reduction in those reporting heroin use, and an increase in those reporting cannabis use (Figure 5.3).

**Figure 5.3** Reported type of drugs most frequently used by the LMPP respondents' associates



Only includes those who report spending any time with people using illicit drugs. Sample size: Entry n=47; Exit n=44

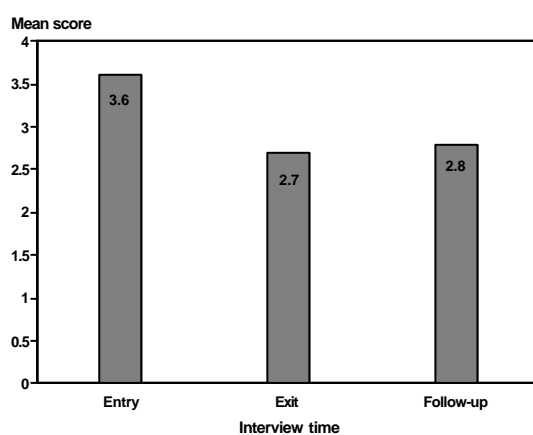
### ***Changes in scores on the Opiate Treatment Index***

For each component of the OTI, the mean scores at each interview time were compared, as described in the methods section. The results are reported below under Drug Use, HIV Risk-taking, Social Functioning, Criminal Activity, and Health. For each component, a lower score is more desirable than a higher score. The data are also presented in a table in **Appendix E**.

### ***Drug Use***

The Polydrug use score is an indication of the number of different classes of drugs (heroin, other opiates, alcohol, cannabis, amphetamines, cocaine, tranquillisers, barbiturates, hallucinogens, inhalants and tobacco) used by the respondent in the previous month. This showed a significant decline from entry to exit, which was sustained at the follow-up interview ( $p < 0.001$ ) (Figure 5.4).

**Figure 5.4** Mean Scores for Polydrug Use on the OTI at different interview times for LMPP participants



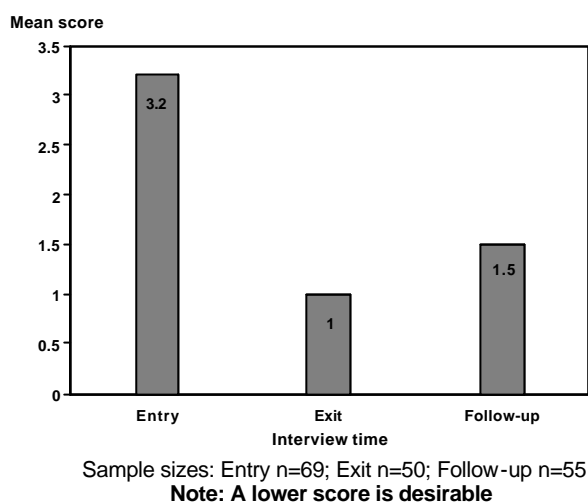
Sample sizes: Entry n=57; Exit n=46; Follow-up n=55

**Note: A lower score is desirable**

### ***HIV Risk-taking Behaviour***

HIV Risk-taking behaviour is assessed for injecting drug use and sexual behaviour. There was a significant decline in the mean score for risk-taking associated with drug use between the entry and exit interviews (Figures 5.5), but no change in the score for sexual behaviour. The decline in risk-taking associated with drug use was sustained, with only a slight increase from the exit interview to the follow-up interview.

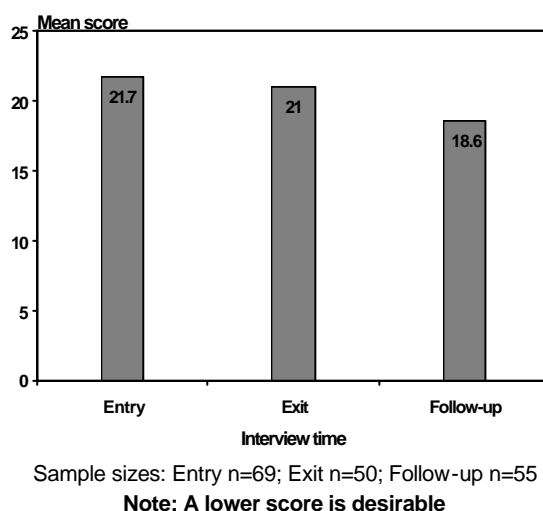
**Figure 5.5 Mean Scores for HIV Risk-taking Behaviour associated with injecting drug use, OTI, for LMPP participants**



### ***Social Functioning***

The OTI social functioning scale measures social integration in terms of employment, residential stability and inter-personal conflict; as well as assessing social support. The mean social functioning scores declined from the entry interview to the follow-up interview, indicating an improvement in social functioning ( $p=0.006$ ). The decline was greatest between the exit interview and the follow-up interview ( $p=0.02$ ). The mean scores at each interview time are shown in Figure 5.6.

**Figure 5.6 Mean Scores for Social Functioning on the OTI at different interview times, for LMPP participants**

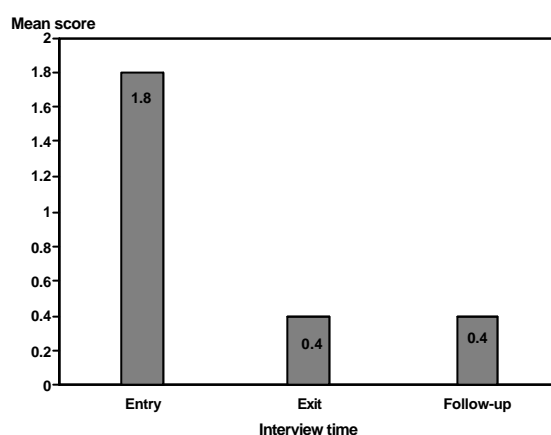


The mean scores for the LMPP respondents at entry and exit are both higher than the corresponding scores reported by Freeman (2002) for the NSW Drug Court participants. She reports a mean baseline social functioning score of 20, with a mean four month score of 16. Data are not available to test the significance of these differences, but they suggest that the LMPP participants have social functioning which is at least as poor as that of the NSW Drug Court participants.

### ***Criminal Activity***

This category asks specifically about property crime, drug dealing, fraud and crimes involving violence, and asks for crimes committed, not just those for which they were caught. Reported criminal activity declined considerably between the entry and exit interviews, with mean scores falling from 1.8 to 0.4 ( $p < 0.001$ ). The decline was sustained at the follow-up interview (Figure 5.7).

**Figure 5.7 Mean Scores for Criminal Activity on the OTI at different interview times, for LMPP participants**



Sample sizes: Entry n=69; Exit n=50; Follow-up n=55

**Note: A lower score is desirable**

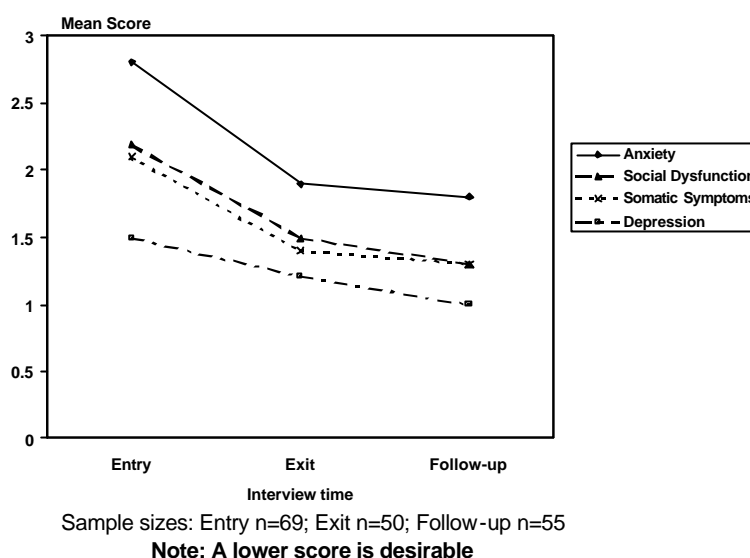
### ***Health***

Health is measured in several different ways. Respondents are asked a number of questions about specific symptoms, some relating to general health, and others relating to specific physiological systems (eg neurological, genito-urinary etc). In addition participants are given the GHQ 28, which assesses psychological well-being. The results are presented as General Health, Total Symptoms, and the GHQ scores for Somatic Symptoms, Anxiety, Social Dysfunction and Depression.

The mean scores for General Health and for the Total Symptoms increased slightly from entry to the follow-up interview, (ie indicating a decline in health), although this was not significant for either score.

By contrast there were significant improvements in psychological well-being, measured by the GHQ, with improvements in every score, although the change in the depression score was not significant. The changes occurred between the entry and exit interviews, with further (non-significant) improvements between the exit and follow-up interviews. These results are shown in Figures 5.8.

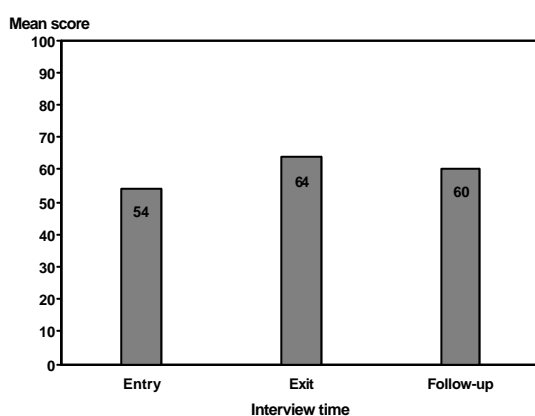
**Figure 5.8 Mean Scores on the GHQ at different interview times, for LMPP participants**



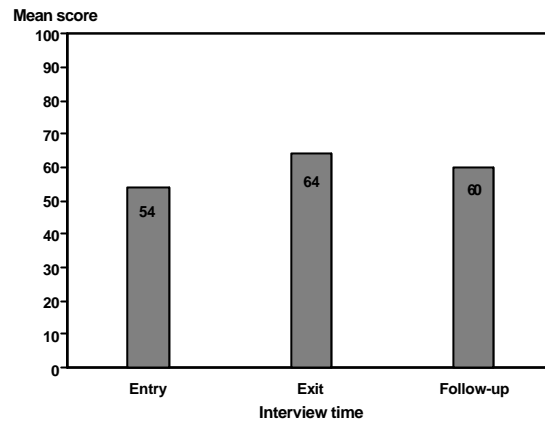
### Changes in SF-36 Scores

The mean scores for each dimension of the SF-36 at the three interview times were compared. In contrast to the OTI, for each component, a higher score is more desirable than a lower score. The data are presented in the figures below and in a table in **Appendix E**. The mean scores increased on every dimension between the entry and exit interviews, although these increases were significant only for Bodily Pain ( $p=0.048$ ) (see Figure 5.9), General Health ( $p=0.001$ ) (Figure 5.10), Vitality ( $p=0.005$ ) (Figure 5.11) and Social Functioning ( $p=0.011$ ) (figure 5.12). On all dimensions except Bodily Pain, there was a slight decline in mean score between the exit and follow-up interviews, although none of these declines were significant.

**Figure 5.9 Mean Scores on the SF-36 Bodily Pain scale at different interview times, for LMPP participants**



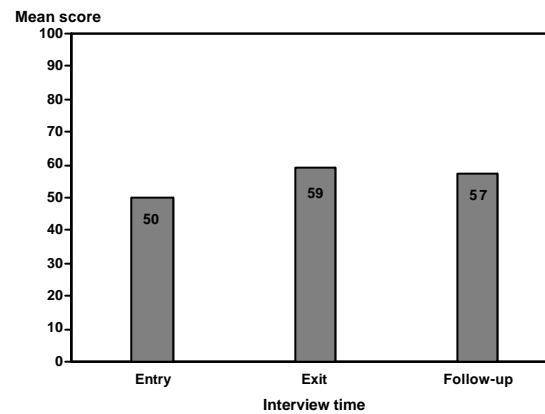
**Figure 5.10 Mean Scores on the SF-36 General Health scale at different interview times, for LMPP participants**



Sample sizes: Entry n=68; Exit n=50; Follow-up n=55

**Note: A higher score is desirable for the SF-36**

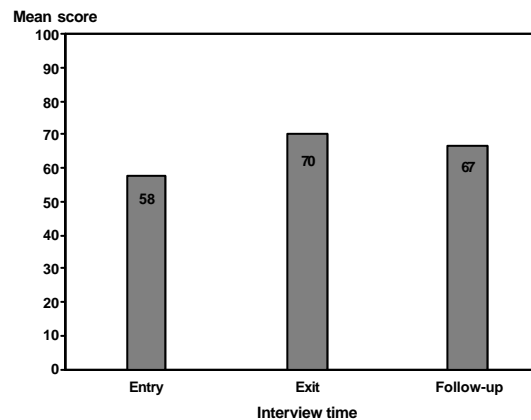
**Figure 5.11 Mean Scores on the SF-36 Vitality scale at different interview times, for LMPP participants**



Sample sizes: Entry n=68; Exit n=50; Follow-up n=55

**Note: A higher score is desirable for the SF-36**

**Figure 5.12 Mean Scores on the SF-36 Social Functioning scale at different interview times, for LMPP participants**



Sample sizes: Entry n=68; Exit n=50; Follow-up n=55

**Note: A higher score is desirable for the SF-36**



It is of note that the mean scores for the LMPP participants on entry were lower than the mean scores reported for the NSW Drug Court participants at baseline on all dimensions except Mental Health (Freeman, 2002).

## **Discussion**

In this chapter we have attempted to assess the impact that the LMPP had on the health and social functioning of participants. In doing so, we have interviewed participants at three points – entry, exit and several months after leaving the Program. A number of standard instruments and additional questions have been used to assess quality of life, drug use, health and social functioning.

There are a number of limitations of this study which need to be borne in mind when considering the results. Firstly, there was a low rate of recruitment at each interview point, particularly the exit and follow-up interviews, resulting in the possibility of selection bias. Although the evaluation of health and social functioning among participants of the NSW Drug Court achieved a higher response rate at entry (95% for the NSW Drug Court; 44% in the current evaluation), those interviews were conducted while the respondents were held in the court cells, (Freeman, 2002). All our interviews were conducted while the participants were free in the community, and we experienced considerable difficulty contacting many of them. Our response rates at exit (28%) and follow-up (27%) were similar to that for the NSW Drug Court evaluation at 12 months (32%). Given the low response rates, there is likely to be considerable selection bias, in that those who were more successful in the program, and those whose lives were less chaotic are more likely to have been contactable and agreed to be interviewed. This is borne out by the high proportion of completers amongst those interviewed. Thus, the results should be considered to be more reflective of the impact of the Program on completers, than of the impact on others.

This study relies on comparisons between participants' responses at entry to the Program, exit from it, and follow-up, i.e. a pre and post intervention design. While it would have been ideal to have a control group to make comparisons with, this was not logistically possible. As the interviews are quite intrusive and time-consuming, it may also be considered unethical to request such interviews with people who do not have the possibility of participating in the program. To our knowledge, no other evaluations of drug diversion programs have attempted to assess changes in health and social functioning, using a control group.

Another methodological limitation is that this study relies exclusively on self-report data. However, measures of quality of life and social functioning are always dependent on self-report, as it is the individual's own experience which is being measured. We used well-recognised, standardised instruments to interview the participants. These same instruments were used in the evaluation of the NSW Drug Court (Freeman, 2002). While use of self-report is essential in assessing quality of life, reliance on self-report data may be problematic when assessing criminal activity and drug usage, and this limitation should be considered when interpreting the results.

The difficulty experienced in contacting participants, then arranging a time for the interviews may have affected our ability to detect changes in respondents health and social functioning. Although we conducted the entry interview as soon as possible after entry into the program, we persisted with our attempts for up to four weeks, with the result that many of the respondents may already have experienced some beneficial impact of the program when the entry interview was conducted. Where this is the case, the effect would have been to reduce the changes detected.

We have found evidence for both a reduction in self-reported drug use, and a change in the drug of choice. There were significant declines in reported drug use between the entry and exit interviews, as measured by the Polydrug score of the OTI. This reduction was maintained at the follow-up interview. The proportion of respondents reporting heroin as their drug of choice dropped considerably from the entry interview to the follow-up interview, with

an increase in those identifying cannabis as their drug of choice. This is also supported by a decline in the mean score for HIV Risk-taking behaviour associated with injecting drug use, in the OTI, which is consistent with a shift away from injecting drugs. The increase in cannabis as the drug of choice may reflect substitution, or continued use of cannabis in the absence of heroin. Respondents also reported spending less time with other users of illicit drugs.

Additionally, the type of drug most frequently used by the respondents associates changed, with a reduction in heroin, and an increase in cannabis, although this change was not statistically significant. A switch from heroin to other drugs, most notably cocaine, but also cannabis, benzodiazepines and amphetamines, has also been identified as a response to the heroin drought which began in NSW in early 2001 (Weatherburn *et al*, 2001).

The findings indicate that there was an improvement in respondents' social functioning, with significant improvements on the Social Functioning scores of both the OTI and the SF-36. There was also a considerable decline in reported criminal activity, another measure of social functioning, which was maintained at the follow-up interview.

There were significant improvements in the health of the respondents. Psychological health was measured using the GHQ, and there were significant improvements in the scores on three of the four scales. However, the improvements on the Mental Health and Role Limits – Emotional scales of the SF-36 were not significant. There were also significant improvements in the Bodily Pain, General Health and Vitality scales of the SF-36, but not in the Physical Functioning or Role Limits – Physical scales, nor in the General Health and Total Symptoms scores of the OTI. Together these data suggest that the impact was more marked on the psychological health of the respondents than on their physical health.

The poor scores on the health scales of both the OTI and the SF-36 indicate generally poor health at entry. The mean scores for the LMPP participants on entry were lower than the mean scores reported for the NSW Drug Court participants at baseline on all dimensions except Mental Health (Freeman 2002). As discussed by Freeman, the scores for the male participants of the NSW Drug Court were significantly lower than those for the general Australian male population. The poor scores on the SF-36 and the OTI among LMPP participants are also consistent with the high prevalence of both physical and mental health problems noted earlier in this report (see Chapter 3 – Program and Participant Profiles). Belenko, in discussing the challenges of evaluating drug court programs, also notes that participants of drug court programs “often have serious physical and mental health problems that can complicate both the treatment and the recovery process” (Belenko 2002, p1643). Thus, it is important to recognise that the prevalence and chronicity of the health and social problems experienced by the participants will affect the impact that treatment programs can have.

The improvements measured on the SF-36 scales and on the OTI Social Functioning scale, were not as great as those reported for the participants of the NSW Drug Court (Freeman 2002). However, there are a number of differences between the two programs, which may account for this. Firstly, the NSW Drug Court participants all go through a detoxification process prior to entering the program, whereas only some of the LMPP participants are referred for detoxification, while others may undergo detoxification in the community. Secondly, the program is less intensive, with fewer urine checks, less oversight by the Court, and more reliance on the case managers to provide treatment as well as case management. Finally, the LMPP is intended to run for three months, compared with 12 months for the NSW Drug Court. Thus the difference in duration and intensity of the two programs may account for the differences in impact on health and social functioning.

In conclusion, the findings suggest that for completers of the LMPP there are significant improvements in the health and social functioning of the participants, with a greater impact on psychological health than physical health. For program completers there was also a reduction in the numbers of classes of drugs used, and a reduction in the use of heroin as the principal drug of concern.

## **Chapter 6 – Participant Perspectives of the Lismore MERIT Pilot Program**

Megan Passey \* and Stella Patete ‡

\* Northern Rivers University Department of Rural Health & Northern Rivers Area Health Service

‡ Southern Cross University & Northern Rivers Area Health Service

### **Introduction**

In this chapter we report the participants' perspectives of the Lismore MERIT Pilot Program (LMPP). Their views were sought to assess their satisfaction with the program; as well as its challenges and benefits; and ways the program could be improved. This qualitative information adds to the quantitative data, with the aim of providing a greater understanding of the actual experience of the program, and the ways it has impacted on participants' lives.

### **Methods**

Participants were interviewed at program entry, exit and a follow-up interview three to nine months after program exit. These interviews were conducted in conjunction with the data collection for the Health and Social Functioning Study described in Chapter 5. All program participants were invited to participate, regardless of exit status, as we were interested in the views of those who didn't complete the program, as well as those who did. Interviews were conducted between 23<sup>rd</sup> April 2001 and 30<sup>th</sup> August 2002.

A standard interview schedule was developed for each interview time. At the entry interview, participants were asked about their reasons for enrolling in the LMPP. At the exit and follow-up interviews, questions focused on their experience of and satisfaction with the LMPP and the impact it had on their lives. They were also asked to suggest ways of improving the program. The majority of the questions were open-ended, allowing participants to express their opinions in their own words. At the exit interview there were also three questions relating to satisfaction and understanding, with scaled response categories.

All data were entered into an Access database. The data were collated and coded for key themes and responses. Frequencies of responses were calculated for categorical variables.

A detailed description of the procedures and eligibility for interviews was given in Chapter 5.

### **Findings**

#### ***Sample Interviewed***

In Chapter 5, we described the sample recruited and reported on its representativeness. In summary, there were 69 participants interviewed on entry to the program (44% of those eligible); 50 on exit (28% of those eligible); and 55 at follow-up (27% of those eligible). The respondents were more likely to be program completers and to live in privately owned accommodation, than non-respondents. In other respects they were similar to all program participants in the first two years, as measured by key demographic, programmatic and health data.

## Reasons for Joining the LMPP

Participants were asked to identify the most important factor in their decision to join the LMPP. The two most common themes were a desire to change their lifestyle, and the expectation that it would influence their court outcome and assist them to avoid imprisonment. Another frequent response related specifically to a desire to give up drugs. Several participants also mentioned improving relationships with their family and getting access to their children.

*“A tie between wanting to get straight and not going to jail.”*  
(24 year-old male completer)

*“To give up drugs. I keep ending up back in the same situation”*  
(23 year-old male completer)

*“I’m on methadone treatment to try to give up my drug-use and MERIT will help me through this and I want my children back from Family Court.”*  
(28 year-old female completer)

## Understanding and Choice

At exit, the participants were asked how well they now believed they had understood the program on entry – with response categories on a five-point scale. The results are shown in Table 6.1.

**Table 6.1 Level of understanding of the LMPP program on entry, among 50 participants at exit from the program**

	No.	%
Very good understanding	2	4
Good understanding	16	32
Neither good nor poor understanding	11	22
Poor understanding	11	22
Very poor understanding	10	20

The results indicate that many of the respondents did not have a very clear understanding of the program and what it involved when they enrolled in it.

Respondents were also asked to consider whether they felt it had been their choice to start the program. Nearly all respondents believed that they had not been forced to enter the program, although nearly half felt that they had limited choice given the likely court outcomes if they did not. Many also mentioned that the program had been recommended by Police, solicitors or others. Less than one tenth felt that they had no choice.

*“Yes because it was either that or go to jail and I chose MERIT.”*  
(27 year-old male completer)

*“No, It wasn’t my choice. The Police said I had to do it or go to gaol.”*  
(18 year-old female completer)

*“Yes, it was recommended to me by my solicitor. I didn’t know it was available.”*  
(40 year-old male completer)

## Satisfaction

At the exit interview, participants were asked about their satisfaction with two aspects of the program, using a five-point scale. They were asked how satisfactory their treatment plan was in meeting their needs, and how satisfied they were with the support they received from their caseworker. As can be seen in Table 6.2 below, the vast majority of participants were either ‘satisfied’ or ‘very satisfied’ with both.

**Table 6.2 Satisfaction with treatment plan and with caseworker support, among 50 LMPP participants at exit from the program**

	Treatment Plan		Caseworker support	
	No.	%	No.	%
Very satisfied	21	42	34	68
Satisfied	21	42	9	18
Neither satisfied nor dissatisfied	2	4	2	4
Dissatisfied	3	6	2	4
Very dissatisfied	3	6	3	6

## Usefulness and Challenges

At both the exit and follow-up interviews, respondents were asked a series of questions about the most useful and least useful aspects of the program, and what they found most difficult to manage.

At both interviews, by far the most commonly identified 'most useful' aspect was the support from the caseworkers. Other common responses were the group sessions (both the content, and the contact and interaction with others), and access to detoxification and/or rehabilitation services.

*"Case-worker support, the way the workers are always positive and give you support, they're more personal, they're there for you."*  
(33 year-old female completer, exit interview)

*"Caseworker, having a counsellor who made me face things."*  
(43 year-old male completer, follow-up interview)

*"Groups because I got to see other people heavily involved with drugs and you don't want to be like them and you can see people fully worse off than you."*  
(24 year-old female non-completer, follow-up interview)

*'Groups, I learnt a lot of stuff I didn't know and now I can prepare for events which I couldn't do before like coping with relationship and depression issues'.*  
(29 year-old male completer, exit interview)

The group sessions were also the most frequently identified 'least useful' aspect of the program. Some respondents found the content of some of the group sessions unhelpful, as they had previously covered it in other groups or elsewhere. Others found the groups distressing because of the behaviour of others, or because they didn't want to be forced to mix with the other participants. Several respondents also mentioned that there were problems bringing a large number of participants together in a group as there could be pressure to use drugs after the meeting.

*"Group stuff. I reckon I'm not real sociable and I never really got nothing out of it because you always got someone there being the town clown or something. You get to know them [injecting drug users attending group] but I don't want to know them..."*  
(25 year-old male completer, exit interview)

*"Groups: one because they were all drug addicts and criminals, two cause they wanted to buy drugs together after group."*  
(35 year-old male completer, follow-up interview)

Other aspects identified as 'least useful' included lack of contact with their caseworker while they were in a residential rehabilitation facility and having to do urine tests. About a fifth of the respondents at each interview were unable to identify a 'least useful' aspect.

When asked what they found most difficult to manage, the majority of respondents at both the exit and the follow-up interviews, identified difficulties with transport as the biggest challenge. Many of these respondents were dependent on either hitch-hiking or using public transport, which they found prohibitively expensive. For these respondents, the requirement to attend weekly group meetings in Lismore was problematic, as they had considerable distances to travel. 'Staying clean' was the second most commonly identified challenge at both interview times. At the follow-up interview respondents also identified the following challenges: negative behaviours in groups; dealing with the drug using lifestyle and their own negative self perceptions; maintaining relationships with family and significant others; and time management.

*"Travel - to be somewhere at a specific date and time was difficult in the beginning."*  
(31 year-old male completer, exit interview)

*"Dealing with my parents and the stigma of drug abuse, and dealing with my self perceptions."*  
(23 year-old male completer, follow-up interview)

## Impact

Participants were asked to describe some of the positive and negative impacts of the program on their lives, at both the exit and follow-up interviews. Respondents identified a number of benefits with the common ones being:

- improved social functioning / increased life skills
- improved relationships with family and others
- abstinence or reduction in drug use
- a more positive attitude
- greater self-esteem

Only a small number (three at exit and six at follow-up) identified a better court outcome as a positive impact of the program on their lives.

*"I've changed my drug using and drinking, I'm more stable and can have a relationship with my 4 year-old daughter."*  
(31 year-old male completer, exit interview)

*"I became more drug educated, I'm clean. I looked at my goals and what I wanted. MERIT was like a new door out of my life. It makes you look at you - it made me think."*  
(28 year-old female completer, exit interview)

*"Better friends, no drug friends, my health is better, I eat well. I've started doing courses & looking for work. My family relationships are better."*  
(24 year-old female completer, follow-up interview)

*"I'm stronger I handle my life better. I plan more, I'm not running on impulses no more."*  
(43 year-old male completer, follow-up interview)

*"I've had a clean head for 13 months [and] I'm in the process of getting my son back. The lifestyle I led before the program was total filth. Early stages of MERIT was difficult but my caseworker kept working with me and steering me the right way and slowly but surely I changed."*  
(28 year-old male, completer, follow-up interview)

*"It really gave me something to work with for example, coping skills. I've changed dramatically since six months ago... I've had 20 years of heroin and poly-drug use. I've been in and out of prisons including juvenile, rehabs and detoxes and each time I left drug treatment or institutions I came out more intent on my drug use and more mixed up than before and very frustrated. Going to MERIT was a turning point in my life.... caseworker and manager both very supportive. I learnt about consequences*

*one-on-one only, as I was barred from groups because others felt threatened.... After the decision - you're going to be in control again not the drugs – [you've] got to want to replace something bad with something good. I channel the energy I used to be a "good" heroin user/dealer into my vegetable garden, fishing and my kid."*

(31 year-old male completer, follow-up interview)

Very few respondents had any comment to make when asked about negative impacts of the program on their lives. A few each reported: stress from frequent court hearings or the demands of the program; disappointment at having "failed" the program; contact with other participants making it easier to buy drugs; and a negative impact on their relationships.

*"I broke up with my girlfriend of four years. It [MERIT] created hassles cause I felt like I had lots of pressure on me."*

(20 year-old male non-completer, follow-up interview)

When asked at the exit interview how confident they were of maintaining any positive changes they had made, the majority of those who had successfully completed the program expressed confidence, with some commenting that they had new skills to draw on. Approximately a quarter had some reservations about their ability, with some of these expressing the view that they could call on their caseworker for additional support if necessary. The majority of the non-completers either had not made many changes, or expressed more reservation about their ability to maintain the changes they had made.

At the follow-up interview, respondents were asked how successful they had actually been at maintaining their changes. The majority claimed to have maintained their changes, with some expressing considerable pride and pleasure in this achievement. Approximately a third reported that they had had a few lapses, but were taking fewer drugs than previously. Others reported that they were struggling. A small number did not respond, or claimed not to have made any positive changes while on the program (all non-completers). Interestingly, approximately one third of the non-completers reported that they were maintaining their changes, or if anything had improved since leaving the program.

*"My whole life changed. I wasn't interested in drugs anymore, or going back to jail. I learnt about drugs and their effects on my life and didn't want them in my life."*

(26 year-old female completer)

*"Pretty well, I'm dealing with everything just day by day."*

(22 year-old female completer)

*"At the time no good, now excellent!"*

(38 year-old female non-completer)

## **Comments, Suggestions and Recommendations**

At both the exit and the follow-up interview, respondents were asked if they had any further comments to make about the program. There were very few negative comments. The majority of comments were positive comments on the program generally, and on its impact. There were also a number of positive comments on specific aspects of the program. These included suggestions for more post-program support; more one-on-one counselling with caseworkers; fewer groups or groups made non-compulsory; the option of male or female caseworkers; and a general increase in resources to allow the program to be available to the general public. There was also a recognition in many of the comments that the program will only work for those willing to put the effort in themselves.

*"Found it a very positive and useful program - a positive alternative to jail. [I] felt respected by staff, no putdowns & treated as equals by staff."*

(47 year-old female completer, exit interview)

*"I think the program is positive cause it's been 8 years since I started using and I'm straight! MERIT showed interest and care - I think that's why it works. I really really*

*wanted to do MERIT and having the case-worker support gave me the strength to do it and when I had the support I didn't want to let them or myself down. I want to still keep seeing my case-worker - possibly post-MERIT supervision by MERIT as a sentence outcome."*

(33 year-old female completer, exit interview)

*"It's a very good program for people who want to change their habits."*

(25 year-old male completer, exit interview)

*"It would be good if there was some support after graduation eg a counsellor or individual post-MERIT case plan. It's like you've been nurtured like a baby and then you've graduated and there's nothing."*

(29 year-old male completer, exit interview)

*"Even though I got kicked off MERIT I have nothing bad to say about them. They could have helped me but I had a lot of other things on my mind. I had a big fight with my mum about my son. I was going for custody and MERIT seemed less important."*

(33 year-old female non-completer, follow-up interview)

Similar themes emerged when respondents were asked for suggestions on ways the program could be improved. Suggestions included:

- Tightening monitoring of urinalysis, with more testing without warning
- Post-program support
- Increase number and depth of content of group sessions
- Create more alternatives to groups, provide them in the smaller centres or provide transport for participants to attend
- Limit caseworker load and increase one-on-one support, particularly while in residential AOD services

*"More one-on-one counselling and more feedback about what you might or might not get in trouble for on a personal basis, not client group basis."*

(21 year-old male completer, follow-up interview)

*"More follow-up [post-program] counselling."*

(35 year-old male completer, follow-up interview)

*"I reckon they should watch people doing urines and have more regular urines and don't let people know when they're due."*

(26 year-old female completer, follow-up interview)

*"Groups... expand on sessions some way... involve participants a bit more. It's quite passive and it'd be better to draw more people in."*

(23 year-old male completer, follow-up interview)

*"Increase access for people in rural areas or have a program at Nimbin."*

(23 year-old female non-completer, follow-up interview)

Finally, at both the exit and follow-up interviews, respondents were asked if they would recommend the program to others. The overwhelming response was "yes", but often with caveats. These included a recognition that it depended on the participant making the effort, and was therefore not to be seen as an easy alternative to gaol. There was also a perception that there were benefits from the program, even if the person didn't successfully complete it.

*"Yes, because if you're honest with yourself & you want to get off alcohol & drugs, you will make it."*

(29 year-old male completer, exit interview)



*“Yes, cause it can help people and if not help it gives time out and teaches basic life skills - maintenance and safety are very important for users especially [those] not willing to stop.”*

(29 year-old female completer, exit interview)

*“Yes, because you're not alone, you never feel alone, 24 hours a day you can contact someone for free. [It] is amazing.”*

(28 year-old male completer, exit interview)

*“Yes, only some - if they're serious about wanting help for their drug problem. MERIT can make things happen.”*

(38 year-old male completer, follow-up interview)

*“Yes because the people there are willing to help you and even more than that they are willing to push you into helping yourself.”*

(29 year-old female completer, follow-up interview)

## Discussion

In this study we have sought information from the participants about their experiences of the LMPP and the impact it had on their lives. We attempted to interview all participants at three points – on entry, at exit, and three to nine months after leaving the program. Unfortunately, as discussed in the chapter on health and social functioning of participants, the response rates were low, and there was a bias toward program completers. The low response rate, combined with the self-selection inevitable in this type of study, is likely to have resulted in a more positive picture than if all program participants had been interviewed. The study also relied on respondent self-report data, with no opportunity for verification of the lifestyle changes reported.

The respondents had a range of motivations for entering the LMPP, with some apparently mainly concerned with improving their court outcome rather than addressing their drug dependency. They also indicated that, on entry, they had a poor understanding of the program and what it would involve. This is not surprising if the program was viewed as a desperate measure to avoid imprisonment, as they may have taken little interest in the program itself. Interestingly, when asked about the positive impacts of the program on their lives, few of the participants mentioned avoiding a prison term or improving their court outcome. Instead they mentioned a range of other outcomes, covering many aspects of their lives, including improved social functioning, improved relationships with others, reduced drug use and greater self-esteem. The follow-up interviews suggest, that at least for those interviewed, the changes they had made were largely sustained.

The satisfaction of respondents with the program was extremely high. The role of the caseworker, as both counsellor and general supporter, was seen as vital to participants' success, and was identified as the most important element. Several respondents suggested that resources should be increased to allow more one-on-one support, including maintaining contact while participants are in residential treatment facilities.

There were mixed reactions to the group sessions, with some seeing them as particularly useful, and others finding them problematic, not useful, and/or difficult to attend. Transport to attend groups regularly was identified as a major problem. There was also mention of the danger of group sessions, as they brought together a group of drug-dependent people, who may encourage each other to use drugs after the meeting.

The respondents made a number of suggestions for improvements including increasing resources for caseworker support; providing support after the program, either with group sessions, case plans, or ongoing individual support; increased rigour of urine monitoring; and modifications to the way in which group sessions are run.

Overall, the majority of interviewed participants reported extremely positive experiences of the LMPP, and would recommend it to others, particularly if they believed the other person was ready to make the commitment and do the work required.

## Chapter 7 – Stakeholder Views of the Lismore MERIT Pilot Program

Stella Patete ‡ and Megan Passey \*

‡ Southern Cross University & Northern Rivers Area Health Service

\* Northern Rivers University Department of Rural Health & Northern Rivers Area Health Service

### Introduction

This chapter will present information obtained from interviews with stakeholders regarding their views of the LMPP and its implementation. The purpose is to identify those aspects of the program which worked particularly well, elements which were critical to its success, and areas for improvement. The stakeholder's perspectives add to those of the participants and help to give a greater insight into the complexities of the program and its effects on participants, providing a depth of understanding to enrich the quantitative data.

### Methods

This qualitative study involved several methodologies – in-depth interviews, informal discussions, participant observation and review of documents. Two sets of interviews were conducted – the first in February 2001, when the program had been running for seven months; and the second in August 2002, when the program had completed two full years of operations. Documents produced by the LMPP were also accessed and reviewed. Finally, the project officer had frequent informal discussions with both LMPP staff and other stakeholders. These discussions, together with personal observations, also informed this chapter.

### Interviewees

In both rounds of interviews personnel directly involved in provision of services to the LMPP participants were interviewed. These included the LMPP staff themselves, Court staff including the Magistrates and clerks, Police officers, Legal Aid solicitors, Probation and Parole personnel, and staff of key health services (the Riverlands Detoxification Unit and Methadone Clinic, and The Buttery Rehabilitation Centre). While participants were sometimes referred to a variety of rehabilitation services across NSW and Queensland, The Buttery was the service most frequently used. A total of 12 people from eight agencies were interviewed in February 2001.

Additionally, in the second round of interviews, staff from a number of local Aboriginal services, (Many Rivers Aboriginal Legal Service, Shared Vision Aboriginal Corporation – Wula Wula Nga, and Rekindling the Spirit) were interviewed to explore issues particular to Aboriginal participants, and to gain an understanding of some of the cultural issues involved. A staff member from NRAHS Mental Health Services was also interviewed to assess interactions between Mental Health Services and the LMPP team. A total of 19 people from nine agencies were interviewed in August 2002. Interviewees are listed in **Appendix F**.

Participants in the program were also interviewed to gain their perspectives. The findings were included in the previous chapter, and where relevant will also be referred to in this chapter.

### Schedule and Procedures

A review of the relevant literature and documents related to the establishment of the LMPP was undertaken. This together with informal discussions with stakeholders informed the

development of standardised interview schedules. Each interview schedule consisted of a core set of questions supplemented by specific questions relevant to the individual's relationship to the program. Questions regarding the individual's knowledge of and experience with the LMPP; its operations; their perception of its progress and achievements to date; any problems or difficulties they had encountered with the LMPP and the extent to which such difficulties had been rectified. Where appropriate, interviewees were also asked about the impact of the program on their agency's operations and resources.

All interviews were conducted in the work setting of the interviewee, in private to encourage open and frank responses. Interviews took 30-45 minutes to complete.

Further discussions have also been conducted with the LMPP manager to clarify and confirm particular issues raised by stakeholders and to identify any subsequent developments related to them.

## ***Data Processing and Analysis***

Interviews were recorded on tape and subsequently transcribed. The transcribed documents were then organised into themes, with grouping of responses from different interviewees. Commonalities and differences were identified, with the results reported below. The observations and informal discussions between the project officer and stakeholders also informed the analysis.

## **Findings**

### ***Program Design Issues***

#### ***Eligibility Criteria***

The inclusion criteria for the scheme were as follows:

- Restricted to adult offenders
- Defendant had a treatable illicit drug use problem
- A suitable treatment place was available
- Defendant gave informed consent to participate

Exclusion criteria from the scheme were as follows:

- Defendants charged at the same time with violent or sexual offences, or with outstanding violent or sexual offences
- Defendants charged with wholly indictable offences, (including indictable drug offences)
- Defendants with other custody arrangements
- Defendants could not be on other court ordered treatment programs
- People who lived outside the catchment area

Most of the stakeholders interviewed, including both legal and health professionals supported the expansion of the current program eligibility criteria, with no-one expressing opposition to this. A more flexible case-by-case approach was preferred particularly in regard to program exclusion for matters before the District Court; and for some levels of minor violence.

Both LMPP staff and legal professionals expressed concern regarding the ineligibility of persons charged under Section 25 of the *Drug Misuse and Trafficking Act 1985* for "on-going supply". This applies when a person is charged with supply of illicit drugs on three or more occasions in a 30-day period. Defendants facing this charge are not eligible for MERIT as the offence is wholly indictable and can only be finalised in the District Court. However, the respondents maintain that, where small quantities are involved and the person is a dependent illicit drug user who is also a street dealer, benefits could flow to both the community and the offenders from their being included in the program. Where frequency of offending behaviour is

directly related to personal use it is likely that engagement in drug treatment would reduce further offending and so these offenders would be highly suited to the MERIT program, assuming they were eligible for bail.

Another issue was the exclusion of persons having current and or outstanding matters related to “significant violence”. The determination of whether a charge involves “significant violence” was made by the Magistrate, taking into account the particular circumstances, as well as the degree of violence. Issues raised focused on balancing the benefits to the individual and the community of engaging these offenders in treatment, against the risks to the staff of the LMPP and other treatment services, as well as the risks to other participants.

Most of the legal and some of the health professionals interviewed supported the inclusion of some participants with current (or outstanding) charges involving minor levels of violence on the basis that the more serious offences make them ineligible for bail. Particular reference was made to those charged with domestic violence offences, or with a current Apprehended Violence Order. To date, some individuals in this situation have been included, and have been as successful as others in completing the program, providing they acknowledge and address their violence issues.

Three of the health staff were concerned about including individuals with a propensity for violence, particularly when referred to the detoxification unit. Their experience was that this group could be particularly disruptive within the unit, impacting on the other patients. The unit did not have the facilities to allow these patients to address their violence or “let off steam”. They were also concerned about staff safety at night, when there are only 2 staff to supervise 16 patients.

Several health staff also pointed out that many of the LMPP participants had themselves been victims of violence, and that being forced to participate in group sessions with perpetrators of violence could be frightening and difficult for these participants. The LMPP staff need to be aware of this possibility and take it into consideration when configuring the group activities.

The Probation and Parole officer claimed that violence issues could be addressed through programs they conduct or refer to. She wanted to see the MERIT program offered to offenders with some violent matters, on the basis that these offenders continue to have problems with drug use and could benefit from the type of intensive intervention offered by the program. These offenders could be jointly case managed by the LMPP and Probation and Parole.

The exclusion of persons having problematic alcohol use was also identified as a gap in the LMPP service. However, several issues would need to be addressed to either include alcohol in the current program design and/or be taken into consideration for a specific MERIT Alcohol program. They include significant increases in participant numbers and therefore the number of caseworkers required, and difficulties associated with excluding violence and sex offences, especially violence, on the basis that consumption of alcohol is a common antecedent to acts of violence. It would also require a substantial focus in addressing issues faced by Aboriginal participants.

**Summary:** The inclusion of people charged with “ongoing supply” is likely to be beneficial. Inclusion of people with minor violence offences is also supported, at the discretion of the Magistrate, with due attention to the circumstances. Where people with a propensity to violence are included in the program, consideration needs to be given to the safety of all health providers, as well as the impact on other participants. While people with problematic alcohol use would likely benefit from a similar program, this would require a number of changes and a considerable increase in staffing.

### ***Program duration***

The length of the LMPP program was intended to be three months, however LMPP staff reported that there is a need for flexibility. Generally participants enter the program at a time of crisis in their lives, “homeless, hungry, owing money”. The team maintain that in order for many participants to engage fully in the program, staff must first spend several weeks working with them to achieve a level of stability from which they can begin to address their drug use.

This may involve detoxification, providing assistance to find suitable accommodation and with meeting other basic needs. Whilst some participants do enter the program ready and willing to engage, the staff reported they are in a minority. Staff felt that this was more likely to occur where participants had stable accommodation, and where their basic needs for food and clothing were being met. Once a participant is relatively stable and has a level of trust with their caseworker, a minimum of three months is required for the program to be effective. The need for persistence was also identified by several staff, who reported that a number of different approaches may need to be tried, before finding the right one for a particular person. This can also affect the time required on the program.

Data on program duration (measured from date of referral to exit date) was presented in Chapter 3. This shows that the mean duration for those who completed the program was 116 days or nearly four months, consistent with staff perceptions.

**Summary:** There is a need for flexibility in program duration, with a minimum of three months from the point when the participant has achieved some stability in their life, their basic needs have been met, and they are engaged with the program.

### ***Program requirements***

Only the LMPP staff were specifically asked about the following program requirements. However, some other interviewees commented on some aspects in response to more general open-ended questions about their perceptions of the programs operations.

### **Urinalysis**

Urinalysis is used primarily as a therapeutic tool rather than for legal monitoring by the Court, and is conducted with participants as an essential part of their therapy. The LMPP staff endorsed the use of urinalysis on the basis that it is a self-monitoring tool for participants; it is a means of positive reinforcement; and it is an objective measure of participants' progress. As noted in the previous chapter, a number of participants found the use of urinalysis by the program was useful to them as it provided proof of their progress and reinforced their participation in the program. Where other attempts to work with participants were unsuccessful due to participant resistance to acknowledging their continued drug use, LMPP staff found urinalysis provided a useful starting point.

The staff stated that it was important to clarify the role of urinalysis with participants at the earliest possible stage. It was considered particularly important that participants understood how and under what circumstances urinalysis information would be provided to the Court. Although "dirty" urines are not reported, abstinence validated by "clean" urines may be reported together with other factors, as an acknowledgement of the participant's progress.

Having urinalysis conducted off-site without direct involvement of the LMPP staff ensured a degree of separation for staff from the process and from manipulation or accusations by participants.

### **Groups**

Lismore MERIT participants are required to attend eight consecutive group sessions during their program. The groups have both an educational and a therapeutic component with a flexible range of topics including: social coping skills; time and financial management; relapse prevention; drug use and its health and social impacts; and anger management. Group content is adapted to provide the maximum amount of benefit for those participants attending. Topics covered in the group sessions are reinforced during individual caseworker/counsellor sessions.

The following issues were identified by LMPP staff, Probation and Parole staff, and Aboriginal stakeholders as having an impact on a participant's ability to attend and participate in groups satisfactorily:

- Low levels of, or a lack of, literacy
- Negative past experiences or trauma associated with educational and other group settings
- Mental health problems

- Lack of social or coping skills resulting in an inability to interact appropriately within a group context
- Past or present conflict with other members of the group
- Having a minority group status such as: a lone female amongst an all-male group; a female who has previously been sexually assaulted in a male-dominated group; or a single Aboriginal participant in a non-Aboriginal group
- Lack of transport

Whilst participation in groups is a mandatory program requirement, flexibility exists when the caseworker recognises that attendance may not be appropriate for that person at that time. Other options such as working through the group topics with their caseworker, attending a relevant group outside LMPP and other arrangements as deemed suitable, are used when necessary.

Although the Lismore MERIT group brings together participants from a local area who might have had conflict and sometimes violence between them, there have been few occasions where it was necessary to move a participant to another group.

### **Home visits**

An initial home visit is conducted as a standard procedure within the first two weeks of a participant commencing their program. Subsequent home visits are at the discretion of the caseworker. Home visits are regarded as an essential aspect of the program providing an opportunity to assess a participant's living arrangements and tailor their individual case plans accordingly. For example, where a participant is in shared accommodation with other drug users, it would be appropriate to support that person to seek accommodation elsewhere and/or to look for other avenues of support for them. Home visits also offer participants an opportunity to relax and discuss issues they are reluctant to raise in the more formal LMPP office setting.

Protocols have been developed to maximise staff safety during home visits. Staff are required to give details of their intended visits to office-based staff and to regularly call the office to report that there were no problems. Ideally two staff attend each home visit, although resources do not allow this in every case. It is however implemented in specific identified cases, based on criminal history and contact with the participant to date.

**Summary:** Urinalysis, attendance at groups, and home visits are all mandatory components of the program, and are considered highly beneficial by the staff. It is important that participants understand the roles that these three elements play. It is also important that there is some flexibility in the implementation of the group programs, taking the participants particular situation into consideration. Attention to staff safety during home visits is crucial.

### **Referrals to the program**

Referrals to the LMPP were possible from a range of sources including Magistrates, Legal Aid solicitors, Many Rivers Aboriginal Legal Service, private legal practitioners, Police, Probation and Parole and self-referral by defendants. As described in Chapter 3, the majority (64%) of referrals to the program were from the Magistrates.

Referrals at court result in a lost opportunity for participants to commence treatment in the period between their arrest date and their first court appearance. Police interviewed stated that targeting potential LMPP participants at the time of arrest was the aim of local Police.

*"...that's when they [arrestees] are most vulnerable and they are most likely going to say 'Well what am I going to do here?' and 'I need help'. Police say we can refer you for assessment now or tomorrow and not three weeks down the track when they go to court. I think we lose, well 3 weeks is a critical time I think in getting those people, so for us that's the most important." Police respondent*

One of the factors impacting on police referral rates was a brief period within the first year of operation of the LMPP, when the program had reached capacity, and Police were advised to

cease referrals until the program could accept them. Unfortunately, police referrals remained low even after they had been advised the program again had vacancies.

Police officers attributed the low referrals at the time of arrest to two factors – training, and the ease of paperwork. They expressed frustration that direction on the referral process to the LMPP hinged upon a brief overview of the program in the Standard Operating Procedures on their corporate intranet, making it only one of many important messages received by Police personnel. Despite this, they felt that local police had a good understanding of the program because most had also received an education package and/or attended a presentation on the LMPP.

The referral system from Police to the program involved completion of loose-leaf forms carried by Police officers in their briefcases, together with other documentation. It was recognised by Richmond Area Command that referrals would be easier if they had a referral pad which could be carried by Police officers in their pockets. A sequentially numbered carbonised referral pad has now been developed and has recently been put into use. However, this is a local initiative only, and has not been used in the state-wide roll-out of the program.

Police have also suggested enhancements to the Police database system to include prompts when they are entering data from their field books. These prompts would include questions related to whether the person meets the eligibility criteria and whether they have been referred. Such amendments are complex and expensive, and the NSW Police have submitted a funding proposal to the Commonwealth to address this issue.

**Summary:** Although referrals are possible from a variety of sources, the majority to date have come from the Magistrates, with missed opportunities for referral at the time of arrest. Appropriate training of Police, and mechanisms to improve the referral process include a carbonised pocket-sized referral book and the possibility of adding prompts to the Police database system.

### ***Working in partnership with other agencies***

The LMPP works closely with local agencies and referral services in the provision of services for their participants. In particular, it has brokered priority access to residential detoxification beds with the Riverlands Detoxification Unit, and beds at The Buttery, a residential rehabilitation facility. Stakeholders reported differing levels of satisfaction with existing inter-agency arrangements. LMPP staff felt that more formal arrangements should be developed between the program and the Police, the Attorney General's Department, and residential drug and alcohol services. They felt that the use of more formalised arrangements and protocols would support the continued credibility of the program.

Court and Police interviewees expressed great satisfaction with the existing level of cooperation and partnership between themselves and the LMPP. These respondents had considerable confidence in the program. They were satisfied with their formal regular program reporting procedures and informal lines of communication with the LMPP management. The program provides a list of all participants to the Police on a weekly basis, with identification of any who have exited the program.

By contrast, staff from drug treatment services receiving referrals from the LMPP, and from Probation and Parole, were less satisfied with the existing levels of cooperation and partnership. They identified a lack of communication and mechanisms to support the flow of information between themselves and the program. Whilst the respondents differed in the kinds of communication matters they would like improved, they shared concerns related to the flow of information between themselves and the program.

Although senior court staff reported that the LMPP worked closely with Probation and Parole, the Probation and Parole officer interviewed in 2002 thought this could be improved. She would like to receive fortnightly updated participant lists for the purposes of monitoring their shared client responsibilities, ensuring the quick identification of participants requiring post-LMPP case management and/or the preparation of pre-sentence reports. It would also increase the opportunities for their caseworkers to confer and network on behalf of their clients.



Staff from NRAHS facilities commented that *“a greater strengthening of the relationship between MERIT [and NRAHS facilities] would benefit both parties, especially the [methadone] service”*. They were keen for caseworkers from both programs to eventually work together on a joint case plan for LMPP participants. NRAHS staff also commented that changes to the LMPP program status of methadone clients, specifically where participants are removed from the program, often has a negative impact on their service and the impact could be reduced if the relevant information was relayed to them beforehand.

*“We need to know straight away when somebody is going to be breached from the MERIT program [as] they often react and the methadone clinic is a good place for them to react because they’ll have a captive audience.. ..the methadone clinic should be aware of that, even if it is for basic security reasons”* Methadone clinic staff member

All staff from residential drug and alcohol services interviewed reported that some of the referrals to them were inappropriate as the participants were either not suitable for their specific programs, or not sufficiently motivated to enter their programs. Some senior NRAHS staff agreed to relax their program entry requirements for LMPP participants when they may not be strictly suitable on the basis that *“they have been assessed prior to coming and we know they are going to have to follow the MERIT program”*. Some clinical staff were particularly concerned about the impact of LMPP participants who come straight from gaol to their facility *“with all those behaviours.... they don’t ‘dog’ [inform on each other] and they stalk around the place with their jail head on”* as these participants require additional supervision and support to enter more fully into their programs. However, it is rare for participants to come straight from custody into the program, as most have been released on either Police or Court bail.

LMPP staff commented that having participants receive intensive support in a residential drug treatment program conducted by another agency allowed more intensive support to be provided to the participants remaining in their care. They also commented on the importance of working closely with other agencies having involvement with their participants to avoid a duplication of services and ensure that the participants’ needs are being catered for.

The Probation and Parole officer expressed confidence in the LMPP and a desire to work in close alliance, to *“somehow meld together ..we are all here for the same purpose”*.

Respondents from Aboriginal support agencies reported that they had received either little or no information about the program and would like to encourage the LMPP to work more closely with Aboriginal agencies and with communities. Issues related to Aboriginal participants are discussed more fully in a later section.

**Summary:** All stakeholders recognised the importance of having close working relationships between the LMPP team and other agencies. In most cases, there was a perception that the relationship could be improved by establishing more formal inter-agency arrangements to address a range of matters including:

- Clarification of agency roles and responsibilities with regard to the management of referred participants
- Clarification of the LMPP requirements and expectations of its participants who are in receipt of referral services
- The establishment of regular inter-agency meetings and forums to facilitate a better working relationship between the LMPP and its referral agencies.

## ***Development of policies and procedures***

The LMPP team maintained documentation on all aspects of their program and its development. Over the first 12 months of the program, the team developed an operations manual, which they have subsequently modified for the state-wide roll-out of the program - Operational Manual for the Magistrates’ Early Referral into Treatment Program (NSW Health, 2002 (a)). The team also developed the MERIT Information Management System (MIMS) and associated Data Dictionary and Collection Guidelines (NSW Health, 2002 (b)), which collects

and summarises all the information required for both internal and external reports. This has also subsequently been implemented across the state. Both the Operational Manual and the MIMS were developed iteratively, with input from the full team and the Steering Committee, thus capitalising on the range of skills and expertise available. The Operational Manual describes all the operations of the program, including the case management model and standardised procedures for referrals and reporting.

Police interviewees commented favourably on the development of these manuals and their usefulness to the implementation and operation of the LMPP and other MERIT programs in New South Wales.

**Summary:** A comprehensive Operational Manual, and computerised information system have been developed, covering the full range of operations and reporting required by the program.

## ***Impact on services***

### ***Police***

Police interviewed maintained that the impact on their service arising from their involvement with the LMPP was both positive and minimal with regard to increased workloads. Some extra work was involved for local senior Police liaising on a regular basis with the program and for officers *'that do the referrals at the point of arrest'*. However respondents felt that the reduced crime figures linked anecdotally with the participation of offenders in the program, more than offset the work of making referrals.

### ***Legal and court***

Whilst some Court respondents commented that there was a small impact upon their workload with regard to the number of adjournments, others felt it had not created extra work. Magistrates interviewed reported that they had not experienced any changes to their judicial role as a result of the LMPP operating in their courts. Respondents from Legal Aid were satisfied with the program and indicated that their usual work on behalf of clients requiring drug treatment referrals was reduced significantly.

### ***Probation and Parole***

Staff from Probation and Parole reported that their workload [ranging from 60 to 100 participants per caseworker] is in many cases reduced as they have less intensive contact with their clients who enter the LMPP than would otherwise be the case. They expressed confidence in the way in which LMPP participants were case managed and believed that this situation allowed Probation and Parole caseworkers to concentrate on their non-MERIT clients until such time as LMPP participants may require further case management.

### ***Health***

Staff from the Riverlands Detoxification Unit commented that extra work was involved integrating some LMPP participants into their drug treatment programs as they were not necessarily ready to engage with the programs.

Staff from outpatient NRAHS facilities claimed that the workload for their caseworkers, who may have up to 60 clients, is reduced for those clients also engaged with the LMPP because they know these clients will be intensively case managed from the beginning of their treatment. As a result NRAHS caseworkers were able to work more closely with their non-MERIT clients.

Drug rehabilitation staff reported they had experienced increases in their workload with LMPP participants accessing their services. These increases involved additional administrative requirements and the extra clinical staff time required to observe and manage the behaviours of LMPP participants on site. Respondents found that in general the character and behaviour of LMPP participants is noticeably different from their non-MERIT clients, and is more disruptive and demanding. They commented that the difference in the entry process between their LMPP clients and non-LMPP clients could both account for differences between these groups and be an important contributing factor to the increases in their workload. While non-

MERIT clients may wait three to four months before they are able to enter the program, during which time they are required to make regular contact with the service, LMPP participants can be fast-tracked into the service, and subsequently staff find their motivation is more difficult to assess. It was also reported that there could be resentment among the non-MERIT clients, because of the ease of access *“and we’ve had comments on many occasions of ‘Well, what do I have to do, do I have to go out and commit a crime to come in?’”*

Clinical staff also believed that some LMPP participants were motivated by reasons other than a desire to address their drug dependency, and that when this occurs program staff need to monitor and minimise their impact upon their non-MERIT clients.

**Summary:** Staff interviewed from all services except AOD services reported a reduction in their workload associated with the program. By contrast, residential AOD services tended to have an increase in their workload associated with managing a more difficult client group than was usual for their service. The brokered detoxification and rehabilitation beds provide the LMPP participants with rapid entry to these services.

## **Resource requirements**

### **Human resources**

LMPP staff noted that their caseloads (an average of 10 participants per caseworker) are necessary for the successful completion of the program for the majority of the participants. They commented that the level of intensity at which the program is currently effective would likely be unsustainable with more demanding staff participant ratios.

*“Particularly good about the program is the intensity of it. It is not one of those programs where they have given the caseworkers a case load which means that service is prohibitive”.* LMPP staff member

The implementation of staff clinical supervision was well received and considered by some program staff to be necessary in this type of work. Prior to clinical supervision being available staff had provided each other with considerable support and peer-supervision. This had been possible, according to their manager, because of the skill mix within the team and their capacity to work well together.

LMPP staff reported that they would like additional training to assist them to work more effectively with participants having mental health problems and the agencies who provide mental health services to them. Additional training in working effectively with Aboriginal participants, local Aboriginal services and communities was also identified as essential. They suggested the addition of an Aboriginal worker to their team on the basis this would encourage Aboriginal offenders into the program and provide support for the program to engage with local communities and agencies more effectively. This idea was strongly supported by other stakeholders, but has not been possible with existing resources.

### **Other resources**

The LMPP staff reported that accommodation, both short and long-term is very difficult to source in the Lismore area and that this situation has a detrimental impact upon their ability to service a large number of the participants. Where a participant's living arrangements are deemed inappropriate, access to more suitable accommodation is considered to be crucial for their progress in the program. The LMPP manager has attempted to address this with relevant agencies, and is involved in a number of committees. The possibility of renting flats or caravans specifically for LMPP participants has also been considered but is beyond current program resources.

Despite the brokered rehabilitation beds with The Buttery, there were times when access to suitable rehabilitation beds was problematic. This was particularly the case for participants with severe mental health problems. The staff stated that there had been occasions when they had been unable to accept these referrals into the program as they could not provide the treatment options required to fully address their needs.

The limited availability of rehabilitation beds and specific services for Aboriginal and female participants, particularly those with dependent children, was also reported by program staff to have negative consequences on their capacity to address issues specific to these participant groups.

**Summary:** Adequate resourcing of the program includes the continuation of manageable case loads, and additional training for staff to meet the needs of Aboriginal participants and those with severe mental health problems. Employment of an Aboriginal worker would greatly enhance the capacity of the program to work with Aboriginal participants and communities. Crucial external resources for the program to operate include adequate access to detoxification and rehabilitation services. Provision of suitable short and long-term accommodation is an ongoing challenge.

## **Overall views**

### ***Perceived positive outcomes***

All stakeholders who have had contact with the LMPP agree that the outcomes achieved by the program indicate it is a valuable addition to the local community, drug treatment services and the Criminal Justice System. Staff from Aboriginal, court, legal, health, police and drug treatment services reported they had observed significant positive changes in the drug use and criminal behaviour of persons known to them professionally who had completed the LMPP program. Respondents from legal services and the Police, who were familiar with drug related activities within the Lismore central business district, had observed a reduction of these kinds of activities. Whilst they did not attribute these changes solely to the LMPP, they were confident that the program had made a significant contribution. Drug treatment clinical staff were supportive of the program and thought it worked well *“at establishing rapport and getting participants out of a pre-contemplative state into actually wanting to do something about their drug use”*.

### ***Aboriginal Participants***

Some LMPP staff and respondents from Aboriginal services were concerned about a lack of direct communication between the program and local Aboriginal services and communities. This was seen as an impediment to the successful participation of some Aboriginal participants. Police and Legal Aid solicitors acknowledged that problematic drug use has become an issue for local Aboriginal communities and their members. A number of these stakeholders thought that having an increased awareness and understanding of both Aboriginal culture and the impact of violence upon contemporary Aboriginal people, could improve the success of the LMPP with Aboriginal participants. They supported increased flexibility with regard to program access by Aboriginal offenders.

Staff from Aboriginal services expressed concerns regarding literacy levels amongst Aboriginal participants and the number of printed handouts they receive. They were also concerned with the cultural appropriateness of the group make-up and encouraged staff to have a greater knowledge of local Aboriginal communities, their existing relationships and issues which might impact upon their members when put together.

### ***Operational Challenges***

Program staff reported difficulties with the interview process for detainees in custody on list days at court, as interviews are conducted in the segregated interview booths available to solicitors. They have found this to be both a difficult and less than satisfactory process for the following reasons: they usually have to wait for an available booth to speak with potential participants by which time they find that the *“person is going to say anything because they want to get out on bail”*; the assessment is often time limited resulting in a very rapid assessment; the rapport needed for a comprehensive assessment is difficult to establish both through the booth glass divide and in the strained environment of the holding cells below court; they are unable to verify with doctors and others information claimed by the potential

participant as there is no access to telephones. This has an impact on the assessment and can result in people being initially accepted who may not be suitable.

The LMPP manager identified that certainty of ongoing funding was an essential element, needed for the retention and recruitment of suitable staff, program planning and the continued success of the program. Uncertainty was a significant problem despite the roll-out of the program across the state.

*"In terms of resources, in terms of office leases, in terms of car leases, in terms of equipment, it's very important to be able to say yes we are going to have funding for the next one or two years".* LMPP Manager

Staff reported that many participants experienced transport and travel difficulties whilst accessing the program. The LMPP program requires participants to attend on a regular basis, sometimes twice weekly and to have regular contact with their caseworkers. Staff also noted that the flexible nature of the program was essential to meeting the needs of participants for whom regular attendance and contact with the program was impeded by the lack of available public transport. Participants of the program claimed that transport to and from the program was the most difficult aspect of their program participation (see previous chapter).

*"Transport is a major problem in this whole area; if you don't have a car your public transport options are very limited and expensive. It is something like \$12 one-way from Ballina to here [Lismore].. if you are on the dole or a pension you can't afford it".*  
LMPP staff member

Access to transport and poor public transport within rural and regional Australia has previously been identified as a significant barrier to health and other services particularly for disadvantaged sections of the population (NSW Ministerial Advisory Committee on Health Services in Smaller Towns, 2000).

LMPP staff reported that female participants tended to have more complex social and health problems than males, making case management more difficult. They reported that females were more likely to have a history of previous physical or sexual abuse, to have started their drug use at an earlier age, and to have more complex family situations. Staff requested additional training to deal with female participants.

**Summary:** Stakeholders from all the key agencies believed the program was having a positive impact and achieving its objectives of reducing drug-related crime and improving the health and social functioning of participants. It was also recognised that the program was less successful with Aboriginal participants, and that more work was needed in liaising with local Aboriginal agencies and communities. The remaining operational challenges faced by the program include difficulties assessing potential participants who are held in custody; funding uncertainty; poor local transport networks; and complexities of working with female participants.

## ***Critical Success Factors***

A number of critical success factors have been identified from interviews with stakeholders, analysis of data, and observations by the evaluation team.

### **Relationship between the senior staff of the critical players – the LMPP, the Court, the Police and the NRAHS**

The involvement of senior staff from these different organisations in the development of the program procedures and ongoing frequent communication and sharing of information, resulted in the development of a close professional relationship based on respect and trust. Senior staff from all these organisations acknowledged the importance of this relationship in generating support for the program and for working through initial teething problems, ensuring rapid responses to identified problems, and refining processes over time.

### **Professionalism of MERIT staff in dealing with the Court and the Police**

Both Police and the court staff commented on the LMPP team's prompt and competent reporting to the Court and notification of breaches to both the Police and the Court. This professionalism earned them the respect of the Magistrates, solicitors and the Police, and was a contributing factor to the support for the program by these groups. Clear and reliable lines of communication between Court personnel and the LMPP team were also important.

### **Adequate resourcing of the program, including brokerage of residential AOD services**

As mentioned above, the case loads of the LMPP staff (10 participants per worker) were necessary because of the degree of chaos, disorganisation and crisis in participants' lives, requiring intensive supervision, counselling and support. The LMPP case workers, unlike case workers in the NSW Drug Court (Taplin, 2002), not only provide case management services (case planning, referrals etc) and general support, but also provide intensive counselling for their clients. The relatively light case loads are seen as vital for provision of the level of support and counselling that the participants need, and a key factor in their successful program completion.

Another aspect of resourcing which was critical to the success of the program, was the brokerage of LMPP-specific beds within the Riverlands Detoxification Unit and The Buttery, a residential rehabilitation facility. This usually ensured availability of these facilities when required. Given the shortage of residential AOD services in rural areas, this was an important element in the program's success.

### **The professionalism and dedication of the LMPP team in working with participants**

The LMPP team consisted of professionals with a complementary mix of skills (Probation and Parole officer, psychologist, DoCS officer, youth worker and registered nurse) providing a range of expertise that was readily accessible within the collaborative working environment of the program. The team was recognised by both participants and other stakeholders as being extremely dedicated. Given the intensity of the work, and its innovative nature, case workers needed considerable support both in discussing difficult case management issues, and in debriefing.

### **Program intensity, structure and flexibility**

LMPP staff, participants, and other stakeholders (Police, Court, Probation and Parole and Health), all identified the intensity of the program as crucial to working through the complex issues with participants and assisting them to successfully complete the program.

The flexibility of the program, both in terms of duration and program requirements, was also considered essential because of the range and complexity of participant needs and the need for several weeks "settling in" period for most participants to achieve some stability before they can start to address their drug dependency issues. The most important program requirement in which flexibility is needed is in attendance at group sessions. A number of participants were unable to attend regularly for a range of reasons both health-related and practical (eg no transport). These participants were sometimes allowed to cover the group topics individually with their case worker, or by attending other groups. This flexibility was seen by case workers as crucial to support participants in making progress.

## **Discussion**

In this chapter we have used interviews with stakeholders, together with a review of relevant documentation and personal observations to assess issues relevant to the implementation of the program and to provide greater insight into its operations. We have identified areas which appear to be working well, critical success factors, and some opportunities for improvement.

One of the limitations of these findings is that, for several of the agencies, only one or two staff were interviewed, and thus the responses may reflect individual opinions rather than those of the group as a whole. However, this is a common situation in qualitative research, and it is worth noting that in this case, there was largely consensus on most issues. Additionally, several of the interviewees mentioned that they had consulted with colleagues prior to the interview, in an attempt to represent the group's views.

Another limitation of this study is the possibility of less than frank responses due to interviewee concern with their views being reported, or a desire to present the program in a favourable light. While this possibility cannot be excluded, a number of methods were used in an attempt to increase the reliability and validity of the findings. These included both informal conversations and observations by the research officers over a two year period, review of documents including reports and minutes of meetings, and clarification of a number of issues with the LMPP manager.

In general, there was broad consensus that the program is working well, and has achieved its objectives of reducing drug-related crime and improving the health and social functioning of participants. Although the program has increased the workload of AOD service staff, and created additional challenges for them in working with the LMPP participants, it has also reduced the workload of some other agencies.

The critical success factors identified by interviewees, were supported by our own observations and analysis. These include issues related to the professionalism and dedication of the staff, relationships between the key players, program intensity and flexibility, and adequate resourcing. All these factors need to be addressed in the broader implementation of the MERIT program across NSW.

Despite the successes, there is still room for some improvement. Suggestions for achieving this are outlined below. However, as the MERIT program is now being rolled out across NSW, any modifications to the model will need to be made at the state level, overseen by the MERIT Statewide Steering Group.

#### **Partnerships and communication**

The development of formal Memoranda of Understanding, outlining the boundaries and responsibilities of each partner are recommended to provide a comprehensive working framework. Possibilities for joint case planning and improving liaison between the LMPP and AOD and Probation and Parole should be explored.

#### **Police referrals at the time of arrest**

There is a need for focused training of Police regarding the MERIT program, including coverage of drug dependency, to encourage referrals at the time of arrest. Changes in referral rates since implementation of the locally developed carbonised referral pad should be monitored, and the pad considered for state-wide implementation. All training programs to date have focused on the procedural aspects of the program, with little coverage of drug dependency issues. It is likely that Police officers would benefit from a greater understanding of drug dependency, and its relationship to offending behaviour. This should be included in any future training programs for Police personnel, including the training currently being provided as part of the state-wide roll-out of the MERIT program.

#### **Post-program support**

Both LMPP staff and participants were concerned that there was inadequate support for participants after completing the program. Although many participants do well while on such a directive program and with close supervision, the short duration of the program means that many have not reached a stage where they can continue to sustain and build on these achievements on their own. Both staff and participants identified a shortage of community-based AOD services as contributing to this problem. This issue could be addressed by including provision of ongoing support to LMPP participants after officially completing the program, but at a less intense level. Another option would be establishing a "Post-MERIT Support Group" in conjunction with other AOD providers.

#### **Meeting the needs of Aboriginal participants and those with concurrent mental health problems**

As discussed above, both Aboriginal people and people with concurrent mental health problems presented a challenge for the program. A number of strategies could be implemented to address the issue, including training in working effectively with Aboriginal participants, local Aboriginal services and communities; employment of an Aboriginal worker;

development of pamphlets and other resources which are culturally appropriate; restructuring of groups, with inclusion of Aboriginal community organisation representatives in groups involving Aboriginal people; and the development of closer working relationships with local Aboriginal legal services. Further staff training in managing participants with mental health problems, and exploration of joint case management, are also recommended.



## **Chapter 8 – An Economic Assessment of the Lismore MERIT Pilot Program**

D.R. Scott and K. Sloan  
Southern Cross University

### **Introduction**

Drug courts have undergone investigations both in Australia and overseas in regard to their efficacy and cost effectiveness. Although a growing majority of studies of drug courts have shown savings, there has been some controversy. For example, in an article published in the University of North California Law Review in June 2000, Judge Morris B. Hoffman wrote, "*Although many studies and many kinds of studies have examined drug courts, none has demonstrated with any degree of reliability that drug courts work.*" (Hoffman, 2000).

Much of the controversy would seem to have resulted from the difficulty in obtaining accurate assessments of the potentially wide range of benefits to be obtained from the drug court procedures. This was highlighted in a recent USA government report, which stated that, "*...obtaining some kinds of data on the behavior and life circumstances of comparison group members as well as on drug court participants...could be extremely difficult.*" (US Department of Justice, 2002).

### ***Aims and objectives of the economic evaluation of the LMPP***

The aim of this evaluation of the LMPP was to undertake a careful analysis of costs and benefits from the program over a one-year period.

The objectives of the economic evaluation were:

- To determine the most applicable method to use in evaluating the economic effectiveness of the program
- To identify the costs and savings elements to be taken into consideration in evaluating the program
- To provide a range of estimates of program evaluations, to allow for aspects that could be directly estimated and those that could not.

In attempting to ensure the validity and availability of data, this assessment has used a known set of persons who have completed the LMPP from the initial cohort of participants and have then been sentenced in court. To overcome the problem with difficulty in obtaining accurate measurements of some potential benefits data, this evaluation has not taken into account a number of possible benefits. However, these have been listed in order to identify such additional potential benefits.

In order to encompass a possible range of results, it has produced three values covering a range of possible quantified benefits from a conservative assessment, where only the direct costs of avoided sentences for the persons who had completed the program were used, to two less conservative cases which also included varying estimates of savings from reductions in criminal activity and hospitalization.

## Economic Assessment Methods

To evaluate the LMPP, two feasible methods of economic assessment were considered. These were cost-benefit analysis and cost-effectiveness analysis. Cost-benefit analysis provides a net benefit or cost of a treatment (in this case, the LMPP) while cost-effectiveness analysis provides an estimation of the cost per unit of effect. Thus, for example, cost-effectiveness ratios could be calculated for reductions in drug use or reductions in crime.

The value of a cost-effectiveness analysis is that it provides a useful method of comparison between different treatment methods. For example, it has often been used to compare the cost per outcome for two different interventions or treatments. However, a cost-effectiveness analysis does not provide an absolute value for the treatment and is therefore seldom used when this type of output is desired.

A cost-benefit analysis does provide an absolute measure of the value of the treatment and is more suited to the assessment of the LMPP. It was therefore decided to use a cost-benefit analysis model for the economic assessment.

### ***The LMPP Costs and Benefits***

For the LMPP, the direct costs that were used were the LMPP costs for the financial year 2000-2001, as provided by the Northern Rivers Area Health Service, with the exclusion of any one-off capital expenditures that would not have been repeated in a continuation of the program.

Possible benefits of drug diversion were identified from studies and reports on drug court assessment programs conducted in other countries. Note that this is by analogy with the LMPP, as Drug Courts are typically more intensive and are targeted at different types of offenders. These studies reflected a range of different benefits. In the USA, potential benefits from drug crime diversion programs were identified as being: re-united families, a criminal justice system freed up to handle violent and other serious cases and an improvement in life circumstances such as education level, acquisition of job skills, employment, income, reduction in reliance on welfare, housing situation, family situation, birth of drug-free babies, and physical health (US Department of Justice, 2002).

Many of these potential benefits could not be assessed for the study of the LMPP either because they required a longitudinal study or because their indirect or intangible nature made accurate measurement impossible. Thus the potential for indirect or intangible benefits from the birth of drug free babies, re-united families, educational level changes; employment and longer-term physical health were not included in the current economic assessment.

More direct benefits have been identified in other studies. Belenko (2000) identified cost saving benefits within the criminal justice system from drug diversion schemes as: incarceration costs, probation supervision, police overtime and other criminal justice costs. Walker (2001) similarly stated that there was *"...general consensus from the evaluations reviewed, that drug courts generate savings in ... jail costs, especially for pre-trial detention, probation supervision, police overtime and other criminal justice system costs."*

In addition to these potential areas of benefits identified from published research, possible benefits from the LMPP were also identified following in-depth discussions with people who had been involved in the delivery of the program.

Based on the foregoing information, the costs and benefits that could be assessed and that were therefore used in the cost benefit analysis of the LMPP are outlined in Table 8.1.

**Table 8.1. Assessable potential LMPP costs and benefits**

LMPP Direct Benefits	LMPP Direct Costs
Gaol and probation supervision costs	Costs of LMPP
Police crime investigation costs	
Hospitalisation costs	
Criminal activity costs	

### **Assessable LMPP Costs and Benefits**

The assessment of the LMPP was based on the costs for a one-year period, namely the financial year 2000 to 2001. The numbers of LMPP completers was similarly based on a one-year cohort of LMPP clients. In order to allow for fluctuations in enrolment from one year to the next, to minimize the possible effect from the timing of the “cut-off” point for the study and to take into account the “start-up” effects of a pilot program, the treatment benefit calculations used the average yearly number of persons who had completed the program as determined from two years of the program’s operation.

It should be noted that some of the persons who partially completed the program may have benefited to some degree from the program in terms of reductions in drug use and consequent reductions in criminal activity, police crime investigation activity and reductions in hospitalisation. These benefits have not been included in the cost benefit assessments. Thus the current assessment, which is based solely on an evaluation of possible savings arising from the LMPP completers, is a conservative estimate.

#### **Direct benefits**

Potential direct benefits were identified in the following areas:

##### **Gaol and probation supervision cost savings**

As indicated in Chapter 4, a sample of randomly selected LMPP completers was assessed by the LMPP magistrate to determine what sentences would likely have been imposed in the absence of their participation in the LMPP. The average per person cost of sentences that would likely have been imposed was calculated for males and females from the sample.

Gaol costs per day detailed in the NSW Drug Court evaluation report by Lind *et al*, (2002) were used, and the NSW daily cost for community corrections from the 2003 report on government services was used for the costs of supervised probation and parole. The costs that were used were as follows:

Male gaol costs - \$170.82 per day  
 Female gaol costs - \$223.03 per day  
 Probation and parole supervision costs - \$8.08 per day

The actual gaol and/or supervised parole sentences imposed by the magistrate on the 39 randomly selected LMPP completers were used to calculate the difference in costs for gaol days and supervised parole days when compared to sentences actually imposed after program completion. The values from the sample of 39 completed cases were then increased proportionately to represent the average yearly number of persons (55) successfully completing the program, based on completion rates for the first two years of the LMPP. The difference between the estimated cost of sentences that would have been imposed and the cost of the actual sentences imposed was determined to be \$1,563,411. This is presented as the gaol and probation savings listed in Table 8.2.

Recidivism levels were not able to be assessed and so savings due to reduced re-offending were not included in the conservative savings case that only evaluated the period up to the post LMPP sentencing of the program entrants.

### **Police crime investigation cost savings**

The LMPP case profile gives some indication of the level of active criminal activity in which the program entrants were engaged, with a mean level of prior offences of 10.5 and with 13 percent reflecting more than 20 prior offences. This level of offending was slightly lower than that of Drug Court entrants, where Freeman (2002) reported that the median number of prior convictions was 12 and the maximum was 62. However, known prior offence levels will not necessarily reflect the level of future criminal activity of the LMPP entrants.

Gebelein (2000) has reported that the rate of offending by drug dependent persons ranged from between 12 and 63 crimes per year, while Stevenson and Forsythe (1998) have reported that the burglars that they interviewed had committed an average of 8.7 burglaries per month with heroin users reporting a higher rate of 12.8 burglaries per month. Based on this information a lower range average level of offending by LMPP clients of 12 crimes per year was used as a "likely" case for the analysis and a maximum number of 63 crimes per year was used for a "potential" case scenario. These levels seemed to represent a reasonable range of possible criminal activity since, on average, 54.1% of the accepted LMPP clients were heroin users, with 22.6% using cannabis and 18.4% using amphetamines. An average net heroin user burglary rate per month based on the difference between the Stevenson and Forsythe burglary rates multiplied by the proportion of LMPP heroin users, would have yielded a value of 26 burglaries per year and with a small allowance for some burglaries from users of other drugs, would have produced a mean value similar to the mean value provided by these two range extremes. As indicated, the two values of 12 and 63 crimes per year were used to derive two levels of cost savings from a reduction in criminal activity, a likely case and a possible case. These evaluations are shown in Table 8.2.

To determine the cost savings, average policing costs for investigating crimes, were derived from the annual police budget. The annual amount of policing expenditure attributable to crime investigation, namely 20% of the policing expenditure (Auditor General's Report to Parliament, 2002), was divided by the annual number of investigated crimes which was derived from the number of crimes against people and property crimes per 100,000 (Auditor General's Report to Parliament, 2002) multiplied by the hundred thousands of population (Australian Bureau of Statistics, 2001). A value of \$48.51 per police investigation was obtained.

The two levels of criminal activity of 12 and 63 crimes per year were multiplied by this cost per investigation and these values were then multiplied by 0.69 - the proportion of LMPP completers who had not re-offended within a 12 month period, and by the yearly average number of 2001 and 2002 LMPP completers (Scantleton and Didcott, 2002). This calculation assumed that this proportion of completers would have ceased all criminal activity for the year under review and that as a conservative estimation, there would have been no reduction in criminal activity by other LMPP entrants. This yielded two possible estimates of police crime investigation savings of \$19,330 and \$114,139 that were used in the likely, and the possible, cost savings cases in Table 8.2.

### **Savings from a reduction in hospitalisation costs**

As indicated in the Chapter on health outcomes, this report has identified a significant change in the SF-36 assessment of health status after entry into the program, including significant improvements in vitality and activity levels. Thus, it is evident that the LMPP does result in improved health for the participants.

Drug treatment also leads to reduced drug use and in consequence to fewer hospital admissions for many health problems. However, not all hospitalisation admissions for drug caused problems such as hepatitis, etc., can be identified from the hospital admission statistics. Data are available for two categories of hospital admissions that relate to costs for the treatment of drug users who were admitted to hospital as a direct result of drug use. These categories cover problems such as withdrawal and drug intoxication. The value of the savings in hospitalisation costs were therefore calculated from the DRG cost weights for Northern NSW using DRG categories 863 "other drug use disorders and dependence" and 861 "drug intoxication and withdrawal", weighted in proportion to the separation numbers in each of the two categories. The resultant DRG cost weight was then multiplied by the average

daily NSW hospitalisation cost and by one fifth of the average number of LMPP completers (Scantleton and Didcott, 2002), based on an assessment by the program management that this was the likely level of direct drug related hospitalisations for drug dependant entrants into the LMPP. This calculation therefore allowed for a single annual admission (separation) for 20% of the LMPP completers. The assessment produced an estimated saving of \$33,576 which was used in both the likely and the possible cost savings estimates shown in Table 8.2.

The overall health improvement of LMPP entrants indicates that there could have been additional reductions in costs for other medical treatments. The current assessment has not been able to estimate savings from a reduction in medical treatments such as visits to private medical practitioners. The assessment has also excluded any estimation of savings in hospitalisation costs from some of the non-completers of the LMPP. The estimate of reduced health care costs should therefore be regarded as a conservative assessment.

### **Savings from reductions in costs of crime**

There is evidence from previous studies that there could be considerable reductions in costs as a result of a reduction in crime. According to Gebelein (2000), in the USA

*"An individual who has an out-of-control addiction commits about 63 crimes a year. If the 200 offenders in Delaware's probation revocation track who comply with all requirements could reduce this to 10 for someone who is in or has completed treatment, and multiplying it, a single drug court may prevent more than 10,000 crimes per year".*

Several UK studies have assessed the costs of crime. Brand *et al*, (2000) reported the average values for crime costs as criminal damage £500, burglaries £2,300, robberies £5,000 and common assault £500, while Dhiri *et al*, (1999) reported somewhat lower costs namely residential burglary victims costs of £1,000 and criminal justice system costs of £500.

In an assessment of overall UK benefits from crime reduction after drug treatment, Jones (1999) reported, "For every pound spent on drug misuse treatment, we save more than three [pounds] associated with the cost of crime."

In addition, it has been shown that some crime levels are linked to drug use, so that French *et al*, (2000) have reported that there is "...a significant linear relationship between criminal activity and frequency of drug use"

In the current assessment, it has been assumed that the typical crime committed by drug dependent persons would have been to obtain household goods for sale to finance their drug habit. The value used to assess the savings from crime reduction was therefore based on a report by Walker (1992) that indicated an average 'break and enter' cost of \$800. This value was not inflated since costs of some electrical goods will have decreased since 1992, while other goods would have increased in cost. It was considered that these variations could have meant that inflation in this area might not have increased at the average inflation level and hence that a conservative approach would be to use the 1992 value. The benefits from crime reduction were therefore calculated as the \$800 cost of break and enter multiplied by the average yearly number of persons who had successfully completed the LMPP and by the two different levels of crime used for the assessment of police crime investigation cost savings namely, 12 and 63 crimes per year. These values were further multiplied by 0.69, which was the proportion of LMPP completers who were found to have not offended within a 12 month period of completion. These values yielded annual savings of \$318,780 and \$1,882,320 that were the values used in the likely and potential cases in Table 8.2.

Stevenson and Forsythe (1998) have reported that heroin users reported a weekly burglary income that was \$2,000 higher than that of non-heroin users. Multiplying this figure by the proportion of heroin users in the LMPP would have produced a higher average burglary income value of \$1,070 per week per LMPP completer and the value of \$800 that has been used should therefore be regarded as a conservative estimate.

## Comparison of Costs and Benefits

Table 8.2 sets out the overall costs and benefits that were identified and the difference between these values. Because of the need for approximations to be made in the case of some of the potential benefits, three cases with differing degrees of conservatism of estimation were included, as a form of sensitivity analysis.

It should be noted that there are intangible benefits relating to crime prevention and community protection that cannot be assigned a dollar value but which are perceived by society generally as extremely important. They are not reflected in the current analysis. As previously indicated, the costs that have been used are based on all clients accepted into the program whereas the estimated benefits relate only to program completers. It is likely that some lower levels of benefits also accrue to at least some non-completers. The current analysis is therefore a conservative estimate of the full benefits of the pilot program.

**Table 8.2. Comparison of costs and benefits**

<b>COSTS</b>			
SALARIES AND WAGES PLUS ONCOST		367,554	
GOODS AND SERVICES *		98,801	
RENT OF PREMISES		30,734	
DETOXIFICATION BEDS		27,880	
RESIDENTIAL REHABILITATION BEDS		50,000	
GP PAYMENTS		12,228	
PURCHASE OF EQUIPMENT AND DEPRECIATION		12,000	
OTHER COSTS WITHIN THE HEALTH SERVICES **		50,000	
<b>TOTAL COSTS ***</b>		<b>649,197</b>	
	<b>Conservative Savings Case</b>	<b>Likely Savings Case</b>	<b>Potential Savings Case</b>
<b>BENEFITS (SAVINGS)</b>			
GAOL AND PROBATION COST SAVINGS	1,563,411	1,563,411	1,563,411
POLICE CRIME INVESTIGATION COST SAVINGS		19,330	114,139
HOSPITALISATION COST SAVINGS		33,576	33,576
SAVINGS FROM REDUCED CRIME		318,780	1,882,320
<b>TOTAL BENEFITS</b>	<b>1,563,411</b>	<b>1,935,097</b>	<b>3,593,447</b>
<b>NET BENEFIT</b>	<b>914,214</b>	<b>1,285,900</b>	<b>2,944,250</b>
<b>RATIO OF BENEFIT TO COST</b>	<b>2.41</b>	<b>2.98</b>	<b>5.54</b>

\* Fuel, light, power, stationery, telephone, security, car leases, transport, pathology, training, accommodation, cleaning, and general administration costs, etc.

\*\* Time of other senior staff and managers, payroll, financial, human resources, information technology, etc.

\*\*\* Capital start-up costs of \$78,703 have been excluded

The costs shown above can be further broken down as follows:

Cost per assessed case	\$3,647.174
Cost per accepted case	\$4,881.18
Cost per completed case	\$11,803.58

## Non-assessed Potential LMPP Costs and Benefits

A number of largely indirect and intangible costs and benefits were identified that were not assessable; some of these were because their assessment required a longer-term longitudinal study. These are listed in Table 8.3.

**Table 8.3. Potential LMPP costs and benefits not assessed**

LMPP Benefits	LMPP Costs
<b>Direct benefits – gains from:</b> Income earned from employment	<b>Direct Costs:</b>
<b>Indirect benefits</b> Reduction in births of drug dependent babies Social service payment reductions -movement of participants to employment from unemployment Reduction in costs to families of visiting persons in prison	<b>Indirect costs:</b> Social rehabilitation – training costs Counselling Aid for housing Aid for food Aid for clothes Reduced gains to customers from purchases of cheap stolen items
<b>Intangible benefits</b> Keep custody of children (reduced care costs) Enhancement of credibility of law enforcement function Family stress reduction Mortality reduction Greater likelihood of obtaining employment due to reduced “prison stigma”	<b>Intangible costs:</b> LMPP staff stress

Although these potential benefits could not be accurately assessed and were therefore not included in the numerical evaluation of the benefits of the LMPP, they represent potentially sizeable benefits. In order to examine the potential size of these benefits, information was obtained from published papers detailing the results of drug court assessments in the USA and UK, where estimates of the values of these benefits have been attempted.

### Indirect Benefits

#### Income earned from employment

A longer study would be required in order to be able to assess this item. For example, Finigan (1998) was not able to determine a value in a study that covered 24 months, as this time was too short. Since the current report has shown a significant increase in vitality and activity in the case of LMPP entrants and a significant reduction in social dysfunction, based on General Health Quality (GHQ), Short Form-36 Health Survey (SF36) and Opiate Treatment Index (OTI) assessments, it should be noted that some benefits would most probably accrue from this item, over time, and that these would represent an increase in potential benefits from the LMPP.

#### Reduction in births of drug dependent babies

Kalotra (2002) reports an estimation of the overall lifetime costs associated with caring for babies that were prenatally exposed to drugs or alcohol as being between US\$ 750,000 to US\$1,400,000 per baby. His paper also listed a host of studies of the costs of different aspects of the costs of care. However, a long-term study is required in order to determine the benefits from reducing the number of births of drug dependent babies. Such a determination would require a time span of 20 years and more. For this reason, no benefit from the reduction in births of prenatally exposed babies was included in this study. However, the reader should be aware of the possible additional unassessed benefits that could arise from this source.

### **Reduction in costs to families of visiting persons in prison**

This is another small potential benefit that could not be assessed. However, the potential benefits from this source were expected to be insignificant in terms of the overall cost benefit assessment.

### **Social service payment reductions - movement of participants to employment from unemployment and reduced long-term unemployment impact**

The assessment of these benefits would require a comprehensive study. However, it should be noted that this source of benefits could represent a considerable increase in potential benefits that might be derived from the LMPP.

### ***Intangible Benefits***

#### **Keep custody of children (reduced care costs) and enhancement of credibility of law enforcement function**

These benefits could not be assessed. An earlier section of this report has identified that there was a significant reduction in anxiety and social dysfunction in the case of entrants into the LMPP and hence potential benefits could exist.

#### **Family stress reduction**

No estimate of this potential benefit was possible without a detailed survey of families. However, Freeman (2002) has stated that there is evidence that the health of drug court participants is improved. This could reduce family stress levels and thus some additional benefits could accrue from this source.

#### **Mortality reduction**

This could not be assessed. However, an earlier chapter of this report demonstrated improvements in health of participants, consistent with the findings of Freeman (2002) in the evaluation of the NSW Drug Court. It should also be noted that it has been reported by Higgins *et al*, (1998) that 640 deaths were identified in 1998 in Australia as having resulted directly from drug usage (other than alcohol and tobacco). Thus there are some potential benefits that could also accrue from mortality reduction.

#### **Greater likelihood of obtaining employment due to reduced "prison stigma"**

This effect could not be assessed and hence no benefit was included. However, it should be noted that this source could provide some additional unquantified benefit from the LMPP.

## **Discussion**

It can be seen that the savings range from the conservative savings case value (where only gaol time and probation supervision cost savings were taken into account), of \$2.41 for every dollar spent, to a possible value of \$5.54 per \$1 spent. These figures appear to fit fairly well with those that have been produced for Drug Court studies in other countries. For example, Finigan (1998) in assessing gaol cost savings as the major benefit, suggested that the Multnomah County criminal justice system was saved \$2.50 per \$1 spent, while, when broader costs such as victimisation and future offending were included, the savings per dollar spent rose to \$10 per \$1 spent.

Some overseas studies have produced a higher ratio of savings as a result of having included a wider range of cost benefits. Gerstein (1994) has been cited by Walker (2001) as having suggested that for Scottish Drug Courts, *"...economic benefits (were) seven times higher than the cost of treatment"*, while in a recent USA study, Fomby and Rangaprasad (2002) have suggested a ratio of benefit to cost of 9.43.

In the United States, the Drug Court Clearing House and Technical Assistance Projects (2003) summary report of Drug Court cost benefits has also listed a number of results of cost benefit analyses, where similarly to this study, the majority of the savings were attributed to savings in "jail" days.



This study has evaluated the effects of the LMPP during its first two years of operation. It is very encouraging that savings are immediately identifiable. This is apparently not always the case and a study by NPC Research Inc and Administrative Office of the Courts, Judicial Council of California (2002), has indicated that there were no savings in the early days of the court's establishment. However, savings were shown to accrue after the first year and the inclusion of victimization costs resulted in a very high return.

The LMPP evaluation has been carried out over a short term and the recidivism data were not considered sufficient to allow for an accurate assessment of the possible future accumulation of savings. It should therefore be noted that such an accumulation should increase the cumulative savings from the LMPP over time.

In addition, the figures that have been used in this assessment are conservative since they are based only on completers of the program, although at least some non-completers are likely to have also benefited to some degree from their participation.

An analysis of the costs of the program shows that the major cost component (56.6%) is personnel costs. The program cost is therefore strongly related to the numbers and skill levels of the personnel that it employs. Based on this, the main area for any cost reduction attempts would probably need to focus on a higher client throughput, or an increased efficiency - possibly by means of a pre-screening of clients.

## Chapter 9 – Review of Legal Issues from the MERIT Program

Steve Bolt\*, Greta Bird# and Kate Lavender#

\* Northern Rivers Community Legal Centre

# Southern Cross University

### Legal Basis of the MERIT Program

MERIT is a pre-plea diversion-to-treatment program in New South Wales for people with an illicit drug problem who are charged with criminal offences. It operates within the jurisdiction of the Local Court. The legal aspects of the program operate under the *Bail Act, 1978*. There are no legislated guidelines for the program. The Chief Magistrate issued a (non-binding) Practice Note on MERIT on 20 August 2002. This Practice Note reflects program arrangements that had been already put in place. It is reproduced in **Appendix G**.

The magistrate, informed by a comprehensive clinical assessment, determines whether or not the defendant meets the eligibility criteria and whether they are prepared to enter into a treatment program to address their drug use. Once the defendant is accepted into the MERIT program the charges laid against them are adjourned. Defendants are bailed by the court on condition that they take part in the treatment program determined by a MERIT caseworker.

Pleas may be entered at any stage, but defendants are not required to plead before the conclusion of their involvement in the program.

### Methodology

The purpose of the legal review is to consider those legal issues that have arisen out of the operation of the LMPP and related issues that appear in the research of comparable schemes.

The methodology of the legal review included a literature review, qualitative data drawn from semi-structured interviews with key stakeholders and use of relevant quantitative data compiled by LMPP staff.

A review of the literature established the major issues involved in drug crime diversion schemes. The issues derived from the literature primarily devoted to United States Drug Courts of various types were confirmed as major issues by key stakeholders. These issues related to:

- the voluntary/coerced nature of offenders' entry into treatment
- the changed roles of legal and health professionals in diversion schemes
- the underlying principles behind a shift from adversarial to "therapeutic jurisprudence"
- the arguments for and against a legislative basis for diversion schemes
- criteria for eligibility into the programs and the criteria for measuring the outcomes of the diversion programs
- the various forms drug diversion programs could take and the strengths and weaknesses of these models from the perspective of the criminal justice system

Semi-structured interviews were conducted with members of five stakeholder groups:

- Magistrates
- Defence solicitors (Legal Aid, Aboriginal Legal Service and private practitioners)
- Police prosecutors
- MERIT officers
- Police officers

Twenty-three interviews were conducted.

Note that all informants were based in the Northern Rivers region of NSW and were commenting on the Lismore MERIT Pilot Program.

## Comparison with Other Diversion Schemes

The MERIT program is one of a number of diversion schemes for drug offenders with drug problems. Indeed, there are a number of quite different diversion schemes in NSW for other categories of offenders. These were described in **Appendix A**.

Other NSW drug crime diversion schemes – the Drug Court, the Youth Drug Court, the cannabis cautioning scheme - operate on the basis of the participant either pleading guilty (or admitting guilt), or after being found guilty. The pre-plea nature of MERIT has the advantage that treatment can begin before the participant's first court appearance. Although the time delay until the first appearance is generally no more than a few weeks, it may be critical to provide access to treatment at a time when the participant is willing to consider change, rather than risk a loss of resolve by the participant from even a relatively short postponement.

Lismore MERIT therapeutic staff report that as a consequence they feel less pressured by participants to discuss the allegations made against them, or the fairness of the penalty consequences, compared to post-plea interventions. The perceived advantage is that therapeutic staff are more readily able to focus on working with participants to address their drug use. It may also minimise potential defensiveness and hostility of participants.

On the other hand, postponing the determination of guilt and/or the imposition of appropriate punishment could be seen as adding to the difficulties of investigating police and prosecutors in preparing their cases in contested matters (although the very large majority of defendants do eventually plead guilty, so contested cases are rare), and delaying resolution for the victims of offences.

From the legal structural point of view, MERIT *could* operate as a post-plea program with little or no other change to its parameters, provided that access to treatment continued to be permitted before plea, and sentencing was postponed until the program was completed or otherwise terminated. Conditional bail can be continued after a plea of guilty and before sentencing.

## Legislative Base

Unlike the Drug Court, the MERIT program does not have its own separate legislative base. The legal framework for the MERIT program is in effect established by the *Bail Act* (especially s36A). Being granted bail is a precondition for entry to MERIT, and satisfactory participation in the MERIT treatment program is a condition of bail continuing.

The eligibility criteria for MERIT – for example, covering the types of offences suitable for referral, or those which are not – are not legislated. Nor is there any explicit provision, other than the Practice Note, that sentencing should take account of the defendant's degree or quality of participation in the program.

There are positive and negative aspects of underpinning a program with a legislative base. Additionally, there is much socio-legal research about the implications of providing a legislative base for a government program (Bird 1992).

Stakeholder arguments for providing a legislative base include that legislation provides evidence of the government's commitment to MERIT. It would offer an added degree of protection against the program's abolition or resource cuts. Requirements for implementing the program (for example eligibility criteria) can be clearly laid down. Non-compliance with a legislative provision offers the possibility of judicial review of individual decisions. Having a specific legislative basis for MERIT could encourage higher levels of accountability through greater scrutiny by Parliamentary committees, Members of Parliament, the media and the public.

Those in favour of legislation argue that the effectiveness of legislation does not lie solely in the attainment of goals but in the broader educative and symbolic role it can play in the community (Bird 1992, p229). In other words legislation can be part of building a consensus in areas that have elements of controversy, such as the desirability of a program which might be seen as allowing drug offenders to avoid punishment.

Arguments against providing a specific legislative base include that legislation is prescriptive and may prove too inflexible to deal with the issues arising from a new program. One of the advantages of flexibility is that long term evaluation studies of the outcomes of new programs, and experience gained by those working in the program over time, can allow for the redefinition and refinements of programs in a way that may be hampered by a strict legislative framework.

Some stakeholders argued that legislation was unnecessary because the program is working well without it. The *Bail Act* (especially section 36A) provides sufficient legal certainty and support.

### ***Possible Forms of Legislative Base***

If a legislated base were favoured, it could be done in either of two ways:

- Specific legislation could be introduced to provide a legislative foundation (a "MERIT Act"), or
- MERIT could be regulated under the *Criminal Procedure Act 1986*. Recent amendments to this Act (a new Part 9 introduced by the *Crimes Legislation (Criminal Justice Interventions) Act 2002*) provide a general framework for the making of regulations to cover particular diversion programs and the like.

Either form of legislative base could address matters such as eligibility criteria, the impact on sentencing of participation in the program, the rights and obligations of MERIT participants, and the evidentiary admissibility of information obtained for therapeutic purposes.

Depending on the scope of the content of any legislative base that may be introduced for MERIT, the current Practice Note *could* become redundant.

### ***Criminal Procedure Act***

If a legislated base for MERIT were to be introduced, regulation under Part 9 of the *Criminal Procedure Act* would be the more convenient mechanism. However, in the Act's present form, it would preclude some presently eligible defendants (eg those charged with drug supply whose matter was being heard at the Local Court) from MERIT, as explained in the following paragraphs. It would also limit the capacity (without legislative amendment) to extend MERIT eligibility to juveniles and those charged with ongoing supply.

Part 9 of the *Criminal Procedure Act* contains a number of provisions. Section 175 allows for regulations to be passed to "declare" programs to be "intervention programs" for the purposes

of the Act. The same section allows for regulations to address an extensive list of issues, including matters such as eligibility criteria, the nature of treatment offered, the role of individuals and organisations within a program, and the conduct or operation of a program. An “intervention program” can include a program to “promote the treatment of or rehabilitation of offenders or accused persons” (s175(2)), which clearly would include MERIT.

The *Criminal Procedure Act* provisions are intended to complement s36A of the *Bail Act*. Section 36A provides that bail may be granted on condition that the defendant agrees to undertake an assessment of their suitability for, or to participate in, an intervention program “or other program for treatment or rehabilitation”. “Intervention program” is defined (in s36A(7)) to have the same meaning as in the *Criminal Procedure Act*. Bail conditions under the section can also require assessment for, or participation in, treatment or rehabilitation programs which are *not* declared as “intervention programs”, so it is not essential to have MERIT covered under the *Criminal Procedure Act*.

Subsection 176(1) provides that offences which can be dealt with under an intervention program are summary offences or indictable offences which may be dealt with summarily. This is consistent with the existing coverage of MERIT.

Subsection 176(2) lists a number of offences which *cannot* be dealt with under an “intervention program”, including malicious wounding and assault occasioning grievous bodily harm, sexual assault, stalking, offences involving the use of a firearm and other offences prescribed by regulation. Current arrangements for MERIT preclude offences which involve “significant violence”, but there is no specific list of excluded offences. This illustrates one disadvantage of legislating for eligibility: s176(2) would not allow a magistrate to assess whether the degree of violence alleged against a defendant charged with one of those specific offences amounts to “significant violence”.

Another point of concern is that s176(2)(f) precludes offences involving drug supply (of any quantity) from being suitable for an intervention program. Drug supply offences are presently included as suitable for MERIT and a significant number of successful MERIT participants are charged with supply. Paragraph 176(2)(f) also explicitly precludes offences involving cultivation of a commercial quantity of prohibited plants - presently redundant because such offences are wholly indictable, and s176(1) prevents those charged with wholly indictable offences from being eligible for an intervention program - and the offence of drug supply on an ongoing basis (also presently redundant as the offence is wholly indictable, but discussed further below).

Similarly, s177 prevents juvenile defendants from being referred to an intervention program. The possible inclusion of juvenile defendants in MERIT is also discussed below.

If MERIT were to be declared as an intervention program under the *Criminal Procedure Act 1986*, an amendment to s176(2)(f) should be considered to allow defendants facing drug supply charges to be eligible. If such an amendment were not possible, then it would be preferable to continue MERIT without a legislative base to allow such defendants to have continued access.

It may also be desirable to amend s176(2) to allow a magistrate an overriding discretion to allow a defendant charged with one of the otherwise prescribed offences to be referred to an intervention program if the charge does not involve an allegation of significant violence.

### **Option**

**Legislation to underpin MERIT is not essential. However, if it is introduced, it should address eligibility criteria, the impact on sentencing of successful participation, and indemnity from prosecution where any evidence of drug use is obtained from therapeutic drug testing procedures, or from admissions made by participants.**

**If a legislated base is supported, the convenient option would be to make regulations for MERIT under Part 9 of the *Criminal Procedure Act 1986*. However, that Act would**

**require amendment to allow defendants charged with drug supply offences to be eligible for MERIT.**

**Consideration should also be given to amendments to the *Criminal Procedure Act* which would allow a Court discretion to refer a defendant charged with an otherwise prescribed offence, if the allegation does not involve significant violence; and to amendments to allow juvenile defendants to be referred to an intervention program.**

## Bail Act

Eligibility for bail is a criterion for entry to MERIT. Should suitability for MERIT be a criterion for the grant of bail? To do so would represent a fundamental departure from the existing scheme. One of the key design features of MERIT is that it is available only to those defendants who otherwise qualify for bail, and are therefore in the community, not in detention. This is an effective method of denying potential MERIT eligibility to defendants charged with more serious offences, or with more significant criminal histories.

There is one sentence in the Practice Note which could be construed as implying that suitability for MERIT could influence the decision whether to grant bail. At clause 10, after indicating that bail may be granted while awaiting an assessment report from a MERIT worker, the Practice Note says: "Alternatively, the defendant may be remanded in custody awaiting the outcome of the assessment report."

The criteria to be considered in bail applications are set out in section 32. One of the matters that needs to be taken into account under that section is "the protection and welfare of the community". In considering this aspect the court may have regard to "the nature and seriousness of the offence, in particular whether the offence is of a sexual or violent nature or involves the possession or use of an offensive weapon or instrument." So the bail decision operates, among other things, as a filter for MERIT.

Where bail is refused, the defendant is held in custody on remand until the case is finalised. Prisoners on remand who have an illicit drug problem may be able to access corrections-based treatment programs.

Participation in MERIT is made a condition of bail. This is provided at Clause 10.1 of the Practice Note, which recommends conditions requiring compliance with directions of the MERIT Team.

Section 36A of the *Bail Act* represents a legislative clarification on the conditions that can be imposed on a grant of bail. Where a magistrate is of the opinion that the person would benefit from undergoing assessment, treatment or rehabilitation for drug or alcohol misuse, the magistrate may grant bail on the condition that the person agree to subject themselves to assessment, and enter into an agreement to participate in a drug or alcohol treatment or rehabilitation program.

A breach of bail conditions (in MERIT or in the criminal justice system generally) is not an offence and does not attract punishment in itself. Where a breach of bail conditions is alleged, the defendant can be brought before the court, and if the breach is established, bail is reconsidered. If the breach is serious enough, the court can revoke bail, so that the defendant is held in custody until the charges are finalised. Alternatively, additional or different conditions can be imposed. In the MERIT context, persistent or wilful failure to comply with program requirements *could* result in the defendant being remanded in custody (as well as termination from the program).

Recent amendments to the *Bail Act* - via the *Bail Amendment (Repeat Offenders) Act 2002* - have the effect of restricting eligibility for bail for "repeat offenders" and those who have committed offences while previously on bail. While the impact of these amendments cannot yet be quantified, it is safe to assume that the result will be an overall decrease in the number of defendants who are granted bail. One consequence of these changes (and any further

measures to restrict access to bail), will very likely reduce the potential population eligible for MERIT.

### **Option**

**The Chief Magistrate could be asked to consider a review of the Practice Note for the purpose of clarifying that the decision making on eligibility for bail should precede consideration of eligibility for MERIT.**

## **Eligibility Criteria**

The criteria for eligibility for MERIT set out in the Practice Note include that “the offences must be related to a serious drug problem” (clause 8 (ii)). There is no attempt to assess or grade the seriousness of the defendant’s drug problem in quantitative terms, but the degree of seriousness is given some practical definition in the subsequent Practice Note criterion that the defendant must have a “demonstrable and treatable drug problem” (clause 8 (iv)).

The extent to which offending is “drug-related” has been given a broad interpretation. While there are some classes of offences which exclude the defendant from eligibility – wholly indictable offences (which must be finalised in the District Court or Supreme Court), sexual assault or offences involving “significant violence” (clause 8 (iii)) - there is no set of offences which are explicitly *included* as suitable for MERIT.

There is no requirement for any causal link to be investigated or established between the offending behaviour and the drug use. MERIT participants are not just charged with drug offences (such as drug possession or supply) or property offences motivated by a desire to obtain funds to buy drugs. Some of those who seek and/or accept referral to MERIT are no doubt taking advantage of an opportunity for treatment for their drug problem, without feeling any causal connection between their drug use and their current charge.

Some MERIT participants may also be innocent of the offence charged. As the Practice Note states (at clause 6), “entry into the program is not dependant on the person’s guilt or innocence”.

As a result, the range of charges for Lismore MERIT participants is quite broad. This feature is a strength of the scheme and should be retained. Some of the referring charges may not be obviously related to the defendant’s illicit drug use. One implication is that the defendant may be generally “criminal” or “deviant” apart from their illicit drug use. Where this is true, this would limit the extent to which MERIT will reduce “non-drug related offending”.

Two specific issues arise. The first is whether the target group for the program should be more narrowly focussed on those defendants who have minimal previous criminal history (which leads to questions about how to accurately and consistently define the qualifying group), or perhaps even be limited to first offenders. The Drug Summit Plan of Action suggested that the target group for MERIT would be people facing relatively minor charges and not already entrenched in offending. In fact, some participants in MERIT with more than minor criminal histories have successfully completed the program, without creating any apparent strain on the resources available or causing any concern to staff or other MERIT participants. Limiting the qualifying criteria further would arguably exclude the great majority of Local Court defendants and would be arbitrary. Why just first offenders? Or those with only two prior convictions? Or three?

The second specific issue is whether additional classes of offence ought to be excluded from MERIT eligibility. It might be thought that certain charges - such as drug supply - should be excluded totally from MERIT, perhaps as representing too great a threat to the other participants. This could be seen to run counter to the presumption of innocence.

More significantly, it is very common that a dependent drug user will also be a small-scale dealer. Offering treatment to minor drug suppliers can have broad benefits to the community

in removing sellers from illicit drug supply networks, by addressing their motivation to sell drugs.

Where the matters charged are not serious enough for the prosecution to elect to have them heard on indictment, and the defendant has had a comprehensive assessment for drug problems (to ensure that treatment may benefit them), then there seem to be no good policy grounds for excluding them from MERIT.

As well, experience to date with Lismore MERIT is that a number of people facing supply charges have completed the program very successfully.

## ***Violence Offences***

The Practice Note excludes from eligibility for MERIT defendants charged with offences involving allegations of “significant violence”.

This reflects public policy concerning community safety and the seriousness of violent behaviour, making such defendants unsuitable for diversion.

The safety of other participants and MERIT staff, or the staff of other services to which a MERIT client may be referred, should also be considered. There is a duty to take reasonable care to provide them with a safe workplace, where they can perform their duties without fear of or having to deal with a violent client. The MERIT Program is not specifically directed at dealing with such behaviours and those in need of attention for their violent behaviours may not be able to receive suitable or sufficient treatment.

In practice, the determination of whether a particular charge involves “significant violence” is made with regard to the particular circumstances. It is recognised that there are degrees of violent conduct – including for offences such as assault, where violence is a central element. Decisions are made on a case by case basis. Less weight is given to the precise offence charged than to the alleged features of the offence.

Such decision making on MERIT eligibility echoes the very similar issues raised in determining bail where violence is involved. Section 32 (1) (c) of the *Bail Act* requires courts to take account of the “nature and seriousness of the offence, in particular whether the offence is of a sexual or violent nature” when determining bail.

## ***Option***

**Continuation of the present arrangements where the magistrate determines, for MERIT eligibility purposes, whether an offence involves “significant violence” on the basis of all relevant material before the Court, is supported.**

## ***“Ongoing Supply” Offences***

Another eligibility issue concerns defendants charged with the offence of “ongoing supply” under section 25A of the *Drug Misuse and Trafficking Act 1985*. This section creates an offence of supply of illicit drugs (other than cannabis) for reward on three separate occasions in a 30 day period. Defendants facing this charge are not eligible for MERIT because the offence is wholly indictable. It can only be finalised in the District Court.

Some stakeholders argue that the program should be expanded to include defendants charged with this offence. These defendants are typically drug dependent, non-violent and deal in small quantities of illicit drugs in order to support their own use. It is argued that the community would be better served by diverting them into a treatment program, rather than the significant prison term a conviction would normally attract (assuming that successful completion of MERIT would substantially reduce the penalty imposed).

The number of prosecutions under this section is quite small, so including defendants facing this charge would not have a dramatic impact on MERIT resources.



Alternatively, the offence could be re-classified as *not* wholly indictable by adding them to Table 1 or Table 2 of the *Criminal Procedure Act 1986*. This would mean that these cases would be dealt with in the Local Court unless the prosecution or defendant elected otherwise (if made a Table 1 offence), or unless the prosecution alone makes an election (if made a Table 2 offence).

### ***Option***

**Consideration could be given to extending the eligibility requirements of the MERIT scheme to include people charged under section 25A of the *Drug Misuse and Trafficking Act 1985*. Alternatively, this offence could be re-classified as not wholly indictable by being added to Table 1 or Table 2 of the *Criminal Procedure Act 1986*.**

### ***Juveniles***

A number of stakeholders support the eligibility criteria being extended to include juveniles. Those who supported this extension stated that the need for early intervention was pressing, not only in the immediate legal situation of young clients, but to prevent their drug use and related problems becoming entrenched.

The possibility of juveniles becoming acculturated into more serious and/or harmful drug use through mixing with older experienced users on the program is an important factor to be recognised.

A number of stakeholders believed that a program similar to MERIT should be set up in the juvenile justice system. This would enable the program to be specifically tailored for the special needs of young persons.

It is noted that there are several legislative impediments to the extension of MERIT to juvenile defendants. One impediment is that s177 of the *Criminal Procedure Act* provides that a person is not eligible to be referred to an “intervention program” if they are facing charges under Part 3 of the *Children (Criminal Proceedings) Act 1987* – that is, if they are in the Children’s Court.

Further, under s36A(6) of the *Bail Act*, a court cannot impose conditions on the young person’s bail to require either assessment for, or participation in, an “intervention program”. There is no difficulty with conditions requiring assessment for or participation in a drug treatment program which is *not* an “intervention program”. Thus, if MERIT is “declared” to be an “intervention program” under the *Criminal Procedure Act*, then juveniles cannot participate (unless their participation was done without it being made a condition of their bail, which would somewhat undermine the broader structure of court-supervised treatment).

### ***Option***

**Young offenders could be deemed eligible persons for the purposes of the MERIT program.**

**Alternatively, a variation of MERIT could be specifically designed for dealing with juvenile defendants.**

**If MERIT is to be regulated as an “intervention program” under the *Criminal Procedure Act*, then amendments to the *Criminal Procedure Act* would be necessary to allow participation by juvenile defendants.**

## **Sentencing**

There are a number of sentencing objectives: among them are deterrence, rehabilitation, restitution, support for victims, proportionality of punishment and the promotion of community safety. These objectives cannot usually be given equal weight in any particular case.

The factors that influence the sentence are connected to the seriousness of the offence and the defendant's prior history, their general character, their contrition and their prospects for rehabilitation. There are sentence discounts for early pleas of guilty. Reports made by professionals such as social workers and health workers, and evidence given by employers, family and friends may be used by the magistrate or judge in deciding the type of sentence to hand down.

The Practice Note (at clause 13.1) says:

*On sentence, the successful completion of the MERIT program is a matter of some weight to be taken into account in the defendant's favour. At the same time, as the MERIT program is a voluntary opt in program, its unsuccessful completion should not, on sentence, attract any additional penalty.*

In addition, some legislative support for an entitlement to favourable sentencing consideration can be found in s21A *Crimes (Sentencing Procedure) Act 1999*. Section 21A(3) provides a list of factors which can be taken into account in mitigation. One of those factors is that the offender has "good prospects for rehabilitation" (s21A(3)(h)).

How much weight should be given to successful participation in MERIT when sentencing offenders? Some stakeholders would prefer a clearer or more predictable guideline (such as a fixed discount) in sentencing, but others felt it would reduce flexibility. Some felt it could encourage more passive compliance with the program – that is, meeting minimal demands but not really taking part. Most stakeholders prefer that the positive sentencing benefit of completion of MERIT should be addressed case by case.

Some MERIT participants, even after successful completion, will subsequently receive a prison sentence. Should defendants who are very likely to be sentenced to prison terms be allowed into MERIT? Perhaps the first point is that pre-judging the likely sentence – especially for a magistrate considering referral to MERIT – can be unwise. Further, most prison sentences are short (three months or less) and the treatment effects would still be beneficial on release to the community. One of the aims of MERIT is to address drug use and offending in the bail period. There is still that benefit even for those who may go to prison post-program.

On the other hand, should a person who declines the offer of referral to MERIT, or who fails to complete the program, have this fact used against them in sentencing? It is clear from the administrative arrangements and the Practice Note that non-acceptance of referral to MERIT, or "failure" to complete MERIT, should not lead to a more severe sentence than if the person had not agreed to take part. It is a point which could be covered in (and arguably reinforced by) any framework legislation that might be introduced for MERIT. However, this is not sufficient reason in and of itself to require such legislation.

### ***Timing of Plea***

Defendants are not required to enter a plea until they leave the program. For sentencing purposes, there is no disadvantage for any delay in pleading caused by participation in MERIT. A defendant who pleads at the court appearance after conclusion of the program can be considered to have pleaded at the first available opportunity, which entitles the defendant to the maximum sentencing benefit for pleading guilty.

However, pleas can be entered at any stage before the conclusion of the program. A defendant could even be referred to MERIT *after* a plea has been entered with any sentencing deferred until the conclusion of the program.

## **Therapeutic Jurisprudence**

A recent shift from the adversarial justice model is towards what has been called "therapeutic jurisprudence" (Hora *et al*, 1999). In therapeutic jurisprudence there is a partnership between health and legal professionals and the alleged offender. Hora *et al* argue that Drug Treatment Courts and similar diversion schemes allow the application of therapeutic jurisprudence

theory. This model of justice requires changes in the roles of legal and health professionals in the criminal justice system.

Therapeutic jurisprudence involves the idea of the justice system not just punishing the offender, but also addressing the “causes” of crime in order to prevent re-offending. This is consistent with one of the traditional goals of sentencing – promoting the rehabilitation of the offender. The shift towards therapeutic jurisprudence represents the Court accepting a closer role in supervising the process of rehabilitation, rather than delegating the supervision of the process to other agencies (prisons or Probation and Parole).

Where a 'therapeutic jurisprudence' approach is taken, legal and health professionals have to adopt new roles and acquire new skills. Judges and magistrates must relinquish their traditional objective role and develop new expertise, understanding harm minimisation policy and drug use behaviour patterns.

Drug diversion programs usually involve more contact between the magistrate and defendants than ordinary criminal trials. The magistrate, using the power and authority of the court, provides the problematic drug user with the incentive to stay in treatment, while the treatment provider concentrates on the treatment itself.

MERIT is an example of the emerging therapeutic jurisprudence. However, the distinctive features of MERIT make direct comparison with other (particularly US) models unreliable. MERIT provides for only relatively weak judicial intervention, in comparison with the NSW Drug Court or Drug Courts in various jurisdictions in the United States. MERIT will involve at most one or two more appearances before the magistrate than the usual Local Court case. The US Drug Court programs are typically very different in terms of target group, the high level of intensity and longer duration of interventions as well as the intensive degree of judicial involvement. The NSW Drug Court involves closer judicial intervention over a longer period – twelve months or more.

MERIT is designed to operate flexibly. The extent to which an individual magistrate involves themselves at review hearings in praising or admonishing participants for their performance in the MERIT program is a matter for each magistrate. The level and style of their intervention is no doubt affected by the magistrate's willingness to play such a role, the skills they have or believe they have, and the length of the court list they are required to process.

## **Restriction on Use of Therapeutic Information**

The practice of MERIT staff in preparing court reports is to *not* provide the court with detailed information on the results of urinalysis. Urinalysis is used as therapeutic tool, to provide positive reinforcement to participants and as an objective measure of their progress in the program.

Whether such information could or should be received as evidence is legally open. Under section 138 *Evidence Act 1995 (NSW)* a magistrate has the discretion to not admit evidence which has been illegally or improperly obtained. Arguably, that could include evidence from urinalysis obtained from the defendant during a treatment program.

Alternatively, if there were to be legislation introduced to provide a foundation for MERIT, then this is a matter that should be included in such legislation to put the matter beyond judicial discretion.

Section 179 of the *Criminal Procedure Act* – one of the potential legislative bases for MERIT - provides that regulations may be made to address the disclosure of information obtained through an intervention program, including the admissibility of any information obtained or admission made.

## Is Coercion Justified?

*'The uncertain results of treatment for heroin dependence must temper our enthusiasm for a whole-hearted embrace of treatment under coercion as the solution for problems of recidivism, infectious disease transmissions and prison overcrowding.'* (Hall 1997, p107)

If the drug treatment is coerced as part of a criminal justice sanction, in many instances it would be arguably more intrusive and restricting of the individual, and operate over a longer period, than a non-therapeutic penalty. MERIT is intended to provide only a short term intervention, with supervised treatment generally limited to 12 weeks (in practice it can sometimes last longer). MERIT is not 'coerced' – participants must agree to the treatment proposed for them.

MERIT participants *opt in* to the program, and can withdraw at any time without penalty. They have access to independent legal advice – either from Legal Aid or private solicitors - about the likely penalty which would be imposed *without* agreeing to participate. Yet entry into the MERIT program is not voluntary in a strict sense because the defendant lacks power when confronted by the power of the court, and there is an incentive offered (sentencing leniency) for participation. The defendant gives consent to participation in the program in what is generally termed a 'constrained choice' situation.

From the point of view of the therapeutic outcomes, entry by constrained choice may be as successful as purely voluntary entry into treatment (Hall, 1997).

## Duration of the MERIT Program

A key issue for MERIT staff is the 12 week duration of the program. For many participants, this is too short a time to significantly address their drug use. There is a concern that many participants will discontinue treatment even after a successful completion of the program. If the program were to be longer, then many participants would continue in treatment for longer, improving the chances of lasting rehabilitation.

On the other hand, increasing the length of the program means greater investment of court time in supervising participants, longer delays in resolving the criminal matters charged (with potential negative effects for victims as well as "the system"), and longer subjection of the participant to criminal justice supervision. If a longer program caused participation to be seen as too burdensome, it would act as a disincentive to potential participants.

## Conclusion

In recent times there has been a shift from an adversarial criminal justice system to one of 'therapeutic jurisprudence' with elements of 'restorative justice.' The MERIT program fits well with these developments. It aims to reduce potential future offending by treating defendants' drug use. Interviews with key stakeholders have established that the LMPP is rated positively.

Stakeholders saw the development of a partnership between legal and health professionals as an extremely positive aspect of MERIT. They also commented favourably on the pre-plea aspects, the flexibility of the program, the dedicated beds, and the intensity of supervision of the defendant. The health benefits to the defendant were more highlighted than the reduction in offending as the health effects are more readily apparent and easier to quantify.

Some stakeholders expressed approval for a shift to a more 'compassionate' criminal justice system. Stakeholders were divided on the desirability of establishing a more specific legislative framework.

### *Evaluation of the Lismore MERIT Pilot Program*

People connected to MERIT, both legal and health professionals, are supportive of it and want to see it continued. They are positive about diverting problematic drug users away from a purely criminal justice regime to a treatment based regime backed up by the authority of the courts.



## Chapter 10 – Final Discussion and Conclusions

Megan Passey\*, Stella Patete‡, John Vail†, Lyndon Brooks#, Don Scott#, Keith Sloan#

& Steve Bolt§

\* Northern Rivers University Department of Rural Health & Northern Rivers Area Health Service

‡ Southern Cross University & Northern Rivers Area Health Service

† John Vail Consulting, #Southern Cross University, § Northern Rivers Community Legal Centre

The Lismore MERIT Pilot Program (LMPP) was successfully implemented for two years from July 2000. Although originally planned as a 12 month pilot, this period was extended, and following initial promising results (Linden 2001; Reilly *et al*, 2002), the MERIT Program is now being rolled out across NSW. During the first two years of operation, the LMPP recruited 238 participants for 266 program episodes, with the majority of those referred accepted to the program, and half of those entering the program successfully completing it. The processes and outcomes of this endeavour have been evaluated using a number of different studies, and the findings presented in this report.

### Evaluation Challenges

The evaluation of interventions involving multiple organisations and institutions is challenging, as these initiatives are implemented within already complex systems and structures. This issue has been previously identified in an evaluation of collaborative initiatives in Australia (Pirkis *et al*, 2001), and in a review of drug court evaluations in the United States (Belenko, 2002). An initiative such as the LMPP has a myriad of potential benefits to the participants, their families and to society as a whole. While these cannot all be identified, and certainly not all can be measured, we have attempted to capture a range of possible outcomes of the LMPP by undertaking a series of studies, utilising a mix of methodologies, both qualitative and quantitative.

In this report the different chapters have presented the findings of these studies. The data routinely collected by the LMPP and entered onto their database has been analysed to provide a profile of the participants and of the program processes. A number of different outcomes have been assessed, including both health and social functioning, and court sentences and subsequent recidivism. An economic analysis has been undertaken to assess the costs and benefits of the LMPP, and a review of the legal issues of the program has been presented. We have also used structured interviews with a range of stakeholders, including the participants themselves to attempt to gain greater insights into the workings of the program, the perceived benefits and challenges, and to gain a picture of the participants own experiences. The qualitative and quantitative data have largely corroborated each other, and the initial reports on the program (Linden 2001; Reilly *et al*, 2002).

In undertaking this evaluation there have been a number of difficulties, and the limitations of the methods must be acknowledged when considering the findings. The limitations of each of the studies have been identified and discussed in the relevant chapters. However, the main ones are presented here briefly. For the outcomes studies, the ideal design would have been to conduct a randomised controlled trial. This would have allowed development of a comparable control group with which to assess the impact of the intervention. However, this would have needed to be built into the design and implementation of the program, and was thus not possible. We attempted to build a comparison group of similar offenders to assess recidivism. Unfortunately this proved unsuccessful, and hence the assessment of the impact of the program on recidivism is limited to a comparison between program completers and non-completers. The evaluation of the impact of the program on health and social functioning utilises a before and after design. Another limitation of the study of health and social functioning was the low recruitment rate, with the majority of respondents being program

completers. Although the respondents were broadly similar to all program participants on most variables, they were significantly more likely to be program completers, and thus the findings should be considered to be more reflective of the impact of the program on completers than on non-completers. Finally, for the economic evaluation, it was not possible to determine all the benefits accurately, particularly those anticipated in the future.

## **Conclusions**

The overall picture of the participants of the LMPP is one of a group of people with complex social and health problems, some of which derive from their drug dependence, and many of them with substantial prior criminal histories. The participants were predominantly male, unemployed, users of multiple different classes of illicit drugs, with heroin as the most common principal drug of concern. This picture is consistent with the picture emerging from other drug courts both in Australia (Briscoe *et al*, 2000; Freeman 2002; Heale *et al*, 2001) and in the United States (Belenko 1998; Belenko 2001; Turner *et al*, 2002). The LMPP has, in large part, risen to the challenge of meeting the needs of this group through a combination of good management, a highly professional and dedicated team of case workers, and forming sound working relationships with key partners. Below we answer some questions emerging from the evaluation of the program.

### ***Is the program acceptable to potential participants and other key stakeholders?***

Evidence from both the program monitoring and from interviews with participants and other stakeholders strongly suggests that the program is both acceptable and well supported. Of the 368 assessments of potential participants undertaken, 287 were successful and resulted in an offer of a place on the program. Of these, only 21 (7.3%) declined the opportunity. Additionally, 33 of those who entered the program were self-referred, indicating that the program was attractive to these people.

The majority of participants interviewed, even those who did not complete, were satisfied with the program, with several claiming that it had changed their lives. Overall, while many participants entered the program primarily in the hope that it would improve their court outcomes, others were motivated by a recognition of the need to deal with their drug problem. Additionally, several of those who were primarily seeking to avoid a gaol sentence, later recognised that the best outcome was in fact the improvement in their social functioning and life skills, and the reduction in their drug use. Interviewees also reported that despite some initial “bad press” on the streets, the LMPP has become widely known and is generally well-regarded within the gaol and user networks.

Although overall the LMPP appears to be acceptable to potential participants, there were some elements of the program which were contentious. Urinalysis is used primarily as a therapeutic tool rather than for legal monitoring by the Court, and is conducted with participants as an essential part of their therapy. Although “dirty” urines are not reported, abstinence validated by “clean” urines may be reported together with other factors, as an acknowledgement of the participant's progress. Some participants disliked the urine testing, while others found it useful as an objective measure of their personal progress. Group sessions were another contentious area, with some participants finding them very useful, while others found that they either learnt nothing new, or were upset at having to associate with people they considered to be “hard core heroin addicts and full on criminals”.

The stakeholders interviewed, including magistrates, court staff, solicitors and legal support personnel, Police officers, AOD staff and the LMPP staff themselves, all overwhelmingly supported the program and believed it was having a beneficial impact on the participants. Although some were initially sceptical, the professionalism of the LMPP staff and the rigour of the program, combined with the changes in the participants, convinced the sceptics of the value of the program.



### ***Has the Lismore MERIT Pilot Program reduced drug-related crime?***

The assessment of recidivism using Police charges as the indicator of reoffending shows that those who complete the program are less likely to reoffend, and take longer to reoffend than those who do not complete the program. This holds true, for both “drug, theft and robbery offences” and for “all offences”, even when other factors associated with recidivism are controlled for, including prior offending and previous incarceration. Given that many of the completers entered the program as recidivist offenders it is highly likely that it is the program, not a chance finding, which has caused this. This reduction in reoffending is supported by changes in the Criminal Activity score of the OTI, which relies on participant self-report of any criminal activity, not just those detected. More importantly, it is also corroborated by key stakeholders including both Police and legal personnel, who have known many of the participants for some time. Their comments regarding the turn-around displayed by some of the participants are most encouraging, with a marked decline in the number of arrests and of Police intelligence reports, for program completers.

### ***Has the Lismore MERIT Pilot Program improved the health and social functioning of participants?***

Both the interviewed participants and key stakeholders indicated that for many participants, and especially for completers of the program, there are substantial improvements in health and social functioning. Participants reported reduction in drug use, or sometimes complete abstinence; improved life skills; improved relationships with family, especially children; more positive attitudes and greater self esteem. Key stakeholders interviewed, particularly AOD staff and Police, agreed with these claims.

These comments are corroborated by findings from the health outcomes study, which indicates that for program completers there are significant improvements in health and social functioning, with a greater impact on psychological health than physical health. For program completers there was also a reduction in the numbers of classes of drugs used, and a reduction in the use of heroin as the principal drug of concern. These outcomes are measured using validated self-report instruments (OTI & SF-36).

### ***Did the Lismore MERIT Pilot Program work better for some participants than for others?***

There is evidence to indicate that the LMPP works better for some participants than others. The analysis of characteristics associated with program completion found that there was a lower completion rate for Aboriginal participants than for non-Aboriginal participants. Some of the issues identified which may contribute to this were low literacy among this group (and use of written handouts in the program), the composition of the groups, with Aboriginal participants often being the only Aboriginal in the group, and poor communication and liaison with Aboriginal legal agencies. It is particularly important that the needs of this group are met, as they were over-represented among participants, relative to the general population, and there is evidence of higher rates of illicit drug use by Aboriginal youth than non-Aboriginal youth (Siggins Miller Consultants and Catherine Spooner Consulting, 2002). There was no evidence that Aboriginal peoples were less likely to be accepted into the program, if referred and assessed, and no data available to assess differential referral rates. The lower rate of completion among Aboriginal participants has been recognised by the LMPP staff. It was evident however that efforts to retain Aboriginal participants often led to “bending the rules” more so than for their non-Aboriginal counterparts. Some greater flexibility in program requirements for Aboriginal peoples may be indicated. Other suggestions are discussed below.

There were lower rates of completion among those who identified heroin or amphetamines as their principal drug of concern, than among those who identified other drugs. This may reflect greater drug dependency and more severe social and health problems. There was a higher

completion rate for people living in privately owned accommodation, compared to any other living situation. This may reflect greater stability in the lives of these participants, particularly compared to those living in hostels, caravan parks or those who are homeless. The higher completion rate may also reflect exposure to more stable social supports among this group. These factors may make it easier for them to comply with the program requirements.

Males were more likely to be considered ineligible to participate, but were marginally more likely to complete the program (not statistically significant). The most common reason for being classified as ineligible was that the person had no demonstrable illicit drug problem; with charges for violence or sexual offences being another common reason. LMPP staff felt that in general, their female clients tended to have more complex social and health problems, which impacted upon their drug use and made them a more “difficult” person to case manage. Female participants also identified lack of access to child care as a problem for meeting the program requirements. Although the LMPP did facilitate and pay for child care where it was considered warranted, it may be able to negotiate better access to child care for program participants in the future. Additionally, there are few residential AOD services available for women with children.

The LMPP staff also felt that participants with severe mental health problems were disadvantaged, as they were sometimes excluded from the program due to a lack of suitable residential detoxification and rehabilitation beds available for them. While only 4 people were identified as being ineligible because of mental health problems, others may not have been referred for assessment because it was recognised that there weren’t adequate facilities to meet their needs within the program setting. Some of the staff also expressed the need for more training in dealing with dual diagnosis issues.

The issues identified here resonate with the findings of Taplin (2002) in the evaluation of the NSW Drug Court. She reported that Aboriginal offenders were disproportionately excluded from the program because of previous violent offences; and that women and people with concurrent psychiatric disorders were also disadvantaged.

### ***Are the costs of the LMPP adequately offset by the benefits?***

Yes, an assessment of the costs and benefits of the LMPP for the financial year 2000-2001 indicates considerable savings from implementation of the program. The assessment was based on cost savings from lower levels of incarceration, police crime investigation, hospitalisation and reduced criminal activity costs for program completers. Three cases were examined to allow for a possible range of costs for police crime investigation and criminal activity. A potential ratio of benefits to costs of between 2.41 and 5.54 to the \$1 was determined, with a conservative estimate of an annual net benefit of \$914,214 for a yearly average of 55 LMPP completers, or \$16,622 per completer.

A number of indirect and intangible benefits could also have accrued as a result of the program. Values could not be determined for these potential benefits, which were therefore not included in the current assessment. Additionally, the figures that have been used in this assessment are conservative as they are based only on completers of the program, although at least some non-completers are likely to have gained some benefit from their participation.

It is encouraging that savings are immediately identifiable, as this is not always the case. A study by NPC Research Inc and Administrative Office of the Courts, Judicial Council of California (2002), indicated that there were no savings in the early days of the court’s establishment. However, savings were shown to accrue after the first year and the inclusion of victimization costs resulted in a very high return.

### ***What are the key legal issues evident from the Lismore MERIT Pilot Program?***

The legal review undertaken as part of this evaluation identified a number of legal issues which could be addressed. These are outlined below. However, it is important to note that there were no critical issues identified.

There are no legislated guidelines for the program. The Chief Magistrate issued a (non-binding) Practice Note on MERIT on 20 August 2002. The question of whether specific legislation should be introduced was raised, with the conclusion that legislation to underpin MERIT is not essential. However, if it is introduced, legislation should address eligibility criteria, the impact on sentencing of successful participation, and indemnity from prosecution where any evidence of drug use is obtained from therapeutic drug testing procedures, or from admissions made by participants.

The MERIT program operates within the legal framework of the *Bail Act, 1978* and in particular section 36A, which allows bail to be granted on the condition that the defendant enters treatment to address their drug use.

Eligibility for bail is a criterion for entry to MERIT. Should suitability for MERIT be a criterion for the grant of bail? To do so would represent a fundamental departure from the existing scheme. One of the key design features of MERIT is that it is available only to those defendants who otherwise qualify for bail. This is an effective method of denying potential MERIT eligibility to defendants charged with more serious offences, or with more significant criminal histories. There is one sentence in the Practice Note which could be construed as implying that suitability for MERIT could influence the decision whether to grant bail. The Chief Magistrate could be asked to consider a review of the Practice Note for the purpose of clarifying that the decision making on eligibility for bail should precede consideration of eligibility for MERIT.

The Practice Note excludes from eligibility for MERIT defendants charged with offences involving allegations of “significant violence”. This reflects public policy concerning community safety and the seriousness of violent behaviour, making such defendants unsuitable for diversion. The safety of other participants and MERIT staff, or the staff of other services to which a MERIT client may be referred, should also be considered. In practice, the determination of whether a particular charge involves “significant violence” is made with regard to the particular circumstances, with recognition that there are degrees of violent conduct. Decisions are made on a case by case basis. Less weight is given to the precise offence charged than to the alleged features of the offence.

Such decision making on MERIT eligibility echoes the very similar issues raised in determining bail where violence is involved. Section 32 (1) (c) of the *Bail Act* requires courts to take account of the “nature and seriousness of the offence, in particular whether the offence is of a sexual or violent nature” when determining bail. Continuation of the present arrangements where the magistrate determines, for MERIT eligibility purposes, whether an offence involves “significant violence” on the basis of all relevant material before the Court, is supported.

Another eligibility issue concerns defendants charged with the offence of “ongoing supply” under section 25A of the *Drug Misuse and Trafficking Act 1985*. Defendants facing this charge are not eligible for MERIT because the offence is wholly indictable. However, it is likely that these people and society would benefit from their participation in MERIT. Consideration could be given to extending the eligibility requirements of the MERIT scheme to include people charged under section 25A of the *Drug Misuse and Trafficking Act 1985*. Alternatively, this offence could be re-classified as not wholly indictable by being added to Table 1 or Table 2 of the *Criminal Procedure Act 1986*.

A number of stakeholders would support the eligibility criteria being extended to include juveniles. A range of possible solutions were considered. Young offenders could be deemed eligible persons for the purposes of the MERIT program. Alternatively, a variation of MERIT could be specifically designed for dealing with juvenile defendants. If MERIT is to be regulated as an “intervention program” under the *Criminal Procedure Act*, then amendments would be necessary to allow participation by juvenile defendants.

## ***What were the critical success factors for the Lismore MERIT Pilot Program?***

A number of critical success factors have been identified from interviews with stakeholders, analysis of data, and observations by the evaluation team. These factors need to be considered in the roll-out of the program throughout NSW, and in the implementation of similar programs elsewhere.

### **Relationship between the senior staff of the critical players – the LMPP, the Court, the Police and the NRAHS**

The involvement of senior staff from these different organisations in the development of the program procedures and ongoing frequent communication and sharing of information, resulted in the development of a close professional relationship based on respect and trust. This degree of respect and trust was crucial in generating support of all the organisations for the program and for working through initial teething problems, ensuring rapid responses to identified problems, and refining processes over time. The establishment of steering committees or working parties involving senior staff from the key agencies to develop a detailed implementation plan, refine processes and oversee operations, is recommended when the program is implemented elsewhere.

### **Professionalism of MERIT staff in dealing with the Court and the Police**

The LMPP team were recognised for their prompt and competent reporting to the Court and notification of breaches to both the Police and the Court. This professionalism earned them the respect of the Magistrates, solicitors and the Police, and was a contributing factor to the support for the program by these groups. Clear and reliable lines of communication between Court personnel and the LMPP team were important. The Operations Manual developed by the LMPP (NSW Health Department, 2002) includes a section on Court procedures and reporting. Adequate training in these areas is considered crucial to the successful implementation of the program elsewhere.

### **Adequate resourcing of the program, including brokerage of residential AOD services**

The case workers on the LMPP had light case loads (10 participants per worker) relative to other services such as Probation and Parole or case managers within the Area Health Service, who can have as many as 60 clients per worker. However, these other case managers have far less expected of them in terms of intervention requirements. The 1 in 10 ratio for LMPP case workers, was seen as necessary because of the degree of chaos, disorganisation and crisis in the participants' lives, requiring intensive supervision, counselling and support. The LMPP case workers, unlike case workers in the NSW Drug Court (Taplin, 2002), not only provide case management services (case planning, referrals etc) and general support, but also provide intensive counselling for their clients. The light case loads are seen as vital for the provision of the intensity of support and counselling that the participants need, and a key factor in their successful program completion. The vast majority of participants interviewed identified the case worker as the "most useful" aspect of the program, and indicated that the extent to which they were able to rely on their case worker was a critical aspect for them. They also see the case workers as coming from a less threatening "health" perspective, than may be the case when dealing with corrections and/or justice staff.

Another aspect of the resourcing which was critical to the success of the program, was the brokerage of LMPP-specific beds within the Riverlands Detoxification Unit and the Buttery, a residential rehabilitation facility. While the LMPP participants sometimes caused difficulties within these facilities, the brokerage ensured availability of these facilities when required. Given the shortage of residential AOD services in rural areas, this was an important element of the programs success.

### **The professionalism and dedication of the LMPP team in working with participants**

The LMPP team consisted of professionals with a complementary mix of skills (Probation and Parole officer, psychologist, DoCS officer, youth worker and registered nurse) providing a range of expertise that was readily accessible within the collaborative working environment of the program. The team was recognised by both participants and other stakeholders as being

extremely dedicated. Given the intensity of the work, and its innovative nature, case workers needed considerable support both in discussing difficult case management issues, and in debriefing. A system for clinical supervision was implemented, and a case management model and standardised procedures for referrals, reporting and other activities was developed using the combined expertise of the team, and incorporated into the Operations Manual (NSW Health Department, 2002). Ongoing personal support for debriefing, as well as training in the case management model, and continued clinical supervision are necessary to support case workers in their difficult and demanding role.

#### **The program intensity, structure and flexibility**

LMPP staff, participants, and other stakeholders (Police, Court, Probation and Parole and Health), all identified the intensity of the program as crucial to working through the complex issues with the participants and assisting them to successfully complete the program. As described above, the case workers play a key role in the success of the program, and the case load of 10 participants for each case worker is considered ideal for provision of this degree of support.

Many clients have also reported that on review, they believe that the structured nature of the program, in which they were required to adhere to minimum standards with regard to maintaining appointment times, attending groups, attending referrals to other agencies and being available for home visits, as a key factor in their successful completion of the program. They identified this structure as lacking in the traditional community based drug and alcohol programs where there is no compulsion to participate.

The flexibility of the program, both in terms of duration and program requirements is considered essential because of the range and complexity of participant needs and the need for several weeks "settling in" period for most participants to achieve some stability before they can start to really address their drug dependency issues. The program completers had a mean duration on the program of 116 days, which is nearly four months, compared with the intended program duration of three months, and one participant was on the program for 245 days before successfully completing it. The most important program requirement in which flexibility is needed is in attendance at group sessions. A number of participants were unable to attend regularly for a range of reasons both health-related and practical (eg no transport). These participants were sometimes allowed to cover the group topics individually with their case worker. This flexibility was seen by case workers as crucial to support participants in making progress.

#### ***How could the Lismore MERIT Pilot Program be improved?***

While it is clear that overall the LMPP has been successful and is working well, there are a number of opportunities for improvement. These should also be considered in implementation of similar programs.

#### **Partnerships and communication**

The LMPP staff, and staff of other agencies believed that more formal arrangements and protocols between the program, and the local Police Command, the Court and the AOD services would support the credibility of the program and would clarify roles and responsibilities. They also suggested that more regular interagency meetings between workers and joint case planning (between LMPP and AOD & Probation and Parole staff), would improve the working relationship between agencies and the outcomes for the participants. AOD staff were particularly concerned about the informal communication and poor flow of information about shared clients. Similar issues have been identified in other drug courts, where informal communication mechanisms were perceived as a problem by treatment providers (Turner *et al*, 2002).

The development of formal Memoranda of Understanding, outlining the boundaries and responsibilities of each partner are recommended to provide a comprehensive working framework. Possibilities for joint case planning and improving liaison between AOD and LMPP staff should be explored.

### **Police referrals at the time of arrest**

The LMPP was designed as an early intervention program, with the expectation that many of the potential participants would be referred by Police shortly after arrest. However, the referral data indicate that the majority of participants in the LMPP were referred by the Magistrate, with only 11% were referred by Police. Police officers have expressed concern at the inadequate training received and the perceived lack of commitment to the program at Police Headquarters. They also report that the information they have received on the MERIT program is lost among the many communications about operational matters that they receive each week. The Richmond Area Command have developed a carbonised referral pad which has recently been introduced in an attempt to increase referrals at the time of arrest.

LMPP staff were also concerned at the delay in referrals, believing that better outcomes could be achieved if the participants were referred at the time of arrest, as this is a critical point when they are most susceptible to treatment.

There is a need for focused training of Police regarding the MERIT program, including coverage of drug dependency, to encourage referrals at the time of arrest. Changes in referral rates since implementation of the locally developed carbonised referral pad should be monitored, and the pad considered for state-wide implementation. All training programs to date have focused on the procedural aspects of the program, with little coverage of drug dependency issues. It is likely that Police officers would benefit from a greater understanding of drug dependency, and its relationship to offending behaviour. This should be included in any future training programs for Police personnel, including the training currently being provided as part of the state-wide roll-out of the MERIT program. Additionally, consideration should be given to enhancements to the Police database to include prompts for MERIT referrals. Both the training and any modifications to the database will need to be adequately resourced.

### **Post-program support**

Both LMPP staff and participants were concerned that there was inadequate support for participants after completing the program. Although many participants do well while on such a directive program and with close supervision, the short duration of the program means that many have not reached a stage where they can continue to sustain and build on these achievements on their own. Both groups identified a shortage of community-based AOD services as contributing to this problem. The data on use of drug treatment services presented in the Health and Social Functioning Outcome study indicates that, among respondents, there was a decline in the number in treatment after leaving the program, with 70% in treatment at the exit interview, but only 53% in treatment at the follow-up interview a few months later. This issue could be addressed by including provision of ongoing support to LMPP participants after officially completing the program, but at a less intense level. Another option would be establishing a "Post-MERIT Support Group" in conjunction with other AOD providers.

### **Meeting the needs of Aboriginal participants and those with concurrent mental health problems**

As identified above both Aboriginal people, and people with concurrent mental health problems presented a challenge for the program: Aboriginal people are less likely to complete the program if accepted; and those with mental health problems are less likely to be accepted onto the program because of a lack of suitable treatment facilities. A number of strategies could be implemented to address the issue, including training in working effectively with Aboriginal participants, local Aboriginal services and communities; employment of an Aboriginal worker; development of pamphlets and other resources which are culturally appropriate; restructuring of groups, with inclusion of Aboriginal community organisation representatives in groups involving Aboriginal people; and the development of closer working relationships with local Aboriginal legal services. Further staff training in managing participants with mental health problems and exploration of joint case management, are also recommended.

## ***What are the outstanding challenges for the LMPP?***

There remain a few challenges faced by the LMPP which are outside their control, but impact upon their work. These need to be acknowledged in the ongoing program implementation, and in the state-wide roll-out.

### **Availability of external AOD services to refer to**

Despite brokerage of beds at residential detoxification and rehabilitation facilities, the LMPP continues to face shortages of suitable residential treatment places. In particular there are difficulties finding suitable places for Aboriginal people, participants with children and people with significant mental health problems. However, with the roll-out of the MERIT program across the state, brokerage for an additional 70 rehabilitation beds has been negotiated and this should help address the problem. There is also an ongoing shortage of community-based AOD workers within the NRAHS, both for additional support during the program, if needed, and for post-program treatment and support.

### **Transport**

The absence of low-cost, reliable public transport presented a considerable barrier to participants involvement in the program. Finding transport to attend group sessions or other program activities was the major difficulty identified by participants in meeting the program requirements, and was also an issue identified by LMPP staff, and highlights the need for flexibility in program requirements. The lack of communal and public transport in rural areas has been recognised as a significant barrier to people accessing health services generally (NSW Ministerial Advisory Committee on Health Services in Smaller Towns, 2000).

### **Housing**

As with transport, shortages of appropriate low cost housing, half-way houses and crisis accommodation are common problems in rural areas. For the LMPP staff, finding appropriate accommodation is an on-going challenge, particularly for participants who are living with other drug dependent people, or experiencing other difficult domestic situations such as violence and abuse.

## **Final Remarks**

The LMPP appears, on the whole, to have been successfully implemented with the evaluation findings suggesting it has achieved its intended outcomes. It is a model which, if adequately resourced, and with due attention to the issues raised in this report, can be implemented in other areas. Any modifications to the program should be implemented consistently across the state, and overseen by the MERIT Statewide Steering Group, with adequate funding for support and training.

It is important to recognise the voluntary “opt-in” nature of the program, and that the program is designed to target individuals who, while not necessarily in the “action” stage of change, are nonetheless willing to participate in the intervention. Its success cannot therefore simply be translated to the total eligible offending population. Equally, its success does not detract from the need for later and more intensive programs such as the NSW Drug Court. It is also important to recognise that the participants of the LMPP were mostly recidivist drug-dependent offenders, and the expectations of the program must be realistic. When considered in this light, and considering the short-term nature of the intervention, the achievements to date are remarkable, and a credit to all the contributors to the program.





## References

- Adelaide Magistrates Court *Magistrates Court Diversion Program* ([http://www.courts.sa.gov.au/courts/magistrates/program\\_information.pdf](http://www.courts.sa.gov.au/courts/magistrates/program_information.pdf) Accessed 7 August 2002).
- Ali, R., Christie, P., Lenton, S. et al. (1999) *The Social Impacts of the Cannabis Expiation Notice Scheme in South Australia* (NDS Monograph No. 34), Commonwealth of Australia, Canberra.
- Anglin, M., Prendergast, M. & Farabee, D. (1998) The effect of coerced drug treatment for drug-abusing offenders. *Paper presented at the Office of National Drug Control Policy's Consensus Meeting on Drug Treatment in the Criminal Justice System: March 23-25, 1998, Washington, D.C.*, Office of National Drug Control Policy, Washington DC.
- Auditor General (2002) *Report to Parliament, Volume Five, NSW Police*, [http://www.audit.nsw.gov.au/agrep02v5/361\\_NSWPoliceService.pdf](http://www.audit.nsw.gov.au/agrep02v5/361_NSWPoliceService.pdf), viewed 20 March 2003, pages 231-238.
- Australian Bureau of Statistics (2001) *Population Census Data at August 8, 2001*, <http://www.abs.gov.au/Ausstats/abs%40census.nsf/4079a1bbd2a04b80ca256b9d00208f92/c2cebc310689361fca256bbe008371f3!OpenDocument/CensusCounts>, viewed 20 March 2003.
- Belenko, S. (1998) Research on drug courts: a critical review, *National Drug Court Institute Review*, 1:1-42.
- Belenko, S. (2000) *Statement to the Subcommittee on Criminal Justice, Drug Policy and Human Resources, Committee on Government Reform*, National Center on Addiction and Substance Abuse at Columbia University, Oversight Hearing, Drug Treatment Options for the Justice System, United States House of Representatives, April 4. <http://www.house.gov/reform/cj/hearings/oo.04.04/Belenko.htm>.
- Belenko, S. (2001) *Research on Drug Courts: a Critical Review 2001 Update*, National Centre on Addiction and Substance Abuse, Columbia University.
- Belenko, S. (2002) The challenges of conducting research in drug treatment court settings. *Substance Use and Misuse*, 37:1635-1664.
- Bird, G. (1992) "Access and Equity as a Legislative Option", in Jupp, J. and McRobbie, A. (eds), *Access and Equity Evaluation Research*, Department of the Prime Minister and Cabinet, AGPS, Canberra.
- Biven, A. & Ramsay, M. (1999) *Drug Diversion Programs - the South Australian Experience Paper presented at the Australasian Conference on Drugs Strategy, Adelaide*. Adelaide.
- Brand, S. and Price, R. (2000) *The Economic Costs of Social Crime*, Economics and Resource Analysis Research, London, Home Office: Development and Statistics Directorate, 217.
- Briscoe, S. & Coumarelos, C. (2000) *New South Wales drug court: Monitoring report (Crime and Justice Bulletin, No. 52)*, NSW Bureau of Crime Statistics and Research, Sydney.
- Briscoe, S. & Doak, P. (2000) *Drug court of New South Wales: Monitoring report*, NSW Bureau of Crime Statistics and Research, Sydney.
- Carrington, P. J. (1998) Changes in police charging of young offenders in Ontario and Saskatchewan after 1984, *Canadian Journal of Criminology-Revue Canadienne De Criminologie*, 40, 153-164.

- Carrington, P. J. (1999) Trends in youth crime in Canada, 1977-1996, *Canadian Journal of Criminology-Revue Canadienne De Criminologie*, 41, 1-32.
- Collins, D. & Lapsley, H. (2002) *Counting the cost: estimates of the social costs of drug abuse in Australia in 1998-9*, Monograph Series No. 49, Commonwealth Department of Health and Ageing, Canberra.
- Coumarelos, C. & Weatherburn, D. (1995) Targeting intervention strategies to reduce juvenile recidivism, *Australian and New Zealand Journal of Criminology*, 28, 55-72.
- Darke, S. & Ross, J. (2000) Heroin-related deaths in regional New South Wales, 1992-96, *Drug and Alcohol Review*, 19, 35-40.
- Darke, S., Ward, J., Hall, W., Heather, N., Wodak, A. (1991) *The Opiate Treatment Index (OTI) Manual*. National Drug and Alcohol Research Centre.
- Dembo, R., Williams, L. & Schmeidler, J. (1993) Addressing the problems of substance abuse in juvenile corrections, In: Inciardi, J. (Ed.) *Drug treatment in criminal justice settings*, pp. 97-126, Sage Publications, Newbury Park, CA.
- Dhiri, S. and Brand, S. (1999) *Analysis of Costs and Benefits: Guidance for Evaluators in Crime Reduction Programmes*, Goldblatt, P. (ed) London, Home Office: Research Development and Statistics Directorate, 39.
- Drug Court Clearing House and Technical Assistance Projects (2003) *Cost Benefits Reported by Drug Court Programs*, US Department of Justice, Office of Justice Programs, Drug Courts Program Office. <http://www.american.edu/justice/publications/costbenefits.pdf>
- Finigan, M. (1998) *An Outcome Program Evaluation of the Multnomah County STOP Drug Diversion Program*, Report prepared for Multnomah County Department of Corrections as cited in Makkai, T. (Separating Drug Addiction from Criminal Behaviour), <http://www.afp.gov.au/publica/platypus/mar99/stud1999>
- Freeman, K., Karski, R. L. & Doak, P. (2000) *New South Wales drug court evaluation: Program and participant profiles*. (Crime and Justice Bulletin No 50), NSW Bureau of Crime Statistics and Research, Sydney.
- Freeman, K. (2001) *New South Wales drug court evaluation: Interim report on health and well-being of participants* (Crime and Justice Bulletin No. 53), NSW Bureau of Crime Statistics and Research, Sydney.
- Freeman, K. (2002) *New South Wales drug court evaluation: Health, wellbeing and participant satisfaction*, NSW Bureau of Crime Statistics and Research, Sydney.
- Fomby, T.B. and Rangaprasad, V (2002) *Divert Court of Dallas County: Cost Benefit Analysis*, Washington: OJP Drug Court Clearinghouse US Department of Justice.
- Fox, R. (1992) The compulsion of voluntary treatment in sentencing, *Criminal Law Journal*, 16, 37-54.
- French, M.T., McGeary, K.A., Chitwood, D.D., McCoy, C.B., Inciardi, J.A. and McBride, D. (2000) Chronic Drug Use and Crime, *Substance Abuse*, 21(2), pp. 95-109,
- Gebelein, R.S. (2000) National Institute of Justice, The Rebirth of Rehabilitation: Promise and Perils of Drug Courts, Washington, DC: US Department of Justice, p.5.
- Gendreau, P. & Goggin, C. (1996) Principles of effective correctional programming, *Forum on Corrections Research*, 8, 38-41.

- Gerstein, D. & Harwood, J. (1990) *Treating drug problems. Volume 1: A study of effectiveness and financing of public and private drug treatment systems*, National Academy Press, Washington, DC.
- Gerstein, G.R. (1994) Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment, as cited in Walker, J. (2001) *International Experience of Drug Courts*, Edinburgh: The Scottish Executive Central Research Unit 2001.
- Goldberg, D. & Hillier, D.F. (1979) A scaled version of the General Health Questionnaire, *Psychological Medicine*, 9: 139-145.
- Hall, W. (1997) The role of legal coercion in the treatment of offenders with alcohol and heroin problems, *Australian and New Zealand Journal of Criminology*, 30, 103-120.
- Heale, P. & Lang, E. (2001) A process evaluation of the CREDIT (Court Referral and Evaluation for Drug Intervention and Treatment) Pilot Programme, *Drug and Alcohol Review*, 20, 223-30.
- Higgins, K. Cooper-Stanbury, M. and Williams, P (1998) *Statistics on Drug Use in Australia*, AIHW Publications, <http://www.aihw.gov.au/publications/health/sdua98/index.html>
- Hoffman, M.B. (2000) Second Judicial District (Denver) State of Colorado, The Drug Court Scandal, *North Carolina Law Review*, Chapel Hill, NC: North Carolina Law Review Association, 78(5):1480.
- Hora, The Honourable P. F., Schma, The Honourable W.G., and Rosenthal J.T.A., (1999) Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionising the Criminal Justice System's Response to Drug Abuse and Crime in America, *Notre Dame Law Review* 74(1) 439.
- Howells, K. & Day, A. (1999) *The rehabilitation of offenders: International perspectives applied to Australian correctional systems (Trends and Issues in Crime and Criminal Justice No. 112)*, Australian Institute of Criminology, Canberra.
- Hser, Y. I., Maglione, M., Polinsky, M. L. & Anglin, M. D. (1998) Predicting drug treatment entry among treatment-seeking individuals, *Journal of Substance Abuse Treatment*, 15, 213-20.
- Inciardi, J. & McBride, D. (1991) *Treatment alternatives to street crime: History, experiences and issues*, National Institute on Drug Abuse, Rockville, MD.
- Jones, J. (1999) Drug Treatment Beats Prison for Cutting Crime and Addiction Rates, *British Medical Journal*, 319: 470.
- Kalotra, C. J. (2002) *Estimated Costs Related to the Birth of a Drug and/or Alcohol Exposed Baby*, American University Washington: Office of Justice Programs Drug Court Clearinghouse and Technical Assistance Project.
- Law Reform Commission (2002) Appendix B: *Costs of a Day in Court*, <http://www.cjc.nsw.gov.au/lrc.nsf/pages/dp43appB>, viewed 15 February 2002.
- Lenton, S., Christie, P., Humeniuk, R. et al. (1999) *Infringement versus Conviction: the Social Impact of a Minor Cannabis Offence Under a Civil Penalties System and Strict Prohibition in Two Australian States*, Commonwealth Department of Health and Aged Care, Canberra.
- Lenton, S., Humeniuk, R., Heale, P. & Christie, P. (2000) Infringement versus conviction: The social impact of a minor cannabis offence in South Australia and Western Australia, *Drug and Alcohol Review*, 19, 257-264.

- Lind, B., Weatherburn, D., Chen, S. Shanahan, M., Lancsar, E., Haas, M., & de Abreu Lourenco, R. (2002) *New South Wales drug court evaluation: Cost-effectiveness*, NSW Bureau of Crime Statistics and Research, Sydney.
- Linden Jeff, (2001) "The MERIT Program: A Holistic Approach to Drug Offenders", 13 *Judicial Officers' Bulletin* 25.
- Loneck, B., Garrett, J. A. & Banks, S. M. (1996) A comparison of the Johnson Intervention with four other methods of referral to outpatient treatment, *American Journal of Drug & Alcohol Abuse*, 22, 233-46.
- Lurigio, A. J. (2000) Drug treatment availability and effectiveness - Studies of the general and criminal justice populations, *Criminal Justice and Behavior*, 27, 495-528.
- MacCoun, R. J. & Reuter, P. (2001) *Drug War Heresies* (Cambridge University Press, Cambridge).
- McGuire, J. (1998) *Alternatives to custodial sentences: Effectiveness and potential for development. Memorandum of evidence to the Home Affairs Committee*, House of Commons, London.
- Magistrates Court of Victoria (a) *Drug Court of Victoria* (<http://www.magistratescourt.vic.gov.au/text/drugcourt1.htm> Accessed 7 August 2002).
- Magistrates Court of Victoria (b) *CREDIT Program* (<http://www.magistratescourt.vic.gov.au/text/credit.htm> Accessed 9 Aug 2002).
- Magistrates Court of Victoria (c) *Court Referral Evaluation & Drug Intervention Treatment* ([http://www.legalaid.vic.gov.au/upload/credit\\_program.pdf](http://www.legalaid.vic.gov.au/upload/credit_program.pdf) Accessed 9 Aug 2002).
- Mahoney, B., Carver, J.A., Cooper, C., Polanksy, L., Weinstein, S., Wells, J.D., Westfield, T. (1998) *Drug Court Monitoring, Evaluation and Management Information Systems*, Drug Courts Program Office, Washington DC.
- Marks, R. E. (1992) Costs of illegal drug use. Sydney: UNSW., in: Swift, W. (Ed.) *The consequences of alcohol and drug use: Implications for policy. Proceedings of the fifth NDARC Annual Symposium*. (NDARC Monograph No. 15) NDARC, Sydney.
- Miller, N. S. & Flaherty, J. A. (2000) Effectiveness of coerced addiction treatment (alternative consequences) - A review of the clinical research, *Journal of Substance Abuse Treatment*, 18, 9-16.
- NPC Research Inc and Administrative Office of the Courts, Judicial Council of California (2002) *California Drug Courts: A Methodology for Determining Costs and Avoided Costs. Phase I Building the Methodology*, final report, October.
- NSW Attorney General's Department - Crime Prevention Division (2000) *Lismore MERIT Program* (unpublished paper) Attorney General's Department, Sydney.
- NSW Bureau of Crime Statistics and Research (1998) *Crime and Justice Facts 1998*, Attorney General's Department, Sydney.
- NSW Bureau of Crime Statistics and Research *Summary statistics for the NSW Local Court, 1996 to 2000* ([http://www.lawlink.nsw.gov.au/bocsar1.nsf/pages/lc\\_stats9600](http://www.lawlink.nsw.gov.au/bocsar1.nsf/pages/lc_stats9600) Accessed 7 August 2002).
- NSW Drug Programs Bureau *NSW Drug Court Program* ([http://www.health.nsw.gov.au/public-health/dpb/projects/drug\\_court.htm](http://www.health.nsw.gov.au/public-health/dpb/projects/drug_court.htm) Accessed 7 August 2002).

NSW Health Department (2002a). *Operational Manual for the Magistrates' Early Referral into Treatment Program*, NSW Health Department, Sydney

NSW Health Department (2002b). *Magistrates Early Referral into Treatment (MERIT) Program Data Dictionary and Collection Guidelines*, NSW Health Department, Sydney

NSW Ministerial Advisory Committee on Health Services in Smaller Towns (2000) *Report to the NSW Minister for Health, A Framework for Change*. NSW Government, Sydney

Pirkis, J., Herrman, H., Schweitzer, I., Yung, A., Grigg, M. & Burgess, P. (2001) Evaluating complex, collaborative programmes: the partnership project as a case study. *Australian and New Zealand Journal of Psychiatry*, 35: 639-646.

Prendergast, M. L., Podus, D., Chang, E. & Urada, D. (2002) The effectiveness of drug abuse treatment: A meta-analysis of comparison group studies, *Drug and Alcohol Dependence*, 67, 53-72.

Polcin, D. L. (2001) Drug and alcohol offenders coerced into treatment: A review of modalities and suggestions for research on social model programs, *Substance Use & Misuse*, 36, 589-608.

Porter, L., Arif, A. & Curran, W. (1986) *The law and the treatment of drug and alcohol dependent persons - A comparative study of existing legislation*, World Health Organization, Geneva.

Queensland Department of Justice and Attorney-General *Introduction to the Drug Court* ([http://www.justice.qld.gov.au/courts/pdfs/qc\\_fact3.pdf](http://www.justice.qld.gov.au/courts/pdfs/qc_fact3.pdf) Accessed 7 August 2002).

Reilly, D., Didcott, P., Swift, W. & Hall, W. (1998) Long-term cannabis use: characteristics of users in an Australian rural area, *Addiction*, 93, 837-846.

Reilly, D., Scantleton, J., Didcott, P. (2002) Magistrates' Early Referral Into Treatment (MERIT): preliminary findings of a 12-month court diversion trial for drug offenders, *Drug and Alcohol Review*, 21, 393-396.

Rutler J. C., Crengle S., Cheek J.E., Lennon D., O'Brien K.L. & Santosham. (2001) Emerging Infectious diseases among Indigenous Peoples. *Emerging Infectious Diseases*. 7:(Suppl 3) 554-555.

Scantleton, J. and Didcott, P. (2002) Annual Report 2001/2002, Magistrates Early Referral into Treatment (MERIT) Program, Lismore:Northern Rivers Health Service.

Siggins Miller Consultants & Catherine Spooner Consulting (2003) *Diversion of Aboriginal and Torres Strait Islander youth from juvenile detention* (ANCD Research Paper No. 6, Australian National Council on Drugs, Canberra.

Single, E., Christie, P. & Ali, R. (2000) The impact of cannabis decriminalisation in Australia and the United States, *Journal of Public Health Policy*, 21, 157-186.

Sinha, R. & Easton, C. (1999) Substance abuse and criminality, *Journal of the American Academy of Psychiatry & the Law*, 27, 513-26.

Spooner, C., Hall, W. & Mattick, R. (2000) *A strategic overview of the diversion of drug-related offenders in NSW* (NDARC Technical Report No. 96) NSW, National Drug & Alcohol Research Centre, Sydney.

Spooner, C., Hall, W. & Mattick, R. (2001) An overview of diversion strategies for Australian drug-related offenders, *Drug and Alcohol Review*, 20, 281-94.



- Stevenson, R.J. and Forsythe, L.M.V. (1998) *The Stolen Goods Market in New South Wales*, Sydney: NSW Bureau of Crime Statistics and Research.
- Swift, W., Hall, W., Didcott, P. & Reilly, D. (1998) Patterns and correlates of cannabis dependence among long-term users in an Australian rural area, *Addiction*, 93, 1149-1160.
- Taplin, S. (2002) *The New South Wales drug court evaluation: A process evaluation*, NSW Bureau of Crime Statistics and Research, Sydney.
- Thompson, B. (1995) *Recidivism in NSW: General study (Research Publication No. 31)*, Department of Corrective Services, Sydney.
- Turner, S., Longshore, D., Wenzel, S., Deschenes, E., Greenwood, P., Fain, T., Harrell, A., Morral, A., Taxman, F., Iguchi, M., Greene, J. & McBride, D. (2002) A decade of drug treatment court research. *Substance Use and Misuse*, 37:1489-1527.
- US Department of Justice (2002) *Evaluating the Impacts and Effectiveness of Drug Courts*, <http://www.ojp.usdoj.gov/dcpo/monitor/eiedc.htm>, sighted March 2002
- WA Department of Justice *Drug Court* (<http://www.justice.wa.gov.au/displayPage.asp?structureID=28527836&resourceID=94482976&division=Court%20Services> Accessed 7 August 2002).
- Walker, J. (1992) Estimates of the Cost of Crime in Australia, *Trends and Issues in Crime and Criminal Justice*, No 39, Canberra: Australian Institute of Criminology
- Walker, J. (2001) *International Experience of Drug Courts*, Edinburgh: The Scottish Executive Central Research Unit
- Ware, J.E., Snow, K.K., Kosinski, M. & Grandek, B. (1993), *SF-36 Health Survey Manual and Interpretation Guide*, The Health Institute, New England Medical Center, Boston, MA.
- Weatherburn, D., Topp, L., Midford, R. & Allsop, S. (2000) *Drug crime prevention and mitigation: A literature review and research agenda*, New South Wales Bureau of Crime Statistics and Research, Sydney.
- Weatherburn, D., Jones, C., Freeman, K., Makkai, T. 2001, *The Australian Heroin Drought and its Implications for Drug Policy*, Crime and Justice Bulletin No. 59, NSW Bureau of Crime Statistics and Research, Sydney.
- Wild, T. C., Newton-Taylor, B. & Alletto, R. (1998) Perceived coercion among clients entering substance abuse treatment: Structural and psychological determinants, *Addictive Behaviors*, 23, 81-95.
- Wild, T. C. (1999) Compulsory substance-user treatment and harm reduction: A critical analysis, *Substance Use & Misuse*, 34, 83-102.
- Wild, T. C., Roberts, A. B. & Cooper, E. L. (2002) Compulsory substance abuse treatment: An overview of recent findings and issues, *European Addiction Research*, 8, 84-93.
- Young, D. (2002) Impacts of perceived legal pressure on retention in drug treatment, *Criminal Justice and Behavior*, 29, 27-55.
- Young, D. & Belenko, S. (2002) Program retention and perceived coercion in three models of mandatory drug treatment, *Journal of Drug Issues*, 32, 297-328.

## Appendix A – Review of Literature on Diversion Schemes

### ***Conceptual background***

Research literature on the rationale for drug diversion programs, a framework for drug diversion programs, and design issues are presented below. It is noted that much of the literature is from outside Australia, particularly the United States. Overseas research provides useful information for Australian programs, but cannot be assumed to be directly applicable to Australia. For example, Australian and US drug laws and drug policy are markedly different, (MacCoun & Reuter, 2001).

### ***Rationale for diversion of drug offenders***

The costs of criminal justice and law enforcement approaches to drug-related offences are difficult to estimate, but arguably high. In 1996/97 the NSW Government spent \$2,090.7 million on recurrent expenses in the area of law, order and public safety (NSW Bureau of Crime Statistics & Research, 1998). In addition, \$189.7 million was spent on capital works such as building police stations, courthouses and prisons. In 2001, 133,150 cases were registered in NSW Local Courts, 7,203 of whom were sentenced to prison for an average minimum/fixed term of 5.3 months for males and 4.4 months for females (NSW Bureau of Crime Statistics & Research, 2002). A minority of charges were for drug offences: 11,648 possess and/or use illicit drugs, 3,913 for manufacturing, dealing, importing or other illicit drug offences. However, many other offences, such as property crime, are drug-related (Spooner *et al* 2000; Weatherburn 2000; Marks 1992). Collins and Lapsley estimated that the national law enforcement costs related to illicit drugs in 1998/99, including police, customs, prisons, and courts, was \$1,427.3 million (Collins and Lapsley 2002). Diversion approaches are based upon the premise that the usual criminal justice process is costly and, as discussed below, not the most effective means of addressing drug-related crime.

The rationale for diversion strategies is different for first offenders relative to recidivist offenders with a drug-use problem. Diversion typically aims to prevent first offenders from entering the criminal justice system. Outcomes such as a criminal record and a history of imprisonment can have negative effects on individuals and their families that go beyond the intended consequences. For example, Australian research compared the outcomes for people who had received an infringement notice with people who received a criminal conviction for a minor cannabis offence (Lenton *et al* 1999; Lenton *et al* 2000; Ali *et al* 1999). The study identified that the convicted group, compared to the infringement notice group, were more likely to report negative employment consequences (32% vs. 2%), subsequent problems with the law (32% vs. 0%), negative relationship consequences (20% vs. 5%) and accommodation consequences (16% vs. 0%) as a result of their apprehension (Lenton *et al* 2000).

For repeat offenders with a drug-use problem, diversion programs aim to reduce reoffending by addressing a significant risk factor for offending: drug abuse and dependence (Sinha *et al* 1999). The Australian Institute of Criminology (AIC) conducted a review of the international literature on the effect of treatment and criminal sanctions on recidivism among offenders (not specific to drug-related offenders) (Howells *et al* 1999). A meta-analysis of the effect of the criminal sanctions, including fines, 'shock incarceration', 'scared straight', intensive probation, drug testing, electronic monitoring, and restitution was reported (Gendreau *et al* 1996). This meta-analysis identified negligible effect sizes (range -.07 to +.06, mean = 0.00) for criminal justice sanctions. In comparison, a meta-analysis of the effect of rehabilitation programs identified small to moderate effect sizes (range +0.10 to +0.36) (McGuire 1998). From this review, the AIC concluded that a) criminal sanctions could reduce recidivism *only* when a treatment component is added, and b) programs delivered in community settings produce better outcomes than those delivered in institutions.

Looking specifically at drug treatment programs, reviews have found that drug-treatment programs reduce drug use and criminal behaviour (Prendergast *et al* 2002), suggesting that,

for those with a drug-related problem, diversion to treatment is likely to have better outcomes than criminal sanctions.

In sum, for those unlikely to re-offend, the negative consequences of criminal justice proceedings can be difficult to justify. For those with significant drug-related problems, treatment can be more efficacious than criminal justice sanctions alone.

### **Framework for diversion of drug offenders**

Diversion options can span the whole course of the criminal justice process: pre-arrest, pre-trial, pre-sentence, post-sentence and pre-release. Options earlier in the criminal justice process are particularly suited to keeping juveniles and young adults out of the criminal justice system, while those later in the criminal justice process focus more on addressing those factors that contribute to repeat offending.

Diversion options at each stage of the criminal justice process are summarised in Table A.2. These are further described elsewhere (Spooner *et al* 2000; Spooner *et al* 2001).

**Table A.2. Diversion options**

Stage	Diversion	Explanation
<b>Pre-arrest</b>	• Police discretion to not take action	Police officer observes an offence but decides not to take action, to ignore it.
	• Infringement notice	Fine issued, no record.
	• Informal warning	Warnings take place 'on-the-spot' without, in theory, any legal repercussions for the individual involved (for example, a verbal warning, escorting a person home, or moving them along). The individual does not receive a police record of warning.
	• Formal caution (no intervention)	A verbal warning, no written information or referral to intervention, record kept.
	• Caution plus intervention	A verbal warning, written information and/or referral to intervention, record kept.
<b>Pre-trial</b>	• Treatment as condition of bail	Might need to plea guilty, treatment a condition of bail, no conviction is recorded if an offender successfully completes the undertakings.
	• Conferencing	In place of a trial, victims of crime and other members of the community, including experts and family members, become involved in dealing with offenders beyond the normal confines of the criminal justice system.
	• Prosecutor discretion	Public prosecutors offer an offender the option of attending a drug-treatment intervention rather than proceeding with prosecution.
<b>Pre-sentence</b>	• Delay of sentence	A magistrate or judge can use adjournments, assessments and other means to delay or stop proceedings prior to sentencing while the offender is assessed or treated. The defence lawyer can initiate the process. Some diversion systems allow for no conviction to be recorded if the person successfully completes the program. Sanctions can also be built in for non-compliance.



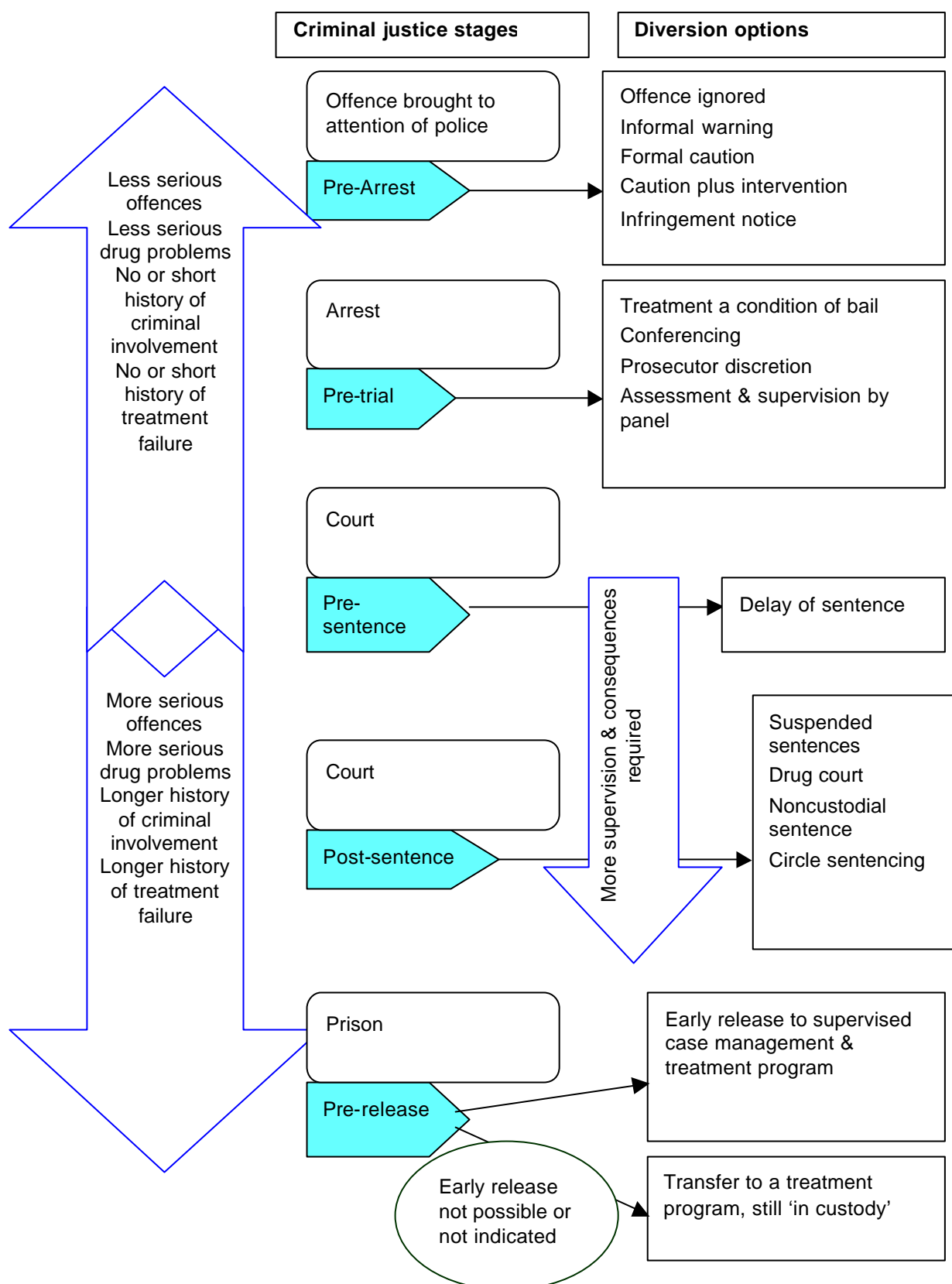
<b>Post-sentence</b>	<ul style="list-style-type: none"> <li>• Circle sentencing</li> </ul>	<p>Circle court participants include the presiding judicial officer, the offender, the defence council, the offender's family and/or support people, the victim and his/her support people, and a community elder. Offender pleads guilty, then participants discuss the case in a circle. Goals are set for the offender such as curfew, work programs, abstinence of alcohol, and/or drug-treatment programs. The circle is then adjourned and these items set as bail conditions.</p>
<b>Post-sentence</b>	<ul style="list-style-type: none"> <li>• Suspended sentence</li> </ul>	<p>Court imposes a sentence of imprisonment, and then suspends its operation for a period of time while the offender is released on specific conditions (bond). Bonds can contain conditions relating to matters such as probation supervision, associates, abstinence from drugs, and participation in treatment. If the offender breaches any of the conditions, he/she might be liable to serve the sentence originally imposed or face other consequences. If no breach occurs during the bond period, the offender can be discharged.</p>
	<ul style="list-style-type: none"> <li>• Drug court</li> </ul>	<p>Courts specifically designated to administer cases referred for judicially supervised drug treatment and rehabilitation within a jurisdiction or court-enforced drug treatment program.</p>
	<ul style="list-style-type: none"> <li>• Non-custodial sentences – supervised order, probation, bond</li> </ul>	<p>A magistrate or judge specifies that offenders participate in a specific drug-treatment program as part of their sentence.</p>
<b>Pre-release</b>	<ul style="list-style-type: none"> <li>• Transfer to drug treatment</li> </ul>	<p>An inmate could be transferred to a community-based treatment program that provides 24-hour supervision. In this latter option, the offender is still regarded as being in custody.</p>
	<ul style="list-style-type: none"> <li>• Early release to treatment</li> </ul>	<p>An inmate may be eligible for early release from detention into a structured, supervised treatment program to address their drug problems and assist with re-integration into the community.</p>

Coumarelos and Weatherburn have argued that 'strategies designed to reduce juvenile recidivism are more appropriately targeted at repeat offenders rather than those with no or little prior criminal record' (Coumarelos *et al* 1995). In contrast, others have argued for intervention at the earliest opportunity in the criminal justice system (Dembo *et al* 1993; Miller *et al* 2000). For example, Miller and Flaherty reviewed the research literature on interventions that referred offenders who had no treatment experience and were not heavily involved in drug use to drug treatment. They concluded that 'The early interruption of the criminal and drug use may have important long-term benefits in reducing both crime and drug use among treated offenders, particularly younger offenders' (p. 11) (Miller *et al* 2000).

These apparently opposing positions can be reconciled if the principle of providing interventions that are appropriate to the offence and the offender is adopted (Figure A.1). (Spooner *et al* 2001). That is, more intensive interventions are reserved for high-need, high-risk offenders; briefer interventions are given to low-risk, first offenders. Further, the principle of the justice response being commensurate with the offence must also be considered. For example, a drug-dependent offender detected/convicted for a first minor offence cannot be sentenced to a 12-month drug-treatment program.

MERIT is one of many options for diversion of drug offenders in the criminal justice system, from pre-arrest to pre-release. As a pre-trial diversion program, the target group is offenders with some drug/crime history, rather than experimental users (for whom pre-arrest diversion is appropriate) or offenders with a significant criminal activity (for whom greater involvement of the court might be appropriate).

Figure A.1. Model of diversion options



## **Diversion Program Design Issues**

### **Coercion to treatment**

There are different types and levels of coercion to treatment. Coercion can come from legal, family or other sources (Wild *et al* 1998). It can be used in various settings, including the criminal justice system, normal therapeutic setting, workplace, and child welfare (Miller *et al* 2000). It can be flexible or rigid (Miller *et al* 2000). The consequences can be more or less severe (Young 2002).

The coercion of offenders to participate in a drug treatment program raises concerns about civil liberties and the effectiveness of treatment under coercion (Wild 1999). The exact nature of the coercion and the type of drug treatment programs involved will vary between cited studies. The following discussion builds upon Hall's analysis of the arguments for and against treatment under coercion (Hall 1997). Firstly, the drug dependence of some offenders contributes significantly to their offending behaviour and treatment under coercion is an effective way of treating that dependence, and thereby reducing the risk of re-offending (Inciardi *et al* 1991; Miller *et al* 2000; Anglin *et al* 1998; Lurigio 2000; Polcin 2001). Coercion into treatment has been associated with increased entry to treatment (Hser *et al* 1998) and retention in treatment (Loneck *et al* 1996; Young *et al* 2002) relative to voluntary treatment.

Second, there is evidence that heroin-dependent offenders tend to relapse to drug use upon release from prison, hence to re-offend, and then return to prison. As treatment reduces relapse to heroin use and criminal recidivism, coerced treatment provides an alternative to prison that can reduce recidivism (Gerstein *et al* 1990; Thompson 1995). Third, it is less costly to treat drug dependent offenders in the community than it is to incarcerate them (Gerstein *et al* 1990).

A World Health Organisation consensus view on the ethics of treatment under coercion is that compulsory treatment is legally and ethically justified only if the rights of the individuals are protected by 'due process', and if effective and humane treatment is provided (Porter *et al* 1986). To this end it has been argued that offenders be allowed at least two types of 'constrained choice' (Fox 1992). That is, firstly a choice between treatment and the usual criminal justice process, and secondly, some choice as to the type of treatment they receive.

While the above research has been positive about coercion to treatment, others have urged caution in its use (Wild 1999). First, Wild argued that diversion programs often lack the administrative, fiscal, and evaluative support to effectively divert offenders to treatment. Second, concerns remain about infringement of civil liberties. Finally, close scrutiny of the research evidence on mandated versus voluntary clients in drug treatment reveals numerous conceptual and methodological problems.

A recent review of the literature on coercion to treatment by Wild and colleagues identified that, while there is evidence that coercion does improve treatment entry and retention, the evidence does not support the view that coercion has positive impacts on treatment outcomes: drug use and recidivism (Wild *et al* 2002). In fact, these authors suggested that coercion might 'undermine client involvement in the process of behaviour change' (p. 90) (Wild *et al* 2002).

In sum, it appears that coercion might not improve treatment outcomes, but it does have benefits in terms of treatment entry and retention. Coercion to treatment is ethical if appropriate treatment is offered and the offender has the right to exercise some choice as to the a) treatment and the usual criminal justice process, and b) type of treatment they receive.

### **Net widening**

Net widening refers to the situation where a diversion intervention increases the number of people involved in the criminal justice system or escalates the severity of the consequences for offenders (Spooner *et al* 2001). For example, if a diversion program is thought to be less burdensome than the usual criminal justice sanction, it might be applied to a person who

would not otherwise be sanctioned at all. In such cases, diversion may increase the number of offenders exposed to criminal justice sanctions. Net widening can also occur when offenders receive a more severe sentence if they commence and then fail in a diversion program than they would have if they had accepted the usual criminal justice process initially.

Evidence of net widening has been identified with police diversion of juveniles in Canada (Carrington 1998) due to reduced use of discretion (Carrington 1999); and Cannabis Expiation Notices in South Australia, particularly among young people who could not afford to pay their fine (Single *et al* 2000).

### ***Impact on treatment services***

Diversion to treatment can increase the demand for drug treatment services. It can be argued that it is unfair to give treatment places to offenders when places for people who voluntarily seek treatment are in short supply. This ethical concern can be addressed by ensuring treatment places for coerced offenders are funded separately, and this funding does not reduce funding for treatment places for people voluntarily seeking treatment.

Another issue of possible concern is the mixing of voluntary with coerced clients in the one treatment service. Clients who are only in treatment to avoid criminal sanctions could negatively influence the motivation of voluntary clients. This could be particularly problematic with treatment programs that utilise group techniques or residential programs. Evidence to support or refute such concerns was not found.

### ***Equity and appropriateness***

If diversion programs are effective, are all eligible offenders able to access them? There is some evidence to suggest that Aboriginal and Torres Strait Islander populations, for example, might be less likely to participate in diversion programs (Siggins Miller Consultants & Catherine Spooner Consulting, 2003).

In 1999, Biven and Ramsay presented the results of a qualitative assessment of a South Australian drug diversion program called DAAP (Drug Assessment and Aid Panel), from the perspective of Panel members (Biven *et al* 1999). The investigation identified that the groups who were excluded or not well serviced by DAAP were as follows:

- Adolescents who were ineligible for DAAP. This meant that adolescents would receive a conviction for a simple drug offence.
- Offenders from different ethnic and cultural backgrounds. The Panel had found it difficult to establish rapport with non-English-speaking offenders for whom an interpreter was required. In addition, Aboriginal offenders tended to not present to the Panel.
- Country offenders tended to not present to the Panel as all DAAP sittings were in Adelaide. Travelling to Adelaide could have been too expensive or too inconvenient.

From a process evaluation of the NSW Drug Court, Taplin reported that Aboriginal offenders tended to be disproportionately excluded from entry into the program because of their 'antecedents' or having committed a 'violent' offence in the past (Taplin 2002). Women also appeared to be disadvantaged. For example, the facilities and services available to women in the Detoxification Unit at Mulawa Correctional Centre were reportedly inferior to those for men. Furthermore, the level of activities required by the program presented difficulties for participants who had primary responsibility for childcare, the majority of whom were women. The need for improved services for those with concurrent psychiatric problems was also identified.

These examples illustrate that consideration needs to be given to program access and appropriateness for all members of a diversion program's target group.

## **Appendix B – Members of the LMPP Steering Committee**

Greta Bird  
School of Law and Justice  
Southern Cross University

Steve Bolt  
Northern Rivers Community Legal Centre

Lyndon Brooks  
Graduate Research College  
Southern Cross University

Peter Didcott  
Lismore MERIT Pilot Program

Bruce Flaherty  
Crime Prevention Division  
Attorney General's Department

Megan Passey  
Clinical Research, Evaluation and Support Team, NRAHS  
and Southern Cross Institute of Health Research (now incorporated into Northern Rivers  
University Department of Rural Health)

David Reilly  
Manager, Drug and Alcohol Services  
Northern Rivers Area Health Service

Keith Sloan  
School of Commerce and Management  
Southern Cross University

## Appendix C – Comparison of Indicative and Actual Offences

Sentences of 39 LMPP completers showing the most severe sentence received and the most severe “indicative sentence” provided by the Magistrate

Actual sentence	Indicative sentence
Suspended sentence 10 months	Imprisonment 3 months
Suspended sentence 12 months	Imprisonment 3-6 months
Suspended sentence 12 months	Imprisonment 6 months
Suspended sentence 12 months	Imprisonment 6 months
Suspended sentence 12 months	Imprisonment 6 months
Suspended sentence 12 months	Imprisonment 9 months
Suspended sentence 15 months	Imprisonment 3 months
Suspended sentence 15 months	Imprisonment 4-6 months
Suspended sentence 15 months	Imprisonment 9 months
Suspended sentence 15 months	Imprisonment 9 months
Suspended sentence 15 months	Imprisonment 9 months
Suspended sentence 18 months	Imprisonment 2-3 months
Suspended sentence 20 months	Imprisonment 6 months
Suspended sentence 9 months	Bond without supervision (unspecified duration)
Suspended sentence 9 months	Imprisonment 6 months
Suspended sentence 9 months	Imprisonment 6 months
Community service order 350 hours	Imprisonment 9 months
Community service order 50 hours	Suspended sentence 9 months
Bond with supervision 12 months	Imprisonment 2-3 months
Bond with supervision 12 months	Suspended sentence 9 months
Bond with supervision 15 months	Community service order (unspecified duration)
Bond with supervision 15 months	Imprisonment 6 months
Bond with supervision 18 months	Imprisonment 1 month
Bond with supervision 24 months	Imprisonment 3 months
Bond with supervision 9 months	Imprisonment 3 months
Bond with supervision 9 months	Suspended sentence 9 months
Bond without supervision (duration not specified)	Imprisonment 1 month
Bond without supervision 15 months	Imprisonment 1 month
Bond without supervision 18 months	Suspended sentence 9 months
Bond without supervision 6 months	Imprisonment 6 months
Bond without supervision 6 months	Suspended sentence 9 months
Bond without supervision 9 months	Suspended sentence 9 months
Bond without conviction (duration not specified)	Convicted and fined (unspecified amount)
Bond without conviction 12 months	Bond without supervision (unspecified duration)
Fine \$600	Bond without supervision (unspecified duration)
Fine (unspecified)	Bond without supervision (unspecified duration)
Rising of the court	Fine \$700
Rising of the court	Suspended sentence 9 months
No conviction recorded	Fine \$200

## Appendix D – Proportional hazards models for time to first offence

The proportional hazards models for time to first offence are presented below for ‘elapsed time’ and for ‘free time’ by both offence categories. The basic models including only ‘completion’ are presented first. The full models incorporating the other variables of interest are then presented, but it is important to note that the addition of the variables beyond ‘completion’ did not significantly improve the models. They are presented only because the additional factors may sometimes be associated with recidivism, and it was considered important to show the impact of program completion, even when these other factors are controlled for. Type of accommodation was not included in these models, as its addition made no difference to the Likelihood Ratio Statistic, and because it is not a factor previously found to be associated with recidivism.

**Table D.1. Proportional hazards model for elapsed time to first offence of any kind, for LMPP participants accepted between 1<sup>st</sup> July 2000 and 31<sup>st</sup> December 2001**

	Hazard Ratio	Hazard Ratio Confidence Intervals		p-value
		Lower	Upper	
Completion (completers vs not)	0.5345	0.3714	0.7693	<0.001

**Table D.2. Proportional hazards model for elapsed time to first drug, theft or robbery offence, for LMPP participants accepted between 1<sup>st</sup> July 2000 and 31<sup>st</sup> December 2001**

	Hazard Ratio	Hazard Ratio Confidence Intervals		p-value
		Lower	Upper	
Completion (completers vs not)	0.4963	0.3235	0.7613	0.001

**Table D.3. Proportional hazards model for free time to first offence of any kind, for LMPP participants accepted between 1<sup>st</sup> July 2000 and 31<sup>st</sup> December 2001**

	Hazard Ratio	Hazard Ratio Confidence Intervals		p-value
		Lower	Upper	
Completion (completers vs not)	0.5589	0.3797	0.8228	0.003

**Table D.4. Proportional hazards model for free time to first drug, theft or robbery offence, for LMPP participants accepted between 1<sup>st</sup> July 2000 and 31<sup>st</sup> December 2001**

	Hazard Ratio	Hazard Ratio Confidence Intervals		p-value
		Lower	Upper	
Completion (completers vs not)	0.5553	0.3534	0.8726	0.011

**Table D.5. Proportional hazards model for elapsed time to first offence of any kind, for LMPP participants accepted between 1<sup>st</sup> July 2000 and 31<sup>st</sup> December 2001**

	Hazard Ratio	Hazard Ratio Confidence Intervals		p-value
		Lower	Upper	
Completion (completers vs not)	0.5264	0.3569	0.7763	0.001
Gender	0.8132	0.4781	1.3830	0.446
Age	0.9727	0.9491	0.9968	0.027
Aboriginality	0.8795	0.5239	1.4760	0.627
Drug of concern	0.9292	0.5860	1.4740	0.755
Prior imprisonment	1.158	0.7444	1.8000	0.516

Note: n = 167

**Table D.6. Proportional hazards model for elapsed time to first drug, theft or robbery offence, for LMPP participants accepted between 1<sup>st</sup> July 2000 and 31<sup>st</sup> December 2001**

	Hazard Ratio	Hazard Ratio Confidence Intervals		p-value
		Lower	Upper	
Completion (completers vs not)	0.4984	0.3179	0.7814	0.002
Gender	1.0180	0.5534	1.8740	0.953
Age	0.9752	0.9476	1.0040	0.086
Aboriginality	0.8303	0.4561	1.512	0.543
Drug of concern	1.078	0.6356	1.829	0.780
Prior imprisonment	1.494	0.8894	2.51	0.129

Note: n = 167

**Table D.7. Proportional hazards model for free time to first offence of any kind, for LMPP participants accepted between 1<sup>st</sup> July 2000 and 31<sup>st</sup> December 2001**

	Hazard Ratio	Hazard Ratio Confidence Intervals		p-value
		Lower	Upper	
Completion (completers vs not)	0.5712	0.3755	0.8687	0.009
Gender	0.6812	0.3889	1.1930	0.179
Age	0.9671	0.9410	0.0039	0.164
Aboriginality	0.8742	0.5072	1.507	0.629
Drug of concern	0.8376	0.5142	1.3640	0.476
Prior imprisonment	1.176	0.7348	1.881	0.500

Note: n = 151

**Table D.8. Proportional hazards model for free time to first drug, theft or robbery offence, for LMPP participants accepted between 1<sup>st</sup> July 2000 and 31<sup>st</sup> December 2001**

	Hazard Ratio	Hazard Ratio Confidence Intervals		p-value
		Lower	Upper	
Completion (completers vs not)	0.5864	0.3621	0.9498	0.030
Gender	0.8330	0.4365	1.5900	0.579
Age	0.9763	0.9465	1.0070	0.131
Aboriginality	0.8039	0.4238	1.5250	0.504
Drug of concern	0.8854	0.5033	1.5570	0.673
Prior imprisonment	1.4460	0.8359	2.501	0.187

Note: n = 151



## Appendix E - Results of Multilevel models and Kruskal-Wallis/Mann-Whitney tests for OTI and SF-36 Scores

Variable	Means			P-values			
	Entry (I1)	Exit (I2)	Follow-up (I3)	I1,I2,I3 <sup>1</sup>	I1vI2	I1vI3	I2vI3
<b>OTI</b>							
<b>Multilevel models</b>							
Polydrug Use	3.6	2.7	2.8	0.000	0.000	0.001	0.879
Social Functioning	21.7	21.0	18.6	0.006	0.466	0.002	0.022
General Health	3.4	3.4	3.6	0.928			
Total Symptoms	8.3	8.4	10.0	0.321			
GHQ-Somatic Symptoms	2.1	1.4	1.3	0.013	0.015	0.010	0.865
GHQ-Anxiety	2.8	1.9	1.8	0.006	0.012	0.004	0.708
GHQ-Social Dysfunction	2.2	1.5	1.3	0.006	0.014	0.003	0.675
GHQ-Depression	1.5	1.2	1.0	0.220			
GHQ-Total	8.7	6.0	5.4	0.002	0.007	0.001	0.591
<b>K-W<sup>2</sup> / M-W<sup>3</sup> tests</b>							
HIV Risk-taking - Drug	3.2	1.0	1.5	0.010	0.003	0.262	0.042
HIV Risk-taking - Sex	3.6	3.3	3.7	0.730			
HIV Risk-taking - total	6.0	4.3	5.3	0.161			
Criminal Activity	1.8	0.4	0.4	0.000	0.000	0.000	0.775
<b>SF36</b>							
<b>Multilevel models</b>							
Bodily Pain	58.8	66.1	66.6	0.060	0.048	0.044	0.896
General Health	54.0	64.2	60.0	0.005	0.001	0.066	0.223
Vitality	50.3	59.4	57.3	0.013	0.005	0.041	0.558
Social Functioning	58.3	70.3	67.1	0.000	0.011	0.066	0.532
Mental Health	59.0	65.3	62.5	0.180			
<b>K-W<sup>2</sup> / M-W<sup>3</sup> tests</b>							
Physical Functioning	86.5	88.6	85.6	0.496	0.567	0.495	0.242
Role limits – physical	54.4	66.0	61.8	0.336	0.149	0.491	0.917
Role limits - emotional	46.1	60.0	58.2	0.156	0.089	0.122	0.865

1 Test of overall significance for the interview factor

2 Kruskal-Wallis tests among 3 distributions (I1,I2,I3)

3 Mann-Whitney tests between 2 distributions

## Appendix F – List of stakeholders interviewed

### February 2001

#### ***Court***

1 Magistrate  
1 Clerk of Court

#### ***Police***

1 Police Officer

#### ***Legal Aid***

1 Senior Solicitor

#### ***Probation and Parole***

1 Unit Leader

#### ***Aboriginal Legal Service***

#### ***Aboriginal Support Agencies***

#### ***Northern Rivers Area Health Service***

1 Senior Nurse

#### ***Drug Rehabilitation Facility***

1 Senior Administrator

#### ***Premier's Department***

1 Senior Officer

#### ***Lismore MERIT Team***

1 Manager  
3 Case workers

### August 2002

2 Magistrates  
1 Clerk of Court

2 Senior Police Officers

1 Senior Solicitor

1 Unit Leader

1 Senior Solicitor

1 Coordinator  
1 Senior Project Officer

2 Senior Nurses  
1 Medical Practitioner  
1 Mental Health Clinician

1 Clinical Administrator

1 Manager  
3 Case workers

## **Appendix G – Local Court Practice Note**

### **LOCAL COURT PRACTICE NOTE NO: 5**

**ISSUED: 20<sup>TH</sup> AUGUST 2002**

### **MAGISTRATES EARLY REFERRAL INTO TREATMENT (MERIT) PROGRAMME**

#### **NATURE AND PURPOSE**

1. The MERIT programme is a pre plea diversion programme for defendants with illicit drug problems conducted in the Local Courts of NSW.
2. The programme provides for the early referral for assessment of arrested persons who are eligible for bail and who are motivated and volunteer to engage in treatment and rehabilitation for their drug use problem.
3. The programme brings together the health, justice and law enforcement systems with the focus on the reduction of criminally offending behaviour associated with drug use.
4. The success of the MERIT programme at each Court will depend to a significant degree on the appropriate professional relationship between the Magistrate and the MERIT Team leader. The thoroughness of the assessments, the appropriateness of the treatment plan, the detail of the reports and the exercise of sound judgement in relation to action on breaches by the MERIT Team will all impact on efficient case management of the criminal charges and hopefully lead to a reduction in drug associated criminal behaviour in the future.

#### **REFERRALS TO THE MERIT PROGRAMME**

5. Referrals to the programme may come from one of the following sources:
  - (i) on apprehension by the Police who may refer a defendant for assessment into the programme
  - (ii) at the commencement of proceedings:
    - \* the defendant;
    - \* the defendant's lawyer; or
    - \* the presiding Magistratemay make a referral for assessment into the programme.

**PRELIMINARY CONSIDERATIONS FOR ENTRY INTO MERIT PROGRAMME:**

6. The MERIT programme is designed as a pre-plea scheme to encourage referral for assessment at an early stage of the Court process and entry into the programme is not dependant on the person's guilt or innocence.
7. Notwithstanding (6) above a plea may be entered at any time from the person's first appearance before the Court until the conclusion of the programme.

**CRITERIA FOR ELIGIBILITY TO PARTICIPATE IN MERIT PROGRAMME:**

8. To be eligible to participate in the MERIT programme the defendant must meet the following criterion:
  - (i) they must be an adult.
  - (ii) the offences charged must be related to a serious drug problem.
  - (iii) the offences should not involve strictly indictable offences, allegations of sexual assault or matters of significant violence and should not have like offences pending before a Court.
  - (iv) the defendant must have a demonstrable and treatable drug problem.
  - (v) the defendant must be eligible for bail and suitable for release on bail into the MERIT Programme.
  - (vi) the defendant must give informed consent to participation into the scheme.
  - (vii) the defendant must be deemed suitable for the programme.
  - (viii) the defendant should usually reside in the defined catchment area. This criteria will have less impact as the scheme is expanded throughout the State where transfers of matters may occur.

**GENERAL PROCEDURE:**

9. If considered eligible to participate, the defendant should be referred to the MERIT assessment team attached to the Court for the relevant assessment to be undertaken to ensure that the defendant is suitable for the programme. The Court proceedings should be adjourned for a short period to allow that assessment to occur.
- 9.1 As part of the assessment, the MERIT case worker will assess the nature of the defendant's drug use and other associated problems.
- 9.2 The case worker is to assess the defendant against the criteria for entry to the programme and then formulate a proposed treatment plan for the defendant to undertake and prepare a report for the Court.

- 9.3** If the defendant is considered suitable for the MERIT programme, the Magistrate will approve placement of the defendant onto the programme.
- 9.4** If the defendant is considered **not** suitable for the programme, the defendant will be asked to enter a plea and the matter will proceed in the usual way.
- 10.** While awaiting the assessment report from the MERIT case worker, bail may be granted with specific conditions such as reporting and particular residential conditions applying. Alternatively the defendant may be remanded in custody awaiting the outcome of the assessment report.
- 10.1** When placed on the programme, bail should be granted in accordance with the Bail Act and consideration should be given to imposing relevant bail conditions such as allowing the defendant to reside where approved by the MERIT Team and requiring compliance with all directions of the MERIT Team. Once on the programme the defendant is, in effect, subject to the supervision of the MERIT Team and will be subject to breach of bail action if there is continued non compliance.
- 11.** Once the Magistrate formally approves the placement of the defendant on the MERIT programme, the treatment plan as devised by the MERIT case worker, if it has not already commenced, will be commenced.
- 11.1** The determination of an appropriate treatment module is a matter solely within the discretion of the MERIT case worker. Their trained role is to identify the needs, risks, long and short term goals of the participant and then to oversee the provision of available treatment services in the best interests of that participant. Examples of the drug treatment programmes available include:
- medically supervised and home based detoxification;
  - methadone and other pharmacotherapies such as naltrexone and buprenorphine;
  - residential rehabilitation;
  - individual and group counselling and psychiatric treatment.
- 11.2** The MERIT programme is generally planned as a 12 week intensive programme. It may be extended in special circumstances with the agreement of the Magistrate, the MERIT case worker and the defendant.
- 11.3** During the treatment phase the Court effectively case manages the process. Once accepted into the MERIT Programme, the defendant is required to return to Court at such intervals as determined by the Magistrate usually on the recommendation of the MERIT Team. At each adjournment, an update report is provided and the defendant required to attend unless excused by the Court with the concurrence of the MERIT Team. At the conclusion of the programme a final report is provided by the MERIT team.

Should the defendant fail the programme despite sufficient opportunities to comply with the directions of the MERIT Team, or commits further offences, or does not comply with other bail conditions, the MERIT Team must, as soon as

possible, notify the Court of these major breaches. Thereafter, the defendant is no longer participating in the programme. The matter should be relisted as soon as possible for normal judicial management. Bail may need to be reviewed and, if required, a warrant issued.

- 12.1** If the breach of bail involves a significant threat to the community or the offender himself then the breach should be reported as a matter of urgency by the MERIT Team to the Police and the Court for their immediate action.
- 12.2** While minor breaches need not necessarily be actioned, reference to such conduct should appear in the interim or final reports.
- 12.3** An appropriate breach policy should be established by the Magistrates at each Court operating the MERIT Programme.
- 13.** At the conclusion of the programme, the final report will set out the achievements or otherwise of the participant under the programme. At that time, the defendant will be asked (if it has not already happened) to enter a plea. The case will then proceed through the normal justice process.
- 13.1** On sentence, the successful completion of the MERIT programme is a matter of some weight to be taken into account in the defendant's favour. At the same time, as the MERIT programme is a voluntary opt in programme, its unsuccessful completion should not, on sentence, attract any additional penalty.
- 13.2** The final sentencing outcome should be formally communicated by the Court to the MERIT Team for their recording purposes.

Patricia J Staunton AM  
CHIEF MAGISTRATE

## **Appendix H – Case Studies of Participants**

The case studies presented in this Appendix were kindly provided by the staff of the Lismore MERIT Pilot Program. They are included in this report to give an understanding of the complexity of the issues faced by the LMPP participants, of the need for flexibility and persistence, and to help paint the “human picture” behind the statistics. We have also included a letter from a participant, written to the LMPP team. We are grateful to the LMPP staff for allowing us to include these materials in our report.

The names of the LMPP participants described in these case studies have been changed to protect their identities.

### **Billy \***

Billy is a 38 year old man who is well known to the Criminal Justice System in the Lismore area. He has an extensive criminal record dating back to 1973 when at age 11 years, he was incarcerated on his first conviction. As an adult Billy has had 54 separate court appearances, most of them for multiple offences. He has been incarcerated on ten occasions as an adult and sentenced to numerous other alternatives to full-time custody. Much of Billy's past criminal offending is related to substance abuse which in the last decade has been primarily heroin related.

Billy and his partner Sally, also a long-term heroin addict, were admitted to the MERIT program following their arrest for breaking into a house. They were charged with offences of Break Enter & Steal and Possession of House Breaking Implements. Despite their significant addictions, they had maintained their relationship for some years though generally this had involved supporting each other's drug abuse and criminal activities. Their relationship necessitated treating them separately whilst in MERIT, without requiring them to cease their support for each other.

Billy's admission to MERIT was problematic. He had not previously accessed drug and alcohol treatment services other than in gaol, though many years ago he attended a residential treatment program. He is positive to hepatitis C and has had chronic back pain which he self medicated with heroin.

Billy continued to use heroin when he presented at MERIT, turning up for appointments and groups in an intoxicated state. Typical of heroin users, he and his partner had largely destroyed all ability to attract emergency welfare assistance including housing assistance which was identified as a major issue in addressing their drug use. MERIT was able to assist them in this regard.

Billy's treatment focused on residential detoxification and then assisting him to maintain stability either by abstinence or placing him on a prescribed pharmacotherapy program. The latter option was identified as the most desirable and a prescribing General Practitioner was located. Despite placement on the methadone program Billy continued to use heroin, as confirmed by supervised urinalysis, and he failed to keep appointments with both his caseworker and the GP. However, caseworker persistence eventually paid off whereby constant chasing him up ensured that he complied with his program goals. Once on the methadone program, he continued to use heroin for a brief period until an optimum methadone level was reached. It was then possible for him to commence making lifestyle changes to complement his new direction in life.

During his three months on the MERIT program Billy did not commit any further offences. At their final court appearance Billy and Sally received good behaviour bonds after pleading guilty to their break-and-enter charges. At the time of preparing this case study, twenty one months after his program graduation, Billy had continued with the methadone program, remained free of illicit drug use and has not been further charged with criminal offences. He has continued his relationship with his partner who has also remained drug and crime free.

Billy continues to maintain contact with the MERIT team.

\* all names changed for the purpose of confidentiality.

John Scantleton  
Manager,  
NRAHS MERIT Program  
Lismore

10/02



### **Grace \***

Grace is a 25 year old Aboriginal woman with 3 children under the age of 5 years. Her partner of nine years, Steve, is a known drug user and offender and their relationship is characterised by domestic violence.

Grace was referred to the MERIT Program with charges of negligent driving and driving whilst disqualified. She is considered to be a habitual traffic offender and had already been disqualified from driving to the year 2011. Her criminal history also includes a number of stealing offences and one assault charge.

Grace reported that between them, she and Steve were spending up to \$400 per week on cannabis; she believes they smoked around half an ounce per week. As both Grace and Steve are unemployed this puts a huge strain on their limited income. Grace says that she is frequently pressured by Steve to 'score'. Steve is reported to also drink heavily.

Grace's MERIT treatment plan included one-to-one counselling, attendance at the MERIT day treatment program, supervised urinalysis and home visits. The goals she set for herself included abstinence from cannabis, developing insight regarding the impact of her drug use on herself and her children and the development of communication and assertion skills in her relationship with Steve.

Soon after Grace began the MERIT program she and Steve relocated with her father to a township some distance away. At this location Grace was isolated from the rest of her family and friends and her family situation deteriorated.

For the majority of the time that Grace was on the program she struggled to meet minimum standards of attendance and participation. Three weeks into the program she was charged with offensive language and assault after being removed from a local club. After twelve weeks in the program Grace had not managed to reduce her cannabis intake and her domestic situation had deteriorated with DOCS now involved. Her casework and monitoring had so far included:

- Counselling and group attendance.
- Supervised urinalysis and home visits.
- Referral to an Aboriginal Women's Group – failed to attend, was afraid Steve would find out.
- Referral to a sexual health clinic due to concerns about Steve passing on STD's to Grace – Grace failed the first and second appointments but eventually did attend.
- Referral to Family Support – failed to attend.
- Referral for Steve to attend the Aboriginal Men's Anger Management Group – refused.

At a MERIT case conference it was agreed that Grace should be offered further assistance. After a long discussion, Grace agreed to attend a detoxification clinic, telling Steve that she had no other option as the alternative was jail. This was not the case but it served her purposes. Her caseworker took the opportunity to do some intense work with Grace at this crucial stage and visited her each day at the detox unit.

Grace described her time in detox by saying she felt as though a fog had lifted. She responded very well to the intense counselling and was able to discuss the reality of the domestic violence perpetrated upon her. She was also able to talk more openly about the impact on her children of being exposed to this violence. She agreed to allow her case worker to contact her mother in Sydney and ask if Grace could relocate there with her children.

Grace's mother was pleased to assist, saying she had asked Grace on many occasions to leave Steve and come to Sydney. After Grace left detox she returned home and remained with Steve for two weeks but remained drug free. During this time she graduated from MERIT, though finalisation of her sentence was adjourned to a later date. Grace's involvement with

MERIT would normally have ended at this point. However, Grace called her case worker shortly afterwards saying that she needed to leave the following day as Steve was going away for the day. Train tickets to Sydney were organised and her caseworker collected her and her children and placed them on the train. Grace settled in with her mother, who offered to care for the children if Grace needed to return to the area to attend court.

This outcome was positive for all concerned. Grace was positive about her ability to remain drug free while not in a relationship with Steve. Her children were in a much safer environment and she had her mother and other family members in Sydney to give her ongoing support. She was very grateful for the opportunity to be a part of the MERIT Program.

\* all names changed for the purpose of confidentiality.

Michelle Skinner  
Case Worker  
NRAHS MERIT Program

### ***Henry & June \****

Henry was assessed and entered treatment with the MERIT Program on the 09/01/01 after being charged with: Larceny; Self administer a prohibited drug; Unlicensed driving & Having goods suspected stolen. Henry has a 14 year history of petty criminal behaviour and has been using heroin for around 11 years. Residential Rehabilitation was seen by both Henry and his case worker as the best treatment option. To complicate matters further Henry was in a relationship with \*June, who was also a MERIT client, she had been diagnosed with Schizophrenia and the couple were strongly co-dependent.

Initially Henry was only interested in entering a rehabilitation facility that would accept couples, his strong focus on June's illness and 'caring' for her had quickly become a useful distraction from the issues around his own drug use and associated criminal behaviour. He proposed to care deeply for June and have her best interests at heart, however there was very little, if any evidence of this. June had never been involved in criminal activity before her association with Henry and although she did have a heroin habit, she had maintained some stability in her life and her family relationships. June's case worker worked with her on reestablishing her relationship with her father, she eventually returned to the care of her father and the mental health professionals who had previously cared for her.

Henry was very impressed with the reputation of The Buttery Therapeutic Community, he had heard very promising anecdotal reports about the Buttery. They did not accept couples, but, due to the prestige he accorded to this community he eventually decided to proceed with an assessment for admission. While this was being organised and detox arrangements were being made Henry and June were frequent visitors to the MERIT office, there lifestyle was completely chaotic in relation to accommodation, food and generally the efforts involved in getting from one day to the next. They were extremely demanding of their case workers, and regularly harassed June's father for money. They repeatedly displayed inappropriate behaviour when in the waiting room, and on one occasion they were observed engaging in sexual activities in the building's female toilets.

On 'the street' Henry was being targeted heavily by the local police, his larceny charges related to \$17,000 only \$12,000 had been recovered by the police. One day in a counselling session Henry disclosed that he had in fact retained \$5,000 dollars, due to the Police regularly searching him and his belongings, he had decided to bury it on a local reserve. Unfortunately at the time of burial, Henry was stoned and neglected to mark the spot adequately, he could not locate the money. Police found him digging several holes in a local reserve one day and warned him they would charge him with malicious damage and trespassing if he continued this behaviour.

Daily counselling sessions were required to assist Henry in maintaining his motivation to attend The Buttery. The Buttery staff attended the MERIT office to assess Henry but he was arrested shortly following the interview. Henry was soon released after being questioned in relation to a crime the police suspected he was involved with. June's father, who was interstate, came to collect her and she entered a support program in the ACT in conjunction with the Mental Health Services and MERIT.

With all of his support removed and his partner showing signs of being serious about her recovery, Henry acknowledged the need to get serious about his issues. Continued offending resulted in him being bail refused but he was not removed from the program and the court endorsed a plan to seek a residential placement. He was discharged into MERIT custody after one week where he was immediately escorted to The Buttery. His ability to leave behind entrenched behaviours around addiction, such as manipulation and dishonesty took time and MERIT worked with The Buttery on these issues.

Henry was discharged and graduated from MERIT after completing phase one of their program. He remained in The Buttery program and completed phase two before entering a halfway and three-quarter-way house in the local area. Despite his graduation, MERIT retained an interest in his progress whilst he did the phase two of The Buttery Program. His

matters were finalised in September 2001 where he received 3 twelve month bonds, fines and Rising Of The Court X 6. Newspaper reports quoted the magistrate as giving a 'watershed sentence', despite a previous reputation as 'being a one man crime wave'.

June has remained in the ACT where she has established a new life with a non-using partner. She has returned to University studies and is also in employment. She returned to Lismore to finalise her court matters and was given a Section 10 (all charges dismissed) at Lismore court on her graduation. She occasionally contacts her caseworker to provide an update on her progress.

\*all names changed for the purposes of confidentiality.

Michelle Skinner  
Case Worker  
MERIT Program  
Lismore

Foot note. Both Henry and June remain drug free and stable as at April 2003. Henry now has his own business and his new partner is expecting their first child. Henry yesterday attended the MERIT accreditation consumer interviews and declined to accept a free movie ticket citing his need to 'put back' into the society.

John Scantleton  
Manager  
11<sup>th</sup> April 2003

## Client Letter

*(Note: This is a transcript of a hand-written document from a client of NRAHS MERIT. Spelling has been corrected.)*

To the MERIT Staff

Your program is extremely well done keep this up and you will be sure to save a lot of your people's lives. I was a young mother of 2 boys I fled from domestic violence and moved downstairs from my parents, they are lovely people but to me they were problematic for a number of reasons.

I was very confused not even knowing where our life was heading, I felt I had no-one because I was on drugs. I was also on methadone, my parents didn't even want to try to understand why this was all happening so when I started MERIT Liz questioned me on what scale from 0 to 10 would I rate myself as, I think it was about 8 or 9.

The first thing we worked on was me to control my drug use, I then moved out of my mother's so my boys didn't see the two people they love the most fighting. I went into crisis accommodation at Jays motel for 7 weeks. It was the most challenge I have come across, not knowing how or where me and my babies were to rest our little heads for the night, having Liz by my side I know deep inside everything will be alright. Just do all I can and I will see the light. Every day I was looking at places putting in applications and getting knocked back, that was the hardest time to stand strong for my babies. I felt like a failure but I was not going to let this one beat me. Three weeks passed and same thing kept on happening,

In the meantime I was coming off my methadone because I hated the effect and my eldest boy used to always ask me: mummy why are your eyes doing this (and he would droop his little eyes) it was very upsetting so within 1 week I cut off my methadone there was nothing in the whole world that could beat me at this one, this is for my babies, and I knew nothing would ever come in between us. As long as I'm around I would always assure my boys everything will be alright.

As weeks passed David kept telling me he hated the motel, he wanted grandma. I felt him drifting which made me more determined to push harder. It was week 6 and getting very stressful for everyone. I got the Weekend Bulletin which I knew didn't have NSW rentals but I was just going to find my bond and rent in Queensland, I have tried everything here. I found one place in the paper 2brm town house Tweed Heads so I rang straight up and went around and looked through it. It's right on the water I knew it wasn't safe for the boys but I just have to take them out more often which is what we all needed. Anyway by Wednesday we got a reply we could move in on Friday. I was wrapped. I have done it.

I didn't let it beat me so this is all meant to be, I'm now off methadone, can control my drug use and have a roof over my little babies heads. I can cope with a lot more now then ever before and that is having no family support which hurt very much knowing Liz could be here for me but my family couldn't. Thanks to Liz supporting and having a bit of faith in me helped a lot just to know someone in this world was there for me when I was feeling down and out. The MERIT program team was always willing to listen and would always cheer me up. When Liz wasn't available Debbie was, she shared her kindness all around I felt very comfortable talking about everything. MERIT you have the best team working in your office and if you all keep up your good work be sure that you will change a lot of troubled people in this world.

Thanks .....

(name suppressed to preserve confidentiality)

10/02