



office of crime statistics and research

# EVALUATION OF THE 6-MONTH DRUG TREATMENT PROGRAM

First published August 2012 by

Sophie Ransom

Office of Crime Statistics and Research  
Strategic Policy and Organisational Performance Division  
South Australian Attorney-General's Department  
G.P.O. Box 464  
ADELAIDE SA 5001

Copyright 2012 South Australian Attorney-General's Department

All rights reserved

# Contents

List of Tables .....	iii
List of Figures .....	iii
Acknowledgements.....	iv
Executive Summary.....	1
Introduction .....	5
Methods .....	7
Findings .....	8
Program Throughput and Profile of Participants .....	8
Program throughput.....	8
Number of referrals .....	8
Referral source .....	9
Court location .....	10
Status of clients .....	10
Repeat referrals.....	11
Completion rates .....	11
Length of time on program .....	12
Profile of participants.....	12
Sex, age and Indigenous status .....	12
Reported drugs of dependence.....	12
WHO ASSIST scores .....	14
Penalties.....	16
Nunga Court Summary.....	18
Stakeholder interviews .....	18
Changes to program since previous evaluation .....	18
The Treatment Intervention Program (TIP) Model .....	18
Designated magistrates.....	19
Roll-out of the program into suburban courts.....	20
Nunga court.....	21
Dealing with under-reporting drug use .....	21
Group therapy .....	22
Documentation and communication.....	24
Access to detoxification facilities .....	25
Exit strategy.....	25
Lack of time in groups .....	26
Current running of the program .....	27
Referral process .....	27

Client group .....	27
Difficulties dealing with alcohol and cannabis .....	29
Drug testing .....	31
Group therapy .....	32
Role of lawyers .....	33
Database upgrade .....	34
Program objectives .....	35
Changes to participants' drug use .....	35
Changes to participants' offending levels .....	36
Main strengths of the program .....	36
Main weaknesses of the model .....	38
Analysis of drug testing data .....	38
Method .....	39
Results .....	39
Conclusion .....	40
Discussion and conclusion .....	40
Key strengths and successes .....	41
Key weaknesses and opportunities for improvement .....	42
Limitations of this study .....	43
Recommendations .....	44
Conclusion .....	44
References .....	45

## List of Tables

Table 1	No. of clients accepted by program and financial year, 2009/10 – 2011/12.....	8
Table 2	Referral source for program clients.....	10
Table 3	Court location for all accepted clients .....	10
Table 4	Status of program participants as at 6 June 2012 .....	11
Table 5	Completion and successful completion rates by program .....	11
Table 6	Length of time in program by participant status .....	12
Table 7	Primary drug of dependence for program participants .....	13
Table 8	Client WHO ASSIST scores – drug posing greatest risk .....	14
Table 9	Client WHO ASSIST scores – highest risk level for one drug .....	15
Table 10	Client WHO ASSIST scores – risk levels for individual drugs.....	15
Table 11	Client WHO ASSIST scores – No. of drugs used at mod. or high risk level .....	16
Table 12	Sentencing status for program participants.....	17
Table 13	Penalties received for finalised cases by 6DTP completion status.....	17
Table 14	Proportion of drug tests showing positive result by month on program .....	39

## List of Figures

Figure 1	Number of clients accepted onto programs by quarter, Jan 2009 – Jun 2012 .....	9
----------	--	---

# Acknowledgements

Thanks are extended to program manager Sue King, for facilitating this evaluation, and to all interview respondents for giving their time to be interviewed. Also, thank you to Margaret Gosling and Marc Marshall at the Courts Administration Authority for providing the data extracts used in this research.

# Executive Summary

This report provides a follow-up evaluation study of the Courts Administration Authority (CAA) 6-Month Drug Treatment Program (6DTP). The program is based on the key components of the 12-month Drug Court program, and includes regular urine testing and court reviews, case management, group therapy and the use of sanction and reward points. However, unlike the Drug Court program, defendants do not need to be facing a possible 12-month custodial sentence to be referred to the 6DTP.

The 6DTP began as an option in the Drug Court in 2009. It then expanded to the Nunga Court at Port Adelaide in May 2010, and was also incorporated into the Treatment Intervention Program (TIP) which commenced at Christies Beach in May 2010, the Elizabeth Magistrates Court in July 2011, as well as the Youth Court (January 2012) and Adelaide Magistrates Court (April 2012).

Incorporating the 6DTP into the TIP enables assessment and treatment of clients with drug and mental health problems in the same program. Clients may be accepted onto the TIP under either the substance use stream, the mental health stream or under the co-morbidity stream, which deals with both drug and mental health (or mental impairment) issues. Under both the drug and co-morbidity streams, clients complete all components of the 6DTP.

A previous evaluation was conducted by the Office of Crime Statistics and Research (OCSAR) in 2010, when the program was in a pilot phase. That report found that the program filled a gap in services at the time between the 12-month Drug Court program and the brief 4-session Courts Assessment and Referral Drug Scheme (CARDS), and was largely successful in reaching its target group of clients. The findings from the evaluation were mostly positive, with some problems identified and recommendations for improvement made.

The aims of the current study are to:

1. Provide a descriptive profile of defendants who participated in the program since its inception;
2. Examine whether participants in the program have shown reductions in their level of drug use while involved in the program;
3. Examine whether program participants have shown a reduction in their levels of offending during and after participation in the program;
4. Assess support for the program amongst magistrates, the program manager and clinicians working with clients; and
5. Examine whether any changes have been made to the program as a result of the recommendations made in the evaluation of the pilot program (see previous *6-Months Drug Treatment Program Evaluation Report*).

A quantitative analysis of clients' offending before, during and after program participation does not appear in the current report, but will be included later as an addendum to this report.

## Methods

The study uses both qualitative and quantitative methods, including: analyses of operational data from the 6DTP database and client files; analysis of sentencing outcomes data from the CAA data warehouse; and semi-structured interviews with seven key stakeholders including the program manager, clinicians and magistrates.

## Summary of findings

### ***Profile and throughput***

- Between January 2009 and June 2012, there were 211 clients accepted into the 6DTP. Overall, 113 were accepted onto either the initial stand-alone 6DTP or the substance use (SU) stream of the TIP, and 98 were accepted onto the co-morbidity (CM) stream of the TIP. These numbers do not include referrals to the Nunga Court Drug program, which are summarised separately.
- The number of clients commencing the program per quarter increased over time.
- Based on outcome data available at the time of writing, 57 clients had completed the program (41 successfully), 51 were currently active on the program, 43 had been terminated, 30 had withdrawn and 9 were transferred to another program (either the 12-month Drug Court program, or the mental health stream of the TIP). Completion rates are comparable with other similar programs in Australia.
- The mean time spent on the mainstream 6DTP by completers was 7.2 months.
- The mean age of clients was 33.4 years, 73.7% were male, and 7.9% of clients were recorded as being of an Aboriginal or Torres Strait Islander background.
- The most common primary drugs of dependence were determined during assessment to be amphetamines for the substance use group, followed by heroin, and cannabis followed by amphetamines for the co-morbidity group.
- Scores for the World Health Organization (WHO) Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) show that amphetamine type stimulants, cannabis and alcohol were the drugs most likely to present the greatest risk to participants.
- Of the 174 clients who completed the ASSIST, 96.6% reported using at least one drug at a level that posed a moderate or high risk to them, with 44.3% at a high risk level.
- An analysis of sentencing outcomes for finalised cases shows that clients who completed the program successfully were less likely to receive a penalty of imprisonment and more likely to receive a more lenient penalty than those who did not successfully complete the program.
- Between April 2010 and April 2012, there were 34 referrals to the Nunga Court Drug Treatment Program. Of them, 28 clients were assessed, and 13 were accepted onto the program. Eight program participants were subsequently terminated, 1 withdrew, 2 were active on the program, and 2 had successfully completed the program.

### ***Stakeholder interviews***

Stakeholders were asked a series of questions about the current running of the program, the impact of any changes that had been made since, or as a result of, the previous evaluation, whether they thought the program was meeting some key objectives, and about their personal level of support for the program.

- Respondents were unanimous in their support for the integrated TIP model, and in the view that these courts should continue to have designated magistrates.
- Roll-outs to suburban courts appear to have gone well, with some valuable lessons learned to assist with future roll-outs.
- Only a few respondents had knowledge of the program operation in the Nunga Court, but they reported relatively low levels of engagement in that court, with low levels of referral and program commencement. Reasons for this and potential remedies may be the subject of a future study.
- Some referred clients appear to under-report their drug use in order to be recommended for the 6DTP rather than the more stringent Drug Court Program. Although transfer between programs in this case is possible, some respondents agreed that they would like to see the process more streamlined.
- Respondents generally agreed that the group therapy sessions were working well. Although all respondents would prefer that courts staff ran the group programs

themselves, they agreed that Offenders Aid and Rehabilitation Services (OARS; who currently run the group program) were doing a good job.

- Respondents generally agreed that Moral Reconciliation Therapy (MRT) was a successful group program for most clients, but some felt that an alternative should perhaps be more readily available for the small number of clients who struggle to engage with the program and some of the values underpinning it.
- Communication between stakeholders was thought to be good overall, with Operations Group meetings felt to be important. Respondents did not identify any major problems with existing program documentation, but reported that there is no program manual, which may become problematic as new staff commence. Further, there is need for clarification on some policy issues, which could be addressed in such a manual. A manual is currently being developed.
- Respondents felt that the referral process was working well and that the right client group was generally being reached.
- Some respondents identified a group of referred clients who were problematic because their drug use appeared too severe for the 6DTP, but their offending history did not warrant referral to the 12-month program. Clarification on how to deal with these clients is needed.
- Some respondents wanted to see individual client readiness to change taken more formally into account in the assessment process, so that they had the option of not recommending clients who were not interested in making change at that time and hence unlikely to succeed.
- Clarity about how to deal with cannabis in the 6DTP is needed, as is consistency in decision-making across sites. Although respondents agreed that a flexible approach is needed, clear guidelines for magistrates and clinicians would be helpful.
- Dealing with heavy alcohol use in the program is problematic, because a substantial proportion of clients report using alcohol at risky levels, but the program is not designed to deal with alcohol use. Drug testing does not include alcohol, but ongoing alcohol use undermines progress through the group programs, and can prevent clients from moving forwards with their lives. Some respondents wanted to see an alcohol treatment stream added to the TIP in the long term.
- Many respondents were disappointed that drug test samples were no longer sent for laboratory testing because they found the reports, particularly in relation to cannabis metabolite ratios, useful in dealing with clients and understanding their cannabis use while on the program. However, with costs making this option unlikely, alternative ways to monitor cannabis use could be investigated.
- Isolated problems with the integrity of the drug testing component were identified, including inaccurate recording of results, a sample not being held to enable results to be challenged, and drug testing staff engaging in inappropriate conversation with clients during tests. These had all been identified prior to the evaluation, and reportedly been addressed. However, these issues should continue to be monitored.
- The previous evaluation recommended that a specialty courts database be developed, or the existing database be upgraded, to enable efficient storage and access of all relevant data. This has not occurred, and the current system makes evaluation and monitoring difficult, results in double-entry of data, extra work for administration staff, and enables inconsistencies in data records.
- Interview respondents felt that participants made substantial changes to their level of drug use while on the program, but could not be certain about whether these improvements were maintained after program completion. Some reported that participants were well placed to succeed after completing steps in the group therapy such as identifying triggers and relapse prevention.
- Respondents felt that most clients reduced their level of offending while on the program, reporting that very few added new offences to their court files. Again, they were unsure about whether this was maintained after the program.
- Respondents identified a large number of program strengths including: that it is evidence-based and reflects best-practice; that it features professional, dedicated and

understanding staff and magistrates; that it requires accountability from clients; and that it is flexible.

- Some weaknesses and areas for improvement were identified, including: urine samples no longer being sent for laboratory testing; accepting inappropriate clients onto the program; and not being able to address alcohol use by clients.

### ***Drug test analysis***

- An analysis of drug test data at monthly intervals throughout the program revealed a strong decrease in the proportion of tests showing a positive result over time. The proportion of tests positive decreased from 70.1% at baseline to 9.8% after 5 months and 0.0% at 6 months. This trend was highly significant (chi square for trend = 61.78,  $p < 0.001$ ).

### **Recommendations**

The following recommendations regarding the 6DTP are made:

- That the integrated Treatment Intervention Program (TIP), enabling treatment of clients with co-morbid drug and mental health problems, be continued with designated magistrates in TIP courts.
- That Operations Group meetings be maintained to ensure good communication between stakeholders. Consideration should be given to including OARS in these meetings.
- That ways to increase engagement by Indigenous clients in both the mainstream TIP and the Nunga Court Drug Treatment Program be investigated.
- That clear guidelines are developed to deal with clients who demonstrate drug problems too severe for the 6DTP, but offending not severe enough for the Drug Court 12-month program.
- That consideration be given to formally incorporating individual client readiness to change into the assessment process.
- That a program manual be developed, which includes clear policies and guidelines for staff to use when making decisions about clients.
- That consideration be given to establishing regular meetings for magistrates involved in the program, to ensure consistency across the program sites.
- That clear guidelines are developed for staff and magistrates to use when dealing with clients who exhibit cannabis use while on the program.
- That consideration be given to expanding the TIP program in the longer term to enable treatment of clients with considerable problems with alcohol use.
- That the drug testing component of the program be monitored closely to ensure the integrity and accuracy of recorded results.
- That consideration be given to either: re-commencing laboratory testing of all urine samples (or at least those reading positive for cannabis) to enable cannabis-creatinine levels to be used by staff and magistrates in dealing with clients who use cannabis; or investigating an alternative method of monitoring cannabis use.
- That funds be allocated by the Courts Administration Authority (CAA) to develop a custom-designed database for courts intervention program data.

### **Conclusion**

Findings overall indicate a successful program. Staff and magistrates interviewed were highly supportive of the program, and dedicated to its success. Referrals are increasing and appear to be reaching the target group of clients. Although long-term outcomes and client views have not been investigated in the current report, based on evidence presented here the program appears to be having a positive impact on the lives of clients, especially those who complete the program. Attention to issues outlined in the recommendations would make for an even more successful and efficient program.

# Introduction

In January 2009 the Courts Administration Authority (CAA) established the 6-Month Drug Treatment Program (6DTP), with the aims of reducing illicit drug use, reducing re-offending, improving the health and social functioning of participants and improving access to intervention services for Aboriginal people and those from culturally and linguistically diverse backgrounds.

The program offers a diversion to drug treatment for adult and young offenders as part of the court process. Successful completion of the program is taken into account in sentencing and may result in a reduced sentence. The 6DTP is situated within the Interventions Programs Branch of the Courts Administration Authority (previously called Specialist Courts).

Section 21B of the *Bail Act 1985* enables the court to make it a condition of the bail agreement for a person to undertake an intervention program such as the 6DTP. (This must be agreed to by the defendant.) Proceedings can be adjourned under common law (Griffith remand) or under section 19B the *Criminal Law Sentencing Act 1988* for up to 12 months for the purposes of rehabilitation.

The program is available to offenders whose offending shows a clear link to drug use, who are suitable for release on bail and who are likely to benefit from a drug treatment intervention. The program was designed to provide an evidence-based intervention for drug-using offenders, who were ineligible for the more intensive and stringent 12-month Drug Court program but who would likely benefit from an intervention. It also replaced the brief 4-session Court Assessment and Referral Drug Scheme (CARDS). Offenders may be referred by their lawyer, by a magistrate or may self-refer, and then undergo an assessment process to determine their suitability for the program.

Following commencement in the Drug Court, the 6DTP was rolled out in the Nunga Court at Port Adelaide (in May 2010), and incorporated as the drug treatment component in the Treatment Intervention Program at Christies Beach Magistrates Court (commencing in May 2010), the Elizabeth Magistrates Court (commencing July 2011), the Youth Court (commencing January 2012) and the Adelaide Magistrates Court (AMC; commencing April 2012). The Nunga Court and Youth Court models are slightly different to the mainstream 6DTP model and are outlined in more detail below.

The Treatment Intervention Program (TIP) has replaced the Magistrates Court Diversion Program in the above court locations and targets eligible defendants with a mental disability or mental health problem and/or a substance dependence problem. This enables concurrent treatment of both drug and mental health problems for clients, where appropriate. Clients with either co-morbidity or straight substance dependence participate in all components of the 6DTP, including group therapy, court reviews and regular drug testing. The mental health component of the program focuses on symptom management and linking clients with relevant community service providers.

The 6DTP incorporates the same features of the 12-month Drug Court program, including intensive case management, regular drug testing, regular court reviews, the use of sanction and rewards points, group therapy sessions based on cognitive behaviour therapy and relapse prevention information (the Moral Reconciliation Therapy (MRT) and Staying Quit programs), and individual counselling for those clients who are not suitable for MRT. A main difference between the 6DTP and the 12-month Drug Court program is that clients must be facing the possibility of a 12-month custodial sentence to be referred to the Drug Court, but there is no similar requirement for the 6DTP. Participants enter the program voluntarily, but at entry sign a Treatment Plan which indicates that they agree to comply with the conditions of the program. Non-compliance with the program represents a breach of bail conditions and may result in termination from the program, or in a small number of cases, a temporary period of imprisonment.

Both the Youth Court and Nunga Court programs feature slightly different models, designed to build trust and address motivation and resistance in the first instance before attempting to engage the offenders in behaviour change. Both programs commence with case management and an offer of drug treatment, but not a requirement to commence drug treatment right away. After ten weekly case management sessions, if the drug treatment option is not taken up by the client, the program is terminated. Currently treatment sessions involve private psychological counselling for Youth Court clients, because there have not been enough referrals to commence group work, but this is an aim for the future. The same is true for the Nunga Court. The Nunga Court program is funded entirely by the Courts Administration Authority (rather than utilising funding from the Department of Health). It is run separately to the mainstream 6DTP and as such it operates as a stand-alone program, which is largely outside the scope of the current evaluation. However, a brief summary of client throughput for the Nunga Court is included in the relevant section, and some mention is made of the Nunga Court program throughout the report where relevant.

In 2010, the Office of Crime Statistics and Research (OCSAR) conducted a process evaluation of the implementation of the 6DTP (Ziersch and Traeger, 2010). That evaluation used both quantitative and qualitative research methods to monitor throughput of the program in its first seventeen months of operation, and determine the extent to which the program was implemented as intended. Findings were largely positive, with widespread support for the program. Initially, numbers of referrals to the program were high, but these declined in the final months of the evaluation period. Overall, the program had been implemented as intended, but some issues and potential areas for improvement were identified in the report. One aim of this study is to examine changes to the 6DTP that have been made as a result of that previous evaluation.

The aims of this research are to:

1. Provide a descriptive profile of defendants who participated in the program since its inception;
2. Examine whether participants in the program have shown reductions in their level of drug use while involved in the program;
3. Examine whether program participants have shown a reduction in their levels of offending during and after participation in the program;
4. Assess support for the program amongst magistrates, the program manager and clinicians working with clients; and
5. Examine whether any changes have been made to the program as a result of the recommendations made in the evaluation of the pilot program (see previous *6-Months Drug Treatment Program Evaluation Report*).

It must be noted that the analysis of clients' offending before, during and after program participation does not appear in the current report, and will be completed as an addendum at a later date.

## Methods

This report uses both qualitative and quantitative methods. Methods for individual analyses are outlined in more detail in the relevant sections.

The program throughput and participant profile section uses data from the 6DTP database and client files, as well as sentencing outcome data from the CAA data warehouse, to provide a summary of clients referred to and commencing the 6DTP program.

The stakeholders interviews section presents data collected through semi-structured interviews with seven key program stakeholders. Interviews investigated changes made to the program since the previous evaluation, current running of the program, support for the program, and to what extent it appears to be meeting its objectives

The participant drug use section features a quantitative analysis of urine test results. The data is used to investigate the proportion of the client group returning positive drug tests at monthly intervals as they progress through the program.

An analysis of offending outcomes for participants, including a comparison of pre- and post-program offending, will be featured in a later addendum to the current report. That analysis will use data extracted from the Justice Information System (JIS), as well as data provided by the Department of Correctional Services regarding time spent in custody during the period under investigation..

# Findings

## Program Throughput and Profile of Participants

This section provides a summary of the throughput of clients undertaking the 6DTP, either as the earlier stand-alone program, or later in either the straight substance use stream (SU) or the co-morbidity stream (CM) of the Treatment Intervention Program (TIP). Clients commencing the stand-alone 6DTP program are combined here with clients commencing the TIP substance use (SU) stream, because the programs are essentially the same and differ in name only.

This section uses operational data from the 6DTP database and client files to provide a picture of the number and types of clients referred to the program, their drug use before commencing the program, and their program outcomes. Data from the Drug Court regarding the Nunga Court drug treatment program is included in a separate summary section. This section also uses data from the CAA data warehouse regarding clients' final sentencing outcomes (for finalised cases).

The section is comprised of three parts. Firstly, the number of clients commencing the program from commencement (January 2009) to the end of the 2011/12 financial year is presented, by financial year and quarter. Secondly, details for clients and their outcomes on the program are presented, but for a subset of clients referred to the program from commencement up to the end of April 2012. Thirdly, the characteristics of clients are summarised for this same group. The reason for this is that at the time of analysis, data was only available up to the end of April 2012.

### Program throughput

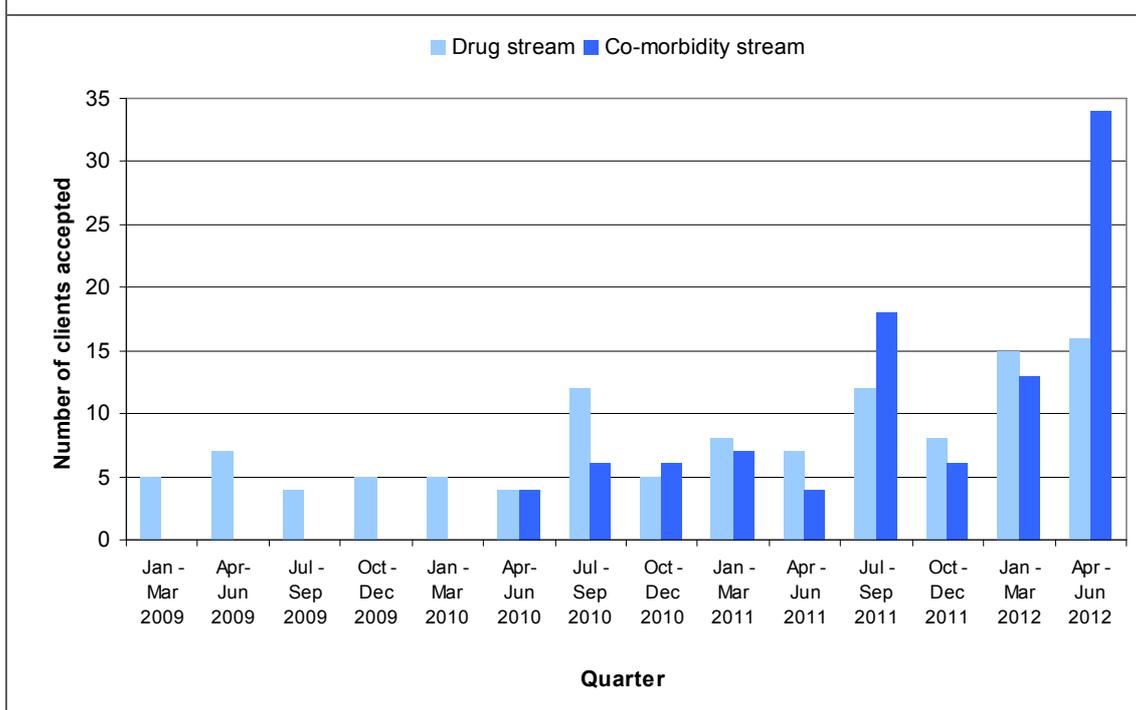
#### *Number of clients*

It is not possible to present the total number of referrals to the 6DTP over time, because as the 6DTP was integrated into the TIP, clients began to be referred to the TIP for assessment, whether they had drug problems, mental health problems or both. Therefore, some of these clients may be referred for mental health problems only, and should not be counted as referrals to the drug program.

Between January 2009 and June 2012, there were 211 clients accepted into the 6DTP. Overall, 113 were accepted onto the substance use (SU) stream (including the initial stand-alone 6DTP), and 98 were accepted onto the co-morbidity (CM) stream. Table 1 and Figure 1 show that the number of acceptances to both programs increased considerably during the 2011/12 financial year.

	Total	SU	CMP
2009/10	22	18	4
2010/11	55	32	23
2011/12	122	51	71

**Figure 1** Number of clients accepted onto programs by quarter, January 2009 – June 2012



The following sections summarise details and characteristics of clients referred and accepted onto the 6DTP between January 2009 and April 2012.

### **Referral source**

Table 2 shows the referral source for clients of each program, and for both combined. There were statistically significant differences between the groups, with CM stream clients more likely to be referred by a magistrate and SU stream clients more likely to be referred by a legal representative ( $\chi^2(4, 190) = 13.67, p < 0.05$ ).

Referral source	Total		SU		CM	
	n	(%)	n	(%)	n	(%)
Magistrate	57	(30.0)	24	22.4	33	39.8
Legal Representative (total)	111	(58.4)	66	61.7	45	54.2
Legal Services Commission (LSC)	6	(3.6)	3	2.8	3	3.6
Aboriginal Legal Rights Movement (ALRM)	1	(0.5)	-	-	1	1.2
Self	10	5.3	10	9.3	-	-
Other	1	0.5	1	0.9	-	-
Unknown	11	5.8	6	5.6	5	6.0
Total	190	100.0	107	100.0	83	100.0

### ***Court location***

Table 3 shows the court location for accepted clients. The majority of clients were from the Drug Court or AMC, followed by Christies Beach.

Court location	Total		SU		CM	
	n	(%)	n	(%)	n	(%)
Drug Court/Adelaide Magistrates Court	89	46.8	76	71.0	13	15.7
Christies Beach	63	33.2	18	16.8	45	54.2
Elizabeth	37	19.5	13	12.1	24	28.9
Youth Court	1	0.5	0	0.0	1	1.2
Total	190	100.0	107	100.0	83	100.0

### ***Status of clients***

Table 4 shows the current status of clients referred to both programs, based on data available at the time of writing. Overall 57 clients have completed the program with another 51 remaining active on the program.

The six 6DTP clients who were transferred to another program were all transferred to the 12-Month Drug Court Program, and the three CMP clients were all transferred to the Mental Health Program only.

Status	Total		SU		CM	
	n	(%)	n	(%)	n	(%)
Active	51	26.8	22	20.6	29	34.9
Completed	57	30.0	36	33.6	21	25.3
Terminated	43	22.6	27	25.2	16	19.3
Withdrew	30	15.8	16	15.0	14	16.9
Transferred to another program	9	4.7	6	5.6	3	3.6
Total	190	100.0	107	100.0	83	100.0

### **Repeat referrals**

Amongst this group, there were four individuals who received referrals to one of the two programs on two separate occasions. Three were initially referred to the 6DTP and one was initially referred to the CMP. Of those referred to the 6DTP, two were terminated and one withdrew. The respondent referred to the CMP also withdrew. Of these four individuals, two were later referred to the same program again (one to the 6DTP and one to the CMP), and the other two were referred to the CMP. One of those referred to the 6DTP then the CMP has since withdrawn from that program, and the remaining three respondents remained active at the time of writing.

### **Completion rates**

Table 5 shows that overall, of those no longer active on the program (n=139), 41.0% had completed the program. There was no significant difference in completion rates for the two programs.

Not all completers of the program are considered successful. Some participants may remain active on the program for 6 months but not complete all the stages of group therapy, and/or not cease or substantially reduce their drug intake during that time. Table 5 shows the proportion of program completers in each program who were considered successful.

	Total	SU	CM
Number of clients accepted and no longer active	139	85	54
Number of clients completing program	57	36	21
% of non-active clients completing program	41.0	42.3	38.9
Number of clients successfully completing program	41	24	17
% of non-active clients successfully completing program	29.5	28.2	31.5

This level of program completion is comparable to those found in studies of other Australian Drug Court programs. For example, the South Australian 12-month Drug Court program showed a completion rate of 36.1% (Ziersch & Marshall 2012), the New South Wales Drug Court showed a completion rate of 40.2% (Weatherburn et al 2008), and the Queensland Drug Court showed a completion rate of 31.2% over its first six years of operation (Payne 2008).

### ***Length of time on program***

Table 6 shows the length of time spent on the program, by program status. The mean time to complete the program (amongst completers) was just over 7 months. Some individuals spent considerably longer than 6 months on the program, but these were relatively small in number. The one individual who had been involved in the program for 519 days (over 17 months) had commenced in the co-morbidity stream and then transferred to the substance use stream after approximately 8 months.

Status	Mean days (months)	Min days (months)	Max days (months)
Active (n=51)	86.5 (2.9)	9 (0.3)	299 (10.0)
Completed (n=57)	216.2 (7.2)	154 (5.1)	519 (17.3)
Terminated (n=43)	78.7 (2.6)	9 (0.3)	266 (8.9)
Withdrew (n=30)	69.6 (2.3)	14 (0.5)	266 (8.9)
Transferred to another program (n=9)	103.9 (3.5)	14 (0.5)	203 (6.8)

## **Profile of participants**

### ***Sex, age and Indigenous status***

Of clients commencing the program, 140 (73.7%) were male and 50 (26.3%) were female. The proportion of females was higher in the Co-morbidity program (34.9%) than the 6DTP (19.6%) ( $\chi^2(1, 190) = 5.65, p < 0.05$ ).

The average age of clients accepted onto either program was 33.4 years (SD=8.1), with a range from 14 to 62 years. Clients accepted onto the 6DTP were on average slightly older (34.5 years; SD=7.8) than those accepted onto the CMP (32.1 years; SD=8.3) ( $t(189) = 2.04; p < 0.05$ ).

Overall, 15 participants (7.9%) were recorded as being of Aboriginal or Torres Strait Islander (ATSI) background. There was no significant difference in the rate of clients with an ATSI background among participants of the two programs.

The proportion of males and females in the program has not changed since the previous evaluation, but the proportion of clients reporting to be Indigenous has decreased from 14.3%.

### ***Reported drugs of dependence***

Table 7 shows the primary drug of dependence for participants on both programs, as assessed by the clinician at the time of the initial assessment. This assessment is based on

participant reports about their drug use, and the perceived level of impact on the client's life. Overall, amphetamines were the most common primary drug of dependence. For 6DTP participants, amphetamines were the most common primary drug of dependence, but for CMP clients, cannabis was the most common.

There were statistically significant differences between the groups ( $\chi^2(9, 190)=47.6, p<0.001$ ), Clients on the 6DTP were more likely than those on the CMP to report amphetamines or heroin as their primary drug of dependence, while those on the CMP more likely than those on the 6DTP to report cannabis to be their primary drug of dependence.

Of the 135 program clients for whom a primary drug of dependence was recorded, 78 (58%) also recorded at least one secondary drug or dependence, indicating poly drug use.

Primary Drug	Total		SU		CM	
	n	(%)	n	(%)	n	(%)
Methamphetamine/Amphetamine	60	31.6	50	46.7	10	12.0
Cannabis	34	17.9	11	10.3	23	27.7
Heroin	16	8.4	13	12.1	3	3.6
Alcohol	14	7.4	7	6.5	7	8.4
Benzodiazepines	4	2.1	2	1.9	2	2.4
Morphine	3	1.6	3	2.8	-	-
Buprenorphine	2	1.0	2	1.9	-	-
Codeine	1	0.5	-	-	1	1.2
Opium	1	0.5	-	-	1	1.2
Unknown	55	28.9	19	17.8	36	43.4
Total	190	100.0	107	100.0	83	100.0

Consistent with the previous evaluation, amphetamines were the most common primary drugs of dependence. The previous evaluation found that heroin was the second-most common primary drug, whereas this study found this to be cannabis. This is likely to be attributable to the fact that cannabis was more common as a primary drug amongst those on the co-morbidity program than the 6DTP. Previously, these clients may have participated only in the Magistrates Court Diversion Program, rather than the combined program as they are now able to do under the TIP. In this way, combining clients from both treatment streams has changed the drug profile, with more clients reporting cannabis as a primary drug of dependence and relatively less reporting heroin. These drugs are very different, with different patterns of use and effects, and this may affect therapy group dynamics and have an impact on the focus of group therapy sessions in the program.

### **WHO ASSIST scores**

Client drug use was also assessed using the World Health Organization (WHO) Alcohol, Smoking and Substance Involvement Screening Test (ASSIST). This tool was developed to detect and manage substance use and related problems in medical care settings, and indicates the level of risk associated with the client's current level of drug use. It can also be used to indicate a recommended level of intervention. The tool is administered by a clinician, and based on self-reported responses from the client.

The ASSIST provides scores for individual drug types. Scores from 0 – 3 (10 for alcohol) indicate a low risk and no intervention required, scores between 4 (11 for alcohol) and 26 indicate a moderate level of risk and recommend a brief intervention, and scores of 27 and over indicate a high level of risk, and recommend more intensive intervention.

The WHO ASSIST is administered to all clients as part of the 6DTP initial assessment, and helps inform the decision as to whether the client should be accepted onto a court drug program, and if so, which one. Although other information about the client is also taken into account, clients demonstrating drug use at a moderate risk level are likely to be considered suitable for the 6DTP, while clients demonstrating drug use at a high risk level may be more suited to the 12-month program (although offending history is also highly relevant), and clients demonstrating use at a low risk level may not be recommended for participation in either program.

To determine the drug which poses the greatest risk for each client, the highest score for an individual drug type was used. Table 8 shows that amphetamine type stimulants were the drugs most likely to pose the greatest risk for clients, especially for those in the 6DTP. For clients in the CMP, cannabis was more likely to pose the greatest risk.

<b>Table 8 Client WHO ASSIST scores – drug posing greatest risk</b>						
Drug posing greatest risk	Total		SU		CM	
	N	(%)	n	(%)	n	(%)
Amphetamine type stimulants	57	32.8	44	44.0	13	17.6
Cannabis	53	30.5	29	29.0	24	32.4
Alcoholic beverages	30	15.5	12	12.0	18	24.3
Opioids	28	16.1	12	12.0	16	21.6
Sedatives or sleeping pills	5	2.9	2	2.0	3	4.1
Inhalants	1	0.6	1	1.0	-	-
Total	174	100.0	100	100.0	74	100.0

Table 9 shows the risk level associated with the drug posing the greatest level of risk for each client. The table shows that only a very small minority of clients referred demonstrated a low risk associated with their drug use. These clients may have been in custody at the time of the assessment, where they cannot access drugs. This would influence their ASSIST scores, because a series of questions relates to drug use over the past three months.

Just over one half of referred clients demonstrated a moderate risk and just under one half demonstrated a high risk. Some cell sizes were too small to test for a statistically significant difference between the two programs, but the 6DTP group were somewhat more likely to demonstrate a high risk while the CMP group were more likely to demonstrate a moderate risk.

Highest risk level	Total		SU		CM	
	n	(%)	n	(%)	n	(%)
Low risk	6	3.4	3	3.0	3	4.1
Moderate risk	91	52.3	49	49.0	42	56.8
High risk	77	44.3	48	48.0	29	39.2
Total	174	100.0	100	100.0	74	100.0

Table 10 shows the risk levels for clients associated with their use of individual drug types. The table shows that a large majority of referred clients reported using cannabis at a level presenting either a moderate or high risk (72.4% overall), while 60.4% reported using amphetamine type stimulants at a level presenting either a moderate or high risk. For both groups, cannabis was the drug most likely to present a moderate risk, but for the 6DTP group amphetamine type drugs were the most likely to present a high risk. For both groups, alcohol and opioid use also posed a risk for a substantial proportion of clients.

Drug type	Total		SU		CM	
	(N=174)		(N=100)		(N=74)	
	Risk level					
	% mod	% high	% mod	% high	% mod	% high
Amphetamine type stimulants	42.0	18.4	46.0	27.0	36.5	6.8
Cannabis	56.3	16.1	62.0	14.0	48.6	18.9
Alcoholic beverages	20.1	12.6	18.0	10.0	23.0	16.2
Opioids	22.4	8.0	25.0	5.0	18.9	12.2
Sedatives or sleeping pills	13.2	3.4	16.0	2.0	9.5	5.4
Cocaine	6.3	-	6.0	-	6.8	-
Hallucinogens	5.2	-	8.0	-	1.4	-
Inhalants	1.1	-	1.0	-	1.4	-
Other	2.3	-	4.0	-	-	-

Table 11 summarises the number of drugs clients reported using at a moderate or high risk level. The majority of the group used more than one drug at a moderate or high risk level, indicating a high rate of poly-drug use. Again, the small number of clients shown not to be using any drugs at a moderate or high risk level may have been in custody prior to or at the time of their assessment, which would influence their recent level of drug use.

<b>Table 11 Client WHO ASSIST scores – No. of drugs used at mod. or high risk level</b>						
Number of drugs used at moderate or high risk level	Total		SU		CM	
	n	(%)	n	(%)	n	(%)
No drug types	4	2.3	2	2.0	2	2.7
1 drug type	40	23.0	16	16.0	24	32.4
2 drug types	66	37.9	39	39.0	27	36.5
3 drug types	40	23.0	28	28.0	12	16.2
4 drug types	18	10.3	11	11.0	7	9.5
5 drug types	5	2.9	3	3.0	2	2.7
6 drug types	-	-	-	-	-	-
7 drug types	1	0.6	1	1.0	-	-
Total	174	100.0	100	100.0	74	100.0

Overall the results from the WHO ASSIST show that clients referred to the 6DTP show a high rate of risky drug use, and that many use more than one drug at risky levels. Almost half of 6DTP-referred clients and over one third of CMP-referred clients were found to have a high level of risk associated with their drug use. This demonstrates both that the program is reaching the desired target group, and also that many clients have significant drug problems which are difficult to address.

### ***Penalties***

Table 12 lists the sentencing status for program participants, as a result of the offences for which they were referred to the program. Overall, 63 cases have not yet been finalised and the outcome or status is unknown for 14 cases. Of those finalised, suspended imprisonment was the most common penalty received.

<b>Table 12 Sentencing status for program participants</b>		
Penalty or status	Total	
	n	(%)
Imprisonment	17	8.9
Suspended imprisonment	57	30.0
Bond	17	8.9
Fine	4	2.1
Community Service Order	1	0.5
Licence disqualification	2	1.1
Convicted without penalty	6	3.2
Dismissed/withdrawn/no action taken	9	4.7
Not finalised	63	33.2
Unknown	14	7.4
<b>Total</b>	<b>190</b>	<b>100.0</b>

Table 13 shows penalties received for finalised cases, for participants who successfully completed the program and those who either did not complete the program or did not complete it successfully. The table shows that participants who successfully completed the program were less likely to receive the most severe penalty of imprisonment and more likely to receive a penalty of suspended imprisonment, another penalty, or have their matter withdrawn or dismissed. Some cell sizes are too small for significance testing, so it is not known whether these differences are statistically significant.

<b>Table 13 Penalties received for finalised cases by 6DTP completion status</b>						
Penalty	Successfully completed		Did not successfully complete		Total	
	n	(%)	n	(%)	n	(%)
Imprisonment	1	2.6	16	21.6	17	15.0
Suspended imprisonment	21	53.8	36	48.6	57	50.4
Other penalty	10	25.6	14	18.9	24	21.2
No penalty	1	2.6	5	6.8	6	5.3
Dismissed/withdrawn/no action taken	6	15.4	3	4.1	9	8.0
<b>Total</b>	<b>39</b>	<b>100.0</b>	<b>74</b>	<b>100.0</b>	<b>113</b>	<b>100.0</b>

## **Nunga Court Summary**

Between April 2010 and April 2012 there were 34 referrals to the Nunga Court 6-month Drug Treatment Program. Of them, 21 were male and 13 were female. The age of referred clients ranged from 19 to 49 years, with an average of 32.0 years (SD = 8.8).

Most referred clients (28) were assessed, one had not yet been assessed and five were not assessed. Of those assessed, 13 were accepted onto the program and 15 were not accepted.

At the time of writing, 8 of the clients commencing the program had been terminated, 1 had withdrawn, 2 (1 male and 1 female) had successfully completed the program and 2 (1 male and 1 female) were active on the program.

## **Stakeholder interviews**

This section summarises responses given by stakeholders during semi-structured interviews. It is presented in three sections: changes made to the program since the previous evaluation and the impact of these; how the program is currently running; and whether the program is meeting key objectives.

Semi-structured interviews were conducted with some key 6DTP stakeholders. Interviews were conducted at the respondents' workplaces and were recorded then transcribed for analysis. Interviews were conducted with the program manager, three courts clinical staff and three magistrates.

### **Changes to program since previous evaluation**

Respondents were first asked about changes made to the program in response to the findings from the previous OCSAR evaluation report, and their perception of the impact of these.

#### ***The Treatment Intervention Program (TIP) Model***

One major change has been the merging of the 6DTP with the previous Magistrates Court Diversion Program into the Treatment Intervention Program (TIP), which is able to treat clients with drug problems, mental health problems, and also those with both.

Interview respondents were unanimously in support of this model. The primary reason given for this was that it deals with clients in a more holistic manner. Respondents felt that in reality the majority of clients have both drug and mental health problems, and that to treat only one while ignoring another does not maximise the benefit for the client. Moreover, treating the problems in separate specialty courts leaves court staff with the difficult task of deciding which problem is the most salient at the time. Another important reason given was that often drug use and poor mental health are often related (with one frequently playing a causative role in the development of the other), and if treating only one, it can be difficult to determine which is the root problem.

*... a significant number [of clients] have co-morbidity, a mixture of mental health problems and drug problems. Sometimes they have an organic mental health problem and a drug problem which develops, and sometimes it's vice versa; their drug problem is so significant that they develop mental health problems. I suppose in a sense it doesn't really matter, they have the dual problem and if you don't have a court with those two issues combined in the court, then you have that difficulty of deciding whether the person should be in a mental health court or drug court and trying to, in a sense, divide up their problem and work out which one is the most serious at the time.*

*Often the drug use goes hand-in-hand with poor mental health. It's often very difficult to know which one is first and which one is second. If you're looking at drug use and treating drug use, at some stage you need to get to grips with the depression, schizophrenia, bi-polar. Is it a pre-existing condition and they're taking the drugs to actually deal with the symptoms of their mental illness or will those mental illnesses resolve once their drug problem has gone away? So by looking at both issues from a health model, you're getting better to the bottom of 'what's the health issue?' From a criminal justice perspective, which is really our main focus, you're much more likely to achieve real change if you can deal with both issues.*

Some respondents also mentioned that having one program with separate streams provides for ease of assessment, and a lack of duplication. A client can be referred to the program before their needs are clear, and then be directed into the appropriate stream based on the assessment findings.

*So I think it's much better to have a program that has the three separate treatment streams, do one assessment and then from that assessment the person is streamed into one of the treatment avenues.*

Overall, respondents were strongly supportive of this new model and unanimous that this approach to clients should be maintained.

### **Designated magistrates**

Since the previous evaluation designated magistrates have been assigned to the TIP at all sites, where either one or two magistrates sit for TIP court days. Where two magistrates share a site, they divide up clients, so that each time a TIP client comes for a court review, they will always see the same magistrate.

All respondents reported that this was extremely important to the success of the program. Respondents mentioned the need for consistency, the importance of trust and continuity between the magistrate and the client, and the benefit of magistrates having the opportunity to gain a full understanding of a defendant and their needs, in order to make fair and balanced decisions.

*...ultimately that magistrate gets to know the clients, gets to know what's going on, is able to then balance a review against what's going on in that person's life, because they're more aware of what's going on. They can actually give a more therapeutic response than a stranger and it's consistent...*

One magistrate also mentioned the benefits of designated magistrates in terms of forming a relationship with the TIP co-ordinator, so they have open lines of communication and a shared understanding of the clients' needs.

*I think a fundamental part of TIP is for the clients and the magistrate to develop a relationship, and for the Magistrate to develop a relationship with the person co-ordinating the TIP program, so they have one contact point and then the court rep. for each program meets with the magistrate before court and talks about any issues that aren't necessarily clear in the report or some things you just can't*

*portray in a report. If a person's having lots of personal issues or lots of money issues, you can't necessarily get those things across clearly in a report.*

One magistrate reported that sitting in this type of court is a lot more tiring for magistrates than general court, and that for this reason the magistrate may need to be replaced after 12 months or so.

Overall respondents felt that having designated magistrates in the TIP courts was in line with international best practice in treatment courts and were unanimous that this aspect of the program should not change.

### ***Roll-out of the program into suburban courts***

Since the previous evaluation, the program had been extended to the Magistrates Courts at Elizabeth and Christies Beach, as well as the Youth Court and Nunga Court at Port Adelaide (although under somewhat different models). Respondents were asked about how successful this roll-out had been, and how the program was working in the new sites. Respondents were all in support of the broader roll-out of the program and felt it was very important to broaden access to the program as much as possible.

*I would like to see a Treatment Intervention Program in as many places as possible because it is my fundamental belief that there is an underlying issue for some people, or ... often more than one underlying issue, and therefore if you come to court, wherever you come to court, you should be able to access an appropriate Treatment Intervention Program.*

One respondent involved in the roll-out at Christies Beach felt that although there were problems right at the beginning of program implementation at that site, valuable lessons were learned which are now helping with further roll-outs.

*There's always teething problems when you roll out a new program. To be frank, we probably rolled it out without everything in place... It's much better now as we roll out, because having done Christies [Beach], we've got things like urine testing already in place ... so I think as each roll-out's gone on it's been easier to roll it out.*

Another respondent, also talking about Christies Beach, felt that the program there now runs extremely well.

*The program staff really do most of the work and they do a very, very good job. Things get done reasonably promptly in terms of when appointments have to be arranged with medical specialists and that sort of thing, or assessments being done. ...I think this works as well as any specialist court I've been in.*

While respondents were unanimously in support of the program rolling out more broadly and felt it had generally gone well, some respondents were concerned about inconsistency between the programs at the different sites.

*I think we've got some inconsistencies between the three courts that have TIP. That doesn't always come from the clinicians, some of that comes from the magistrates... [in terms of] ...who they accept and who they don't, awarding of points.*

*I think there has been some inconsistency around awarding of points, but really that comes down to the magistrate, they ultimately make that decision anyway but there was an occasion where we were trying to work out what to do with cannabis use ... Elizabeth at one stage was holding off awarding points for cannabis use over x number of weeks and we weren't doing that at Christies Beach...*

There was general agreement that although decisions would always differ somewhat between magistrates, general consistency across sites was highly desirable. Several respondents, both magistrates and clinicians, mentioned the possibility of establishing a forum for magistrates to discuss decisions and ensure they are taking a consistent approach.

*I think we should aim for consistency of practicing and in order to do that I think we need to co-ordinate the people who are sitting in those courts and get them talking to each other and try and have as much consistency between them as possible.*

*I think those of us that are sitting in these courts at the moment are aware that we should try and be as consistent as we can be. One of the things that we're looking at doing in the future is try to have a time when all of us can meet, possibly by video, so we can actually discuss the issues that relate to consistency.*

Overall respondents were strongly supportive of the TIP expanding and did not identify any major problems with the current expansion to new sites. A regular meeting for magistrates is something that should be investigated in future, because all respondents were supportive of such an idea and felt that consistency in decision-making across sites was very important.

### ***Nunga court***

Although largely beyond the scope of the current evaluation, respondents were asked about the running of the Drug Treatment Program in the Nunga Court. Many were not involved in the Nunga Court program, but some respondents had knowledge of the program there and were able to comment on it. Generally they reported that there was a low level of engagement with the 6DTP there, with few referrals and little willingness from clients to commence the program. It appears that the program is facing difficulties in this court, and reasons for this and ways to remedy them may be the focus of a subsequent evaluation.

### ***Dealing with under-reporting drug use***

In the previous evaluation it was found that some clients would intentionally under-report their drug use during initial assessment in order to be placed on the more lenient 6-month program rather than the 12-month Drug Court program. It was recommended that a protocol be developed to easily transition them to the 12-month program when this was found to be the case. Respondents felt that this type of transfer had become much easier with a uniform assessment for both programs, but this was also flagged as something that will become even more streamlined in future.

*We have this where we suspect, 'Well, looking at the offences, this is more than just cannabis use', so we would say, 'Well, based on what you've told me it's the 6-month program and you should go to TIP. But really, we're not sure. We think you've understated. So we'll put you on the 6-Month program and we'll keep you and we'll put the rider in that "if the person struggles to do well, then we'll move you to the 12-month"... So it is possible.*

*...we'll get some protocols in place so whoever we assess and whoever Drug Court assesses, if Drug Court think they should be on just the straight 6-month program, they'll flip them over into what we're doing in the 6-month in TIP and if TIP thinks they should really be in the Drug Court 12-month program they'll go to Drug Court ...it hasn't really been stream-lined.*

Overall, respondents agreed that while transferring clients from the 6DTP to the Drug Court was important, it was not necessarily easy to do, and this is identified as something to be improved in future. However, it must be noted that difficulty in transferring clients was not identified as a major problem by any respondents.

This problem also relates to another problem, where clients with drug problems too severe for the 6DTP are referred and accepted, but there is little alternative because their offending level does not warrant involvement in the 12-month Drug Court program. This problem is discussed in more detail later, but where a client is clearly suitable for the 12-month program, the process of transferring them to that program should be made as straightforward as possible.

### **Group therapy**

There have been two main changes to the program in relation to the group therapy component, since the previous evaluation. Firstly, with an increasing number of clients engaging in the new co-morbidity stream, rather than just the drug program, an increasing number of group therapy clients are likely to also have mental health problems. The second major change is that the group therapy is now outsourced to Offenders Aid and Rehabilitation Services (OARS), rather than run by court staff.

Respondents did not feel that having clients with concurrent drug and mental health problems impacted on the success of the group therapy, especially considering many clients previously had mental health problems anyway, they were just not recognised and addressed by the program as they are now. Some respondents mentioned that not all clients were suitable for the group therapy, and if their mental health did not allow it, they would be recommended for individual counselling instead.

*What OARS have found is that MRT just works brilliantly with our 6-month group. We knew that because we've got feedback from the States where they're running it with people with mental health problems in the States. They say that they take to it really well, they really enjoy it, they see results quickly.*

*That's [suitability for group therapy] the very first thing we look at. If there's a mental health issue that would stop them being able to participate in a group, they won't go in the group. So they all have to be functioning at a reasonable level. The other thing we might do is get a psychiatric review and get their medication sorted before they start group.*

*The other thing is that not everybody's suitable for MRT, so I haven't been able to recommend everybody and sometimes the psychologist will... if somebody's*

*got high anxiety or another psychiatric illness that would probably preclude them from being able to actively engage... then we don't recommend them.*

With regard to OARS running the group programs, respondents held mixed views. Although they all agreed that OARS seemed to be doing a good job, almost all respondents would prefer to see the program run by courts staff, for various reasons.

*I think generally that's working pretty well... I think generally I have found that all [OARS] facilitators are very approachable, very reasonable, willing to discuss issues and I've had no problems at all.*

*The ideal would be that we'd do it ourselves... but I think we're getting the best we can. OARS are certainly doing a very good job.*

*... [I would like to see] less outsourcing to outside agencies, your own experts being involved in the program so that you've got real consistency in the way your programs are being delivered and clear expectations. I'm not saying the people that are doing it are not good at the moment, but I think you'd rather have your own staff delivering the program.*

One main concern was that clients would be able to lie to OARS staff and get away with it because they may not have the same level of knowledge about their recent drug use and behaviour as would courts staff. One respondent felt that because of the increase in opportunities for clients to manipulate any gaps in communication between the courts and OARS, their progress was not as quick in group therapy now.

*...research has shown that the more services and the more service providers there are, the more chance there is for this client group to start driving wedges in and create problems,.. What we're finding is the progress, the speed, the rate of the progress that we were seeing where people would start to accept what was happening to them and realise that they had a huge part to play in where they are, that's happening, but not as quickly.*

One concern was that court clinicians would lose a lot of knowledge about how their clients were going because they would not get to hear what they said each week in the group therapy. Another respondent felt that it was difficult to make spur-of-the moment decisions, for both clinicians and OARS facilitators, because of the time-lag in the sharing of client information back and forth.

*... because we make the decision whether someone's given us a positive [drug test], declared, not declared... it's a carry-over. They [OARS] don't know that, so they've got to wait for us to tell them that. It has created problems between them and us in the sense of they are making a decision but it's not always the right one.*

On the other hand, one benefit of OARS providing group therapy, mentioned by clinicians, was that they had more time for other work now that they did not have to run the groups themselves. This was especially true for groups in the suburban courts, which required considerable travel time from the city.

Overall, respondents felt that involving clients with mental health problems in the 6DTP therapy groups was not problematic. Although respondents would prefer the groups to be run by court staff, the current system seemed to be working well, with only minor problems, and they were generally happy with the service provided by OARS.

### **Documentation and communication**

In the previous evaluation, it was recommended that a range of documentation for the program be developed, and also that ways to improve communication between stakeholders be considered.

When asked about documentation, respondents generally felt that although there was no formal policy and procedure manual, there did not currently seem to be a need, because communication was good and they felt clear on the general running of the program. However one respondent felt that others may need such a document.

*We don't have a manual, but I think people are pretty clear. We do have documentation and I think people are reasonably clear about it. We certainly haven't had any complaints since that time.*

*I haven't sighted any [manual] as such. I know that is something that has been raised by some other staff members who aren't as familiar with TIP. All the other documentation that's relevant to clients seems to be appropriate, our induction information for clients and so forth.*

With regard to communication between stakeholders, all respondents felt that it was very good. Regular meetings between stakeholders seemed to be important to maintaining this.

*The communication process within intervention programs seem to be a lot more open than it had been in the past. I'm not sure why that is, but it's very fluid. Maybe it's because TIP is rolling out and we all need to be aware of what's happening and why and so forth.*

*I don't think there are any major problems. We have Operations Group meetings once every two months, so that involves the magistrates, and one of the clinicians, not always all of them, but at least one... I think that we could probably bring OARS into that mix because I think they're a major part of our services. I think that would be a positive change we could make.*

*Yes [communication between stakeholders is good]. We have a steering committee that meets on average every three months down at Christies Beach, but it's a very small court and jurisdiction and the same lawyers from the area tend to refer into the program and again there's a lot of open communication.*

Some respondents felt that communication with OARS could still be improved, but that this seemed to be getting better the longer they worked together.

Another respondent mentioned lawyers, and felt that when the TIP rolled out to new areas, it was important to make sure lawyers fully understood the nature and workings of the program. Although in suburban courts there were likely to be smaller groups of local lawyers who were easy to reach, in the city this was more of a concern. However, this respondent felt that knowledge about the program was spreading amongst defence lawyers through word-of-mouth, and also noted that there was a pamphlet about the program available,

Overall, although there were some minor issues, no respondents felt that lack of documentation or communication were serious problems for the program at this stage. Regular meetings seem important and should be maintained, and communication processes should be monitored as the program continues to expand.

Although current respondents did not feel the need for a policy and procedure manual, good practice would suggest that one would be useful, again especially as the program expands. Further, although clear on the general goals and running of the program, some respondents did express uncertainty about some policy issues at various times in their interviews (such as how to deal with ongoing cannabis use by clients, discussed in more detail later), and these could be dealt with clearly in such a document. A policy and procedures manual is reportedly being developed and expected to be available for consultation with staff and magistrates in September 2012.

### **Access to detoxification facilities**

The previous evaluation recommended the program improve access to detoxification facilities for those who need it before commencing the program. Respondents were mixed in their views about whether this was still a problem. One respondent felt it was still an important problem, which was more apparent with the 6DTP than with the 12-month Drug Court program, because since the client was not necessarily facing a custodial sentence it was not appropriate to place them in custody for detoxification.

Two respondents felt that there was little need for detoxification amongst the 6DTP clients (unlike Drug Court clients), and one felt that if need be they would try to access existing services in the community. However one other respondent felt that it was sometimes difficult to access existing services for those with a criminal background.

*We can't justify putting these people into custody for detox as we do for the Drug Court because they're not necessarily looking at custodial sentences. Services are just getting tighter and tighter and the waiting lists are longer, services are closing. That need is definitely still there but I'm now sure how to address it...*

*It would be nice if we had the facility where anyone that needed help then we could give that help and start the program, rather than 'come back in a month and see if you can detox'. So, yes, it would be useful, but I wouldn't say it was an essential thing...*

*With some of them I'll discuss the option of going into detox for a short period of time and that's allowed by the court and the program. Sometimes before they come onto the program I'll recommend that they undergo detox before they're accepted or before they formally commence on the program. It hasn't been an issue.*

Overall it seems clear that getting access to detoxification facilities for clients is not a problem that has been resolved, but the need has perhaps lessened because of the type of clients currently being referred to the 6DTP. This issue should be monitored and if a greater need arises, a solution should be sought.

### **Exit strategy**

The previous evaluation recommended that the exit strategy for the program be reviewed to ensure that clients are linked in with community services and equipped to succeed after leaving the program.

Generally respondents reported that although no ongoing support was available from the program after completion, they felt that successful clients were well equipped to continue to succeed after leaving the program. Several respondents emphasised that the group therapy programs included sections on relapse prevention, such as identifying and dealing with triggers, so clients were well placed to remain abstinent if they had come this far on the program.

Some clinicians mentioned that if there was a clear need for ongoing support, they would refer the client to an existing agency, such as Drug and Alcohol Services South Australia (DASSA), State Gambling Services, OARS, or a local health service (and had done so). Some clients were already involved with these services when they commenced the program and maintained their involvement during and after the 6DTP. One clinician reported that she had contacted clients a few months after completing the program, to see how they were going.

*...in their MRT and their last few steps they've been goal-setting and looking at what they want to be able to achieve and I would also sit down with them and talk about ongoing therapy ... Or if they don't feel that they need to continue with treatment, for them to at least be well equipped in terms of having knowledge of where those services are and being confident enough to approach those services if they feel the need. Sometimes I will ring people a few months down the track and see how things are going and so forth.*

*They don't get any ongoing support from us but they do get linked in to services and told where they can get treatment and access to things, especially the co-morbid group because they've already been linked in for their mental health, so we would assume there'd be an ongoing case management from a key agency, whether it's Community Mental Health or whatever.*

One magistrate mentioned that if they had concerns about a client they could place them under supervision of Correctional Services for a period of time, to ensure they had some continued support. However, this respondent also expressed uncertainty about how closely the court program and Correctional Services were linked, so the type of support and the approach were likely to be very different.

Most respondents acknowledged that ideally there would be additional support available to program completers, but all recognised that with limited resources this was difficult. Overall, respondents felt that some more follow-up would be desirable but not necessary to the continued success of the program.

*But it's clearly the case that if they're stable in terms of housing and education and income and family and support, then they're less likely to revert. Can we do it better? I'm sure we can, but bearing in mind that all this is already done on a fairly limited budget I'm not sure that practically, without other inputs from other agencies - which would be a good thing I think - we could do much better than that.*

### **Lack of time in groups**

In the previous evaluation it was reported by program participants that there was often not enough time in the groups for them to present their work, and this hampered their progress through the therapy steps. When the program first began, there were small numbers of clients and clients from both the 6-month program and the 12-month Drug Court program were sometimes combined in groups. As program numbers increased, this began to result in

groups that were too big. Respondents all agreed that this was no longer a problem because they now have more groups with smaller numbers.

Separating 12-month program and 6-month program clients is also desirable for other reasons, and program staff now ensure that OARS runs enough separate groups to have only 6DTP clients in each group. Numbers are far smaller and no respondents felt that group numbers were too big.

## **Current running of the program**

Respondents were asked a series of questions to monitor the current running of the program, and identify any problems.

### ***Referral process***

Respondents were asked how the referral process was working for the program. They generally agreed that the referral process was working well, with both magistrates and legal representatives making referrals. One magistrate reported that they felt referrals worked best when made by a lawyer who works locally and knows the area and clients well, so they have a sound understanding of the client's needs. Magistrates also reported that they were comfortable making referrals themselves when a defendant was unrepresented, or for some reason a lawyer had not recommended the program to a prospective client.

One problem identified was a recent temporary delay in assessments (due to staffing issues) which resulted in a backlog of acceptance hearings. These acceptances took up a lot of court time on one particular day, leaving little time and a long wait for current clients attending reviews. However, this was thought to be a one-off problem and not a regular occurrence.

One magistrate mentioned that making a referral themselves depended on the length of their general list on a given day, and that they often needed to depend on information provided by lawyers, which may or may not be accurate. However, magistrates generally felt that ideally an offer of assessment should be made for all clients who show signs of a drug and/or mental health problem.

### ***Client group***

Respondents were asked whether they felt the desired target group were being referred to the program. Although they generally thought that they were, several respondents also mentioned a problematic group who were sometimes referred but were not always appropriate. They reported that there was a group of clients who displayed relatively serious substance dependence, but whose level of offending did not warrant referral to the 12-month Drug Court program. They felt that with such serious drug problems, they were unlikely to be suitable for the 6-month program, but were concerned that if they were not accepted onto that program they would not receive treatment at all.

*With the 6-month drug use stream, what I've been finding more recently is that we're getting people with quite prominent long-standing drug use, but who wouldn't be considered eligible for the 12-month Drug Court program because of either their offending history and/or their current offences in terms of the likely penalty. I always put in the report, 'It appears they need something beyond the scope of the 6-Month Program', however it doesn't always sit comfortably with me that somebody should be denied treatment and opportunity to engage in treatment when their drug use is so high.*

While some preferred to give offenders like these the opportunity to receive some sort of treatment even if it did not seem to be the right program, others felt that these clients brought down completion rates and potentially impacted on the motivation of other clients. Some respondents preferred to have the option to recommend that some clients, who they felt had a low likelihood of succeeding, were not accepted onto the program, in order to make room for those with a higher chance of succeeding.

*For example, people with a very high level of substance use that wouldn't necessarily be suitable for the shorter program, the 6-Month program, but without an offending history that would make them eligible for the Drug Court, but they've been accepted onto TIP. They generally don't do well and it really drags down success rates.*

*...the one thing that we ... [have] been saying to our respective magistrates, is, 'Yes, this person may have an issue, but we can't fix it. We're not appropriate. What we offer doesn't fit, or that person won't fit into it'.*

One respondent also mentioned that lawyers sometimes referred clients who were inappropriate because it seemed to get the best outcome for the client, rather than weighing up what would actually benefit the client best.

*What we also find, especially with the old program, and it's still happening, lawyers will shop for the best outcome for their client. So they turn around and say, 'You've got a drug issue so we'll refer you to TIP because it's easier than the 12-Month program'.*

Almost all respondents mentioned clients' individual stage of change in relation to addressing their drug use and offending behaviour. They emphasised that although a person may seem eligible for the program, they may not be personally ready to make changes in their life, and hence were extremely unlikely to succeed.

*...you can have a whole heap of issues, as we know, and ... being human beings, not be ready to address them. And at that stage you may be suitable for the program, but if you're not ready to address them, then you're not going to benefit from the program.*

*...when you run these intervention programs, the best practice people tell you that the person's actually got to want to make a change in their life. There are plenty of defendants who are not yet at that stage and so even if they're referred to the program, if they haven't come to grips with the fact that they need to address their drug issue and mental health issue, they're not going to do well on the program because they're not committed to it.*

Some felt that they would like to see this readiness to change more formally taken into account in the assessment process.

*On the other hand, if they have very low motivation, it doesn't matter what service they go to, they're not likely to make any great changes. I think that perhaps what needs to be recognised is the stage of change the person's at, and*

*I think we could probably put some more focus on and maybe even formally use the stage of change model at the start of our assessment process. If someone's, just for example, pre-contemplative and they're really not ready to make any changes, then they probably shouldn't be recommended.*

*If we could have some kind of independent assessment which would give us a better idea of where they really are on the rehabilitative line of development, then we could target the things that we can tell them to do in a much better way.*

Some respondents, such as this magistrate, reported that they already took this readiness to change into account during the referral process, and that they would not refer a client they did not think was ready to change.

*Well, I won't refer someone to the program if they say, 'No, I'm not interested', because there's no point. It is voluntary and there's just no point, they just end up breaching straight away. There are some people obviously who tell you they really want to change and they're the easy ones to send on.*

Overall, it seems that the right target group is largely being reached. However, some issues identified suggest that developing some clearer guidelines and criteria around program acceptance would be advisable. With most respondents mentioning client readiness to change, it seems that to factor this into the assessment process in a formal way would be beneficial, and clearer guidelines regarding referred clients whose drug use is too severe for the 6DTP would also be useful.

### **Difficulties dealing with alcohol and cannabis**

Some respondents felt that at times there were ambiguity and inconsistency around dealing with both alcohol and cannabis in the 6DTP. The program is not designed to deal with alcoholics, but one respondent reported that many clients have both alcohol and illicit drug problems, and that alcohol use can undermine their progress on the program.

*...if there is also illicit substance use we can accept them, they're eligible, but if there's a high level of alcohol use it's likely they're not going to do well because we can't monitor alcohol ... with urine testing, it's easily available. It's really difficult to monitor and difficult to change. It's things like that where we need to have some clearer guidelines and we've certainly discussed those and it's an ongoing discussion.*

Another respondent felt that not being able to deal with clients with predominantly alcohol problems was a shortcoming of the TIP. They reported that in the future they would like to see the TIP also able to deal with clients whose offending was related to alcohol use as well as drug use and/or mental health problems.

Several respondents mentioned problems dealing with cannabis. The 6DTP is an abstinence-based program, meaning that to remain on the program clients must work towards ceasing all drug use, including cannabis. However, for some clients with extremely heavy use of several other illicit drugs, cannabis use can seem relatively minor. In these circumstances clients may feel as though they have made substantial progress in ceasing other drug use, but feel discouraged when they are penalised for continuing to use cannabis.

*...but there was an occasion where we were trying to work out what to do with cannabis use because people can rack up points like they're going out of fashion every time they declare that they've had a smoke. So we were finding that people might have been abstaining from methamphetamine or heroin, but continuing to smoke, and the report wasn't reflecting as such on paper that they were attempting to address their drug use.*

*...if they continue to use [cannabis] and they continue to declare, it also impacts on their ability to progress in MRT, which is incredibly problematic, because again, the cannabis nine times out of ten won't be connected with their offending anyway. It's just that it happens to be an illegal activity and we're an abstinence based program. But if they've ceased using the other drugs, then for some of them it feels like a slap in the face.*

As mentioned previously, at one stage there was inconsistency across the Elizabeth and Christies Beach courts over whether or not points should be awarded for cannabis use, and several respondents felt that there was still ambiguity about how they should deal with a client who was otherwise making good progress, but continued to use cannabis. However, some mentioned that it was difficult to provide a clear guideline because it depended heavily on individual client circumstances.

*But on the other hand if you've got somebody... who's taken on the program and their main problem is cannabis, then obviously yes you do award points because they've come on to say they want to get off the cannabis and if they're not making progress towards that, then that's what their treatment plan is designed to do.*

Almost all respondents reported that dealing with cannabis in the 6DTP has become more difficult since a recent decision was made to no longer send urine samples for additional laboratory testing. Cannabis use is particularly difficult to measure because metabolites can be present in the body for a number of weeks after use. Previously, all client urine samples were sent to the Institute for Medical and Veterinary Science (IMVS) for testing and a report listing levels of all drug metabolites was provided. This report included ratio levels of cannabis metabolites, and for a client reducing their level of use, this would be reflected by decreasing levels. Therefore, if a client tested positive to cannabis but at least showed a declining trend, magistrates and clinicians could use this information to help them decide whether to assign penalty points to the client for drug use, or whether they should instead receive encouragement for showing a decrease in levels. Although all respondents understood that this was a budgeting decision, and that working within funding constraints is an issue for all programs, both magistrates and clinicians felt that with the ceasing of laboratory testing, they had lost an important decision-making tool.

*The other problem at the moment that we've had ... is that the urine testing hasn't been sent off since I think the beginning of the year for laboratory testing. We've had information about whether cannabis or some other form of drug shows up but not levels ... We'll get people with chronic cannabis usage saying, 'I'm getting better, I'm smoking less', and we can't tell whether that's true or not and they can't be validated...*

*And one of the problems, from where I sit, is the fact that we no longer send the samples off. We used to send the samples off so we could check the levels and*

*if the levels were reducing, then that was evidence that obviously they were reducing their cannabis use and that would be acknowledged in the court. Often, it meant that we didn't award points as well...*

*When we began the program at Christies [Beach], we were able to test for cannabis-creatinine levels, but because of lack of funding we can't do that under TIP. Participants in the program actually like the cannabis-creatinine levels. Because of the long lead time of the elimination of cannabis, they can keep on actually testing positive for cannabis even when they've started significantly reducing or even stopping completely, so from their perspective they're coming back and there are still dirty urines and they're not getting any encouragement. ... So the cannabis-creatinine levels were a good tool that we don't have available because of funding issues, as I understand it.*

The program manager reports that a return to laboratory testing for drug samples is unlikely because the cost is prohibitive, and that the new system has the additional benefit for both staff and clients of providing an immediate result. Further, the issue of how to monitor cannabis reduction is clouded by contradictory scientific evidence about how long THC takes to be excreted from the body. Nevertheless, the issue needs further discussion, and consideration should be given to finding a workable solution to this issue.

### **Drug testing**

At the time interviews were conducted, most respondents reported there had been some problems with the drug testing component of the program. Three main problems were reported. The first two problems were that there has been instances of the wrong results being recorded and on one occasion a sample was not held so the results could not be disputed and re-tested.

Respondents emphasised the importance of accurate test results in the program because both the client and the clinician must be able to trust the results. When clients are addicted to drugs and prone to lying about their use, clinicians emphasised the need to be confident in their test results when confronting clients with a positive result. Similarly, it is important when a client returns a clean sample that the clinician can also trust that result and give praise and encouragement accordingly. An additional implication of test results is that progressing through the MRT program depends on ongoing clean drug tests, so when there is uncertainty, a client's progress may be unnecessarily hampered.

*...when someone uses [drugs], you need to talk to them about that use. Now, if you're saying, 'Your test results are saying there that you've used', and then they're saying, 'What! I did not use!', then it really erodes the trust on both sides. And also for them to dispute the result, they have to pay \$25 to have it sent to IMVS. Now if it comes back as negative they get that money back, but it's not always easy for them to come up with that \$25.*

*...clients' [drug] use affects their progress through MRT. It's a fundamental part of our program and it has to be one that's done right.*

*The other issue ... was that there'd been a couple of disputed results but the samples weren't being held. So [we] ended up saying 'just ignore those results' and I had let the client's know. Again, they can take advantage of that ...the clients should have right of appeal...*

One other more minor problem relating to the accuracy of test results was mentioned by one respondent, and that is that results provided by the testers can differ to those provided by IMVS when a sample is sent there for testing. This difference in measurement can be as damaging to the trust between client and clinician as an inaccurate result, because it detracts from the credibility of the court testing process and undermines faith in the process on both sides.

*What can happen is the level that we test at is slightly different to that of IMVS, not much, but it can be a positive here and a negative at IMVS. IMVS will also look at if it's at a certain level, they give benefit of the doubt. So it might be that we've got the same test, but they've decided that this person's now negative because it's at that threshold. It's difficult.*

The other problem reported with drug testing was that one of the previous agency staff employed to supervise drug testing had been engaging in conversation with the clients and commenting on the test results, which they were not supposed to do. One respondent reported an incident in which a comment by the drug tester severely upset a client and almost resulted in them withdrawing from the program..

Respondents reported that 6DTP management had been made aware of the problems, and that action to remedy the situation had been taken. There is now a different system in place for the recording of test results, with all entries checked by a second person. There have also been changes to the agency staff used, and supervision of the agency staff has been increased. A small fridge has been purchased to hold samples at Christies Beach and a portable cooler for transporting samples from Elizabeth to the city.

Maintaining the integrity of the drug testing component is a very important issue that needs constant monitoring and remedial action to avoid problems before they arise and to address them promptly if they do occur.

### **Group therapy**

When asked about the current success of the group therapy programs, all respondents reported that they were generally working extremely well. Both clinicians and magistrates felt that most clients gained a lot from the group programs, including a better understanding of reasons for their drug use, and ways to manage their own behaviour.

*MRT and Staying Quit, I think, are very good structured programs... I think [MRT is] an excellent program and the clients get a lot out of it. It really contributes to developing their insight, and Staying Quit contributes to developing their relapse prevention and sets them up, and develops their awareness of when they're likely relapse, their trigger points and how to deal with those.*

*Most of the people, certainly the people who do best on the program, with a few exceptions, find that those programs are really helpful to them. They discover things about themselves and the reasons why they use drugs or commit offences which they hadn't really thought about prior to that.*

Two respondents expressed the belief that although MRT is great for most clients, it is not suitable in every instance. As mentioned previously, clients with certain and severe mental health problems are not able to participate effectively in the group programs, and some other individuals are not entirely suited to it either. One respondent described two clients who were doing well on the program and abstaining from drugs, but chose to withdraw from the program because they did not agree with some of the values behind the MRT program. According to

the respondent, one individual was forced to leave the program because they did not want to complete MRT, and the respondent felt it would be a good idea to have an alternative for some people who do not connect with the MRT program.

*I don't personally believe that MRT is suitable to everybody. I've seen a lot of people gain a hell of a lot out of it and really embrace it, which has been fabulous... But I don't believe it's the be-all-and-end-all. I think that there needs to be other options in the 6-Month drug program other than MRT.*

Another respondent reported that in some cases they had found alternatives to the MRT program for Aboriginal clients.

*We tend to be flexible about allowing a few... we've had a few Aboriginal people who are not comfortable, particularly in a majority group with non-Aboriginal people, talking publicly about their problems, so we use some different ways to get around that and have sent them to other programs.*

One respondent reported that in some cases individual therapy was available for clients, but that this therapy is more expensive, and usually only available to clients with mental health problems which prevent them from participating in groups. Introducing another alternative for group therapy would clearly involve costs and time to assess options and implement the change. The program manager confirmed that other options such as individual counselling could be used as required. At this stage, most respondents agreed that MRT suits most clients, so with a limited budget there is perhaps no need to investigate alternatives at this stage. However, this issue should be monitored and if the use of MRT begins to prevent a larger number of clients, who are otherwise doing well, from participating in the program, alternatives should be investigated.

One respondent reported that in one of the sites the therapy group was fairly small and that the personalities of clients in the group did not mix well. Reportedly, the problems stemmed from having illicit drug users mixed with other clients who were primarily alcohol users, and that this group found it difficult to work together. This issue highlights the difficulty in balancing group size and client type in groups. Although it is not possible (or perhaps desirable) to separate individual clients who do not get along, if placing clients with different types of drug problems in the same groups becomes a systematic problem, solutions should be investigated.

### **Role of lawyers**

Some respondents suggested that the presence of lawyers sometimes hindered clients' success in the program, because they tried to make excuses for their behaviour and drug use, rather than encouraging them to take responsibility for it. Some respondents felt that it was difficult for lawyers to adjust to the non-adversarial court and allow their clients to admit to drug use and accept the consequences.

*We've got a client group that will lie and cheat. That's why they've managed to survive. They learn the negative behaviours, they've lied, they've cheated, and in an adversarial court it promotes that. So what you're saying is, 'Yes, you carry on behaving in that way'. Whereas, we're a therapeutic court and it's very difficult for lawyers to grasp that.*

*Sometimes, and the obvious example is drug testing, 'So and so, did you have .000 ... percentage of methamphetamine? That means you've used methamphetamine' ...if that test showed that they used, then the therapeutic court has to operate on the basis that they used... I don't think it's helpful in that context to have any lawyers saying, 'Oh, well.. X happened and Y happened, and ...as it were excuse the behaviour.*

For this reason, some respondents went as far as to suggest that lawyers should not be included in regular 6DTP court reviews. However, all agreed that lawyers had an important role when clients were in danger of being removed from the program, in order to ensure that it was done fairly.

*Well, really ... once that person's come on the program I don't think we need the DPP or a lawyer. Basically who should be there is the magistrate, the participants and [the clinician] reading the report. It's as simple as that, just the three... The only reason that the DPP, the lawyer, needs to be there is, 'Right, ok, you're not having a good review. We're going to terminate off the program if you don't pick up'. Then you've got a lawyer and the DPP there to make sure that it's done fairly. That's the only reason you need them there.*

One magistrate emphasised that although a lawyer may address them, they always spoke directly to the client rather than to the lawyer. They didn't mind if lawyers were present or not for reviews, but did emphasise that they wouldn't remove someone from the program without a lawyer present.

Some respondents felt that although the presence of lawyers could be problematic in the Drug Court, there were signs that with the TIP this was not such a problem.

*The big difference I notice between TIP and Drug Court, from my experience there, is the lawyers in TIP at Elizabeth tend to be much less adversarial and much [more] willing to speak with me ... about the client's progress. It wasn't a fight, whereas every court day at Drug Court is a battle with lawyers.*

Overall, respondents mentioned that communicating with and educating lawyers about the aims of the program were important to its success, and it seems as though improvements can be made in this area.

### **Database upgrade**

In the previous evaluation it was recommended that consideration be given to upgrading or developing a database for the collection of all specialty courts data. The program manager reported that this had not happened because there were other more pressing priorities for the courts overall, but that this was very frustrating for staff. Data is currently recorded manually in a number of different locations because existing databases are no longer suited for their current use and do not enable entry of all relevant data. The result of this is extra work for administration staff, a piecemeal approach to data storage, and difficulty of accessing some data because it is stored only in paper files rather than on an electronic database.

In order to provide the relevant data for the current evaluation, 6DTP staff had to manually extract and record data from several different sources, which resulted in inconsistencies and some inaccuracies, as well as taking up extra time. A custom-designed database for all courts intervention programs would ensure accurate and thorough data storage, make complete

client records more accessible for staff, saving time and effort, and enable more efficient evaluation and monitoring of the program. Once again, it is recommended that a database upgrade be considered by the CAA.

## **Program objectives**

Respondents were asked their opinion about to what extent the program was meeting its objectives, and about the main strengths and weaknesses of the program. Whether the program has met key objectives of reducing drug use and offending are also investigated in quantitative analyses, which are presented later in this report and an up-coming addendum respectively.

## **Changes to participants' drug use**

Respondents were asked if they felt that overall participants were reducing their drug use. Most were quick to differentiate those who engage in the program and complete it with those who don't. Although most acknowledged that with such a difficult client group, no program would ever reach all of them, all respondents felt that a significant number of clients ceased or substantially reduced their drug use during the program. Although they were unable to say what happened to clients after the program ended, most respondents reported feeling hopeful for a large proportion of clients, who did well on the program and seemed likely to succeed in the longer term.

*If they continue to the end of the program, yes, definitely reducing their drug use. If they're not reducing their drug use, they're removed. So, if they complete the program, their tests are negative. There may be an occasional lapse, but generally it should be all negative results. So, yes I do think absolutely it's helping them reduce substance use.*

*We know that reasonably accurately because they're tested twice-weekly. Some become abstinent, some don't, but they reduce their drug use. I had someone recently who in the end just couldn't get off cannabis, but he stopped use of amphetamines and various other drugs... So, yes, I think almost everyone has some success, and those who don't, it's because they're not committed to it.*

*Yes [I think they are using less drugs], and so do the magistrates. I think everyone feels that it's very successful in that regard. What we're not so sure about, of course, is long term, but we know that substance dependence is a chronic disease, a chronic issue, so there are always going to be problems with relapse. But we definitely think that while they're on the program they're reducing...*

Apart from urine tests to prove that clients were abstinent, or working towards abstinence, two respondents reported that a number of clients were obviously benefiting from the program, based on their appearance. They reported that it was easy to tell with some clients that they were not using drugs and were making positive changes in their lives because they looked more healthy.

*And they were clearly doing well on the program, it's not just the urine test, you actually see that they've started to change their life, they're looking better, when you've been in their courts you can actually see the way in which they present is indicative of the fact that they're not using drugs.*

### **Changes to participants' offending levels**

Respondents were asked if they felt the participants were reducing their drug-related offending, and other types of offending. Generally they agreed that participants on the program did seem to show a reduction in offending overall, but that they were uncertain about how they fared after program completion. Several respondents were able to recall clients who had succeeded on the program but then re-offended and returned to court soon after, but they reported that these were in the minority. Most felt that clients who succeeded on the program had a good chance of reducing or ceasing offending following the program, particularly for offending that was related to drug use, such as property crime.

*Certainly, if part of the program is that they need to not re-offend, then certainly while they're on the program they're offending is lessening, but how long that lasts after they finish, I'm not sure. I think what they get from this program is that through MRT they actually develop insight into the effects of their behaviour, including their offending behaviour, on themselves and their family and the community. So I think that would contribute to a reduction in their offending behaviour.*

*Anyone that we've had on the 6-Month and the TIP program, there have been less new charges so it would suggest it [offending] is reducing.*

*Well, I can't say after they finish the program... but there's very limited re-offending whilst on the program. I've got them before me, by the time they get finalised, for seven or eight months, and very few add files.*

One respondent emphasised that although a program cannot succeed with every client, when there is a success and someone turns their life around, there are important flow-on effects.

*...you might see those improvements in the program and I think you then want to be confident that the program has given those individuals the best skills that they can, but other than that I don't think that you can assume that it's necessarily worked for everyone or even for a majority. But for every person that it does work for, not only do you not get them back, you don't get their family members back and possibly you don't get their children back, so there are positive flow-on effects as well...*

Overall, while acknowledging that it is a difficult group and that it is also difficult to measure offending after the program, most felt that most clients were less likely to re-offend following program participation.

### **Main strengths of the program**

Respondents were asked what they thought the main strengths of the program were. They were overall strongly supportive of the program and listed a wide range of strengths. These included:

- that the program is evidence-based and reflects best practice;
- that it includes a drug testing component;

- that it includes cognitive-behaviour therapy (CBT)-based group therapy programs (i.e. MRT and Staying Quit);
- having a magistrate who is interested in participants' welfare and can form a relationship with them;
- that it uses rewards and sanctions;
- that the program requires participants to become accountable for themselves and their behaviour;
- that the program is supportive and non-judgemental;
- that it features highly-trained and professional staff;
- that it features understanding and dedicated magistrates;
- that it includes regular court reviews;
- that the program can identify and treat co-morbidity;
- that the program encourages honesty;
- that it provides objective evidence of behaviour change (through drug-testing);
- the length of time (6 or more months);
- the flexibility to vary treatment plans for individual clients; and
- that it is a closed court model.

The following quotes highlight some of the strengths that respondents saw in the model, and some positive comments they made.

*...it's [TIP] much better than a general court. We just deal with people there on much less information and with much less tools to help them avoid coming back to the court again.*

*I think the strength of the model is that most people accept that the court is there actually to try to help them, so you actually get a level of honesty by people about what they've done and what their problems are that you don't get normally in a court. That's because I think those people after a while learn to trust that ... they won't be punished for being truthful...*

*...they've got a really significant level of support, not just with the programs they've got, but they've got a person who's supervising them. The people who work here and I'm sure at the other places, they've really very, very good.*

*I think the strengths are judicial supervision, regular drug testing, identification of co-morbidity and I think probably to try and keep it as flexible as possible, so if you do need to change them from stream to stream, you can do it.*

*That fact that there are regular court reviews I think, is a strength, that there is a reward in terms of them going on to monthly reviews, which is an acknowledgement of progress, that people have done ok. I think there's ongoing support, ongoing acknowledgement by the court and by program staff for the efforts that people are undertaking to address all of their issues.*

*Accountability. What we're looking at is helping get offenders to realise and recognise what their role is and why they're where they are, to take responsibility for what they are doing and to learn that every action has a*

*consequence, and the reason why they're facing court is because of their behaviour, and how to change that.*

*I think the main strengths are that it reflects what best practice is with drug using offenders. It uses drug testing, so it's objective and it helps them monitor what they're doing as well because they know that they're going to be tested. It uses a CBT-based intervention, which looks at criminal thinking and criminal attitudes. It builds on what we have seen as therapeutic jurisprudence, which is having an authority figure like a magistrate who's interested in their welfare and uses rewards and sanctions, basic behaviour management, to encourage and motivate and keep people doing what they're doing. So to me they're all the key components of what is a good program.*

### **Main weaknesses of the model**

Respondents were also asked what they thought were the main weaknesses of the model. Responses included:

- the length of the program (6 months is considered a bare minimum);
- acceptance of inappropriate clients;
- inconsistencies between program sites;
- not being able to deal with excessive alcohol use;
- the lack of group therapy options for clients who do not connect with MRT;
- not sending drug test samples for laboratory testing;
- inaccuracies with recording of drug testing results; and
- the assessment process' limited ability to take into account individual readiness to change.

The problems listed as weaknesses have all been described in more detail elsewhere in this report. The most commonly listed weakness was no longer sending away urine samples to be drug tested in a laboratory, which was mentioned by both clinicians and magistrates, followed by accepting inappropriate clients onto the program.

## **Analysis of drug testing data**

This section presents findings from a quantitative analysis of participants' urine drug test results over time, while participating in the program. The analysis compares drug tests at entry into the program (baseline) and at monthly intervals thereafter, and examines the proportion of clients returning a positive result at each data point. It would be expected that, if the program is effective at curbing drug use, the proportion of clients returning a positive result would decrease over the time that they are on the program.

There is one important confounding factor with this analysis which must be kept in mind when interpreting results, and that is that if clients do not reduce their drug use, they are removed from the program. Therefore, only clients who show a reduction in drug use remain on the program, and continue to participate in testing. This makes it highly likely that a positive result will be found. However, it is still likely that a proportion of participants will relapse at times and not be removed from the program if they are generally making good progress. If these relapses are frequent, the analysis would show a relatively constant level of drug use, but if they are rare and decreasing, a more linear reduction in the proportion of positive tests over time would be expected.

## **Method**

This analysis includes only participants who are no longer current participants, i.e. they have either completed the program or withdrawn or been terminated. The analysis uses drug test results from the first baseline test for each participant, and then tests as close as possible to one month after that date, two months after that date, and for each subsequent month up to the sixth month. The number providing tests at the seventh test mark was small so those results were excluded.

The analysis presents the proportion of tests that were positive, indicating drug use, at each monthly point. Positive tests for drugs which had been prescribed were treated as negative tests. These drugs included methadone, buprenorphine, anti-depressants, some painkillers such as panadeine forte, and benzodiazepam. Most such results were for methadone or buprenorphine. If a test indicated use of both a prescribed drug and another illicit drug, the test was treated as positive.

A complication with this type of analysis is that cannabis can take a long time to be metabolised by the body, and may result in positive tests up to 6 weeks after the last use. For this reason, it would be justifiable to treat any positive cannabis tests in the first month following baseline as false positives because they would not indicate new cannabis use with certainty and may be a carry-over from previous use. However, this analysis has taken the stricter approach of treating all positive tests for cannabis as positive tests.

## **Results**

Initially 130 clients who were no longer current on the program were included in the analysis. However, nine did not remain on the program long enough to provide a baseline drug test and were excluded. At the first four testing data points, between one and four clients either did not produce enough urine for a drug test or produced a diluted sample, providing inconclusive results. These were treated as missing data.

Table 14 shows that the proportion of tests showing a positive result demonstrates a clear decrease with time on the program. The proportion of tests positive showed a steady decline from 70.1% at baseline to 0% six months later. A chi square for trend test was calculated using the first five data points, because cell sizes for the subsequent data points were too small to include in the analysis. A strong linear relationship was demonstrated ( $\chi^2 = 61.78$ ,  $p < 0.001$ ).

<b>Time on program</b>	<b>Number of tests</b>	<b>No. of tests positive</b>	<b>% of tests positive</b>
Baseline test	117	82	70.1
1 month	94	39	41.5
2 months	77	24	31.2
3 months	59	11	18.6
4 months	53	9	17.0
5 months	41	4	9.8
6 months	15	0	0.0

**Conclusion**

These results indicate that participants in the 6DTP continue to make progress during the program, and do not frequently relapse. Although a positive finding was likely in this analysis, this very strong effect confirms that participants in the program continue to make steady progress and that they are clearly reducing their drug use while on the program, with most ceasing completely.

## Discussion and conclusion

Overall the findings in this report indicate a successful program, which continues to evolve in response to needs, and is highly valued by staff and stakeholders involved in it. However, some operational and philosophical problems were identified in this evaluation, and addressing these would make for an even more successful program. This section summarises key findings from the evaluation by outlining the main strengths and successes of the program, as well as the main weaknesses and areas where improvements could be made. Recommendations regarding the future running of the program are also made.

### Key strengths and successes

- The number of referrals to the 6DTP (including those to the co-morbidity program) have steadily increased since the program commenced, with referrals in 2011 (84) almost doubling those in 2010 (46).
- The referral process appears to be working well. The majority of referrals came from legal representatives (58.5%), with almost one third coming from magistrates. Magistrates interviewed as part of the evaluation reported that they preferred referrals to come from legal representatives who knew their clients well, but that they were also happy to refer a client where they perceived that drug use played a role in the clients' offending.
- The WHO ASSIST scores for participants show that the majority of referred clients report using drugs at a level which poses a moderate or high risk to them, and that the majority use more than one drug at this problematic level. These findings confirm that the program is attracting the desired target group, but also that this group shows significant problems, which are difficult to address.
- The program completion rate of 40.1% (and successful completion rate of 29.5%) is comparable to other similar Australian court-based drug treatment programs.
- Although it was not possible to test for statistical significance, sentencing outcomes indicate that participants who successfully completed the program were less likely to receive a sentence of imprisonment and more likely to receive a more lenient sentence, such as suspended imprisonment, a bond or a fine. This is important because it provides incentive to prospective clients to engage in the program, knowing that their good progress on the program will be taken into account when they receive their sentence.
- Stakeholders interviewed generally reported that the roll-out of the program to suburban courts had gone well, and that lessons learned in the Christies Beach roll-out had been valuable and helpful in subsequent roll-outs.
- With regard to the program model, interview respondents were unanimously in support of the TIP model which enables concurrent treatment and management of both drug and mental health problems. Respondents did not feel that the presence of an increased proportion of clients with mental health issues had impacted on the effectiveness of the group work, and all felt that the program should continue in this way.
- Respondents were unanimous in their support for designated magistrates for the TIP/6DTP, feeling that the opportunity for clients to establish a relationship with the magistrate, and for the magistrate to have a sound understanding and knowledge of the relevant issues, were extremely important to the success of the program.
- Respondents felt that communication between stakeholders on the program was generally very good.
- The group therapy was evaluated positively by all respondents, and most felt that MRT was an effective tool for working with the client group. Respondents all agreed that there was now sufficient time in groups for all participants to present.
- Although all respondents reported that they would prefer courts staff to run the group programs, they generally felt that OARS were doing a good job and could not identify any major problems in this area.

- Interview respondents generally felt that the program was achieving its objective of reducing drug use by participants, at least while they were involved in the program. A quantitative analysis of urine drug test data confirmed that participants made strong decreases in their drug use while involved in the program.
- Respondents generally felt that the program was achieving its objective of reducing offending by participants. A quantitative analysis of pre- and post-program offending will follow as an addendum to this report.
- Interview respondents were extremely supportive of the program and unanimously wanted to see it continue and even expand.

### **Key weaknesses and opportunities for improvement**

- The clients referred to the 6DTP were mostly male (73.7%) and only a small minority (7.9%) reported being of an Aboriginal or Torres Strait Islander background. These proportions have not changed significantly since the previous evaluation although the proportion of participants reporting being from an ATSI background has decreased from 14.3% previously.
- The Nunga Court summary shows that participation and completion rates in the Drug Treatment Program there are low. While it was beyond the scope of the current evaluation to investigate the program in the Nunga Court, some interview respondents mentioned that there is a different culture around the Nunga Court and little encouragement to engage in offered programs. With a low level of Indigenous participation in the mainstream 6DTP and low levels of engagement in the Nunga Court program, ways to better reach and assist Indigenous defendants with drug problems relating to their offending should be sought.
- Several interview respondents felt that there were a group of clients being referred to the 6DTP who were not suitable for the 6-month program because their drug problems were too severe, but their level of offending was not serious enough to warrant their referral to the 12-month Drug Court program. Some felt that to include them in the 6DTP was preferable because this meant those clients received access to some treatment, but others worried that they affected completion rates and potentially impacted on the motivation of the whole group. This is an issue that needs some consideration and clarification.
- Several interview respondents mentioned the importance of client readiness to change and would like to see this taken into account in a more formal way in the assessment process, with the potential to exclude referees who were in no way ready to change.
- Previously, the under-reporting of drug use by clients at assessment, possibly so that they would be recommended for the more lenient 6-month program rather than the 12-month Drug Court program, has been a problem. It was recommended that the process for transferring clients from one program to the other in this case be made more streamlined, and although it appears that this has improved somewhat, some respondents felt that the transferring process could be simpler and more streamlined.
- Some inconsistencies between decisions made at different program sites were identified, and all respondents felt that maintaining consistency was important. Some respondents mentioned the possibility of commencing a regular meeting for magistrates to discuss issues and ensure they are taking a consistent approach. This could occur by telephone or video conference to save time.
- Although documentation was not seen as a major problem by respondents, there is no program manual available, and this could be problematic in future as new staff are employed. Also, some policy issues were raised by interview respondents which would benefit from clarification, and for these reasons it is recommended that a program manual be developed.
- Some respondents were concerned that an alternative was not available for participants who showed good progress with their drug use and were keen to engage, but didn't connect with the values behind MRT. This should be monitored and if this problem becomes more common, an alternative to MRT should be investigated.

- One respondent highlighted the problem of having a small group with users of different drug types. The client mix and size of groups should be monitored to ensure the therapy groups are positive environments for clients to address their drug and other problems in a productive way.
- Clarification is needed about how to deal with cannabis use in the program. Although a flexible approach to cannabis use is needed to take into account individual drug use and circumstances, a consistent approach across sites and across magistrates is important. Some respondents wanted clearer guidelines and this could be addressed in a program manual.
- The program does not enable treatment of clients who primarily have problems with alcohol over illicit drugs, and several respondents saw this as a shortcoming of the program. Although if clients use illicit drugs they may be accepted onto the program, if they continue to use alcohol at high levels it can undermine their progress on the program and make long-term success unlikely. The profile section shows that alcohol use poses a moderate or high risk to more than one third of program participants, and for many it was considered to be their primary drug of dependence. How to deal with alcohol use on the program, and whether the TIP can be expanded to include participants with alcohol problems, should be investigated in future.
- Problems with the drug testing component were identified by interview respondents. These were: inaccurate recording of results on some occasions; samples occasionally not being held to enable subsequent challenging and retesting; inappropriate remarks made by drug testers to clients (who are not supposed to make any comment except to communicate test results); and the fact that urine samples are no longer sent to a laboratory for comprehensive testing including cannabis-creatinine levels. Interview respondents reported that the first three problems had already been reported to management and since been addressed. The situation must be monitored because respondents felt strongly that accurate drug testing was crucial to the ongoing success of the program. With regard to the final problem, the possibility of re-commencing laboratory testing of samples should be investigated, as almost all respondents, including magistrates, felt that it had been a very useful tool which they would prefer to be able to use.
- The previous evaluation recommended that a database upgrade for specialist courts be considered, and this has not occurred. Data for the current study came from several different sources, meaning some was conflicting, and that duplication of entry had occurred. Further, some was stored only in paper files which makes it extremely difficult to access in a useable format for future evaluation and ongoing quality monitoring.
- The previous evaluation found that support for clients was limited once they left the program, and recommended that the exit strategy be re-visited. Although most respondents felt that clients who successfully completed the program were well-placed to succeed after leaving the program, several acknowledged that the exit strategy could perhaps be improved to increase available support for client.
- Access to detoxification facilities for some clients was identified as a lack in the previous evaluation, but respondents in the current study were mixed in their views about whether this was still a problem. Some felt that there was a still a need and this should be monitored on an ongoing basis.

### **Limitations of this study**

It must be noted that there are several important limitations to this study, which are outlined below.

- Whether the program is meeting its objective of reducing drug use by program participants has not been fully assessed here. Although interview responses and a quantitative analysis of drug test results show that participants have reduced and/or ceased their drug use over the course of the program, whether these decreases and/or cessation rates have been sustained beyond the time on the program has not been examined. This type of analysis requires re-contacting program participants later and

asking them about their current drug use, which presents several important methodological difficulties, and is certainly beyond the scope of this evaluation project. However, it remains an important question which could be investigated more fully at a later date.

- Whether the program is meeting its objective of reducing offending by program participants has not yet been quantitatively assessed and will be included in a subsequent addendum.
- The current study has not investigated the program success from the perspective of clients. This was done in the previous evaluation, and participants generally evaluated the program positively, with a few relatively minor complaints. A far larger number of participants have now been involved in the program, and also many 'teething' problems have been resolved since the previous evaluation. It is important to regularly monitor the success of the program from the point of view of the clients themselves, and this should be done again at some point in the future as part of overall program quality monitoring.
- The current study did not involve interviews with all stakeholders working on the program, so cannot be considered to represent the views of all staff and stakeholders.

## **Recommendations**

Based on the findings from this report, the following recommendations are made:

- That the integrated Treatment Intervention Program (TIP), enabling treatment of clients with co-morbid drug and mental health problems, be continued with designated magistrates in TIP courts.
- That Operations Group meetings be maintained to ensure good communication between stakeholders. Consideration should be given to including OARS in these meetings.
- That ways to increase engagement by Indigenous clients in both the mainstream TIP and the Nunga Court Drug Treatment Program be investigated.
- That clear guidelines are developed to deal with clients who demonstrate drug problems too severe for the 6DTP, but offending not severe enough for the Drug Court 12-month program.
- That consideration be given to formally incorporating individual client readiness to change into the assessment process.
- That a program manual be developed, which includes clear policies and guidelines for staff to use when making decisions about clients.
- That consideration be given to establishing regular meetings for magistrates involved in the program, to ensure consistency across the program sites.
- That clear guidelines are developed for staff and magistrates to use when dealing with clients who exhibit cannabis use while on the program.
- That consideration be given to expanding the TIP program in the longer term to enable treatment of clients with considerable problems with alcohol use.
- That the drug testing component of the program be monitored closely to ensure the integrity and accuracy of recorded results.
- That consideration be given to either: re-commencing laboratory testing of all urine samples (or at least those reading positive for cannabis) to enable cannabis-creatinine levels to be used by staff and magistrates in dealing with clients who use cannabis; or investigating an alternative method of monitoring cannabis use.
- That funds be allocated by the Courts Administration Authority (CAA) to develop a custom-designed database for courts intervention program data.

## **Conclusion**

Overall, the findings in this report are very positive. The number of referrals to the program is steadily increasing, stakeholders at different levels are highly supportive, and the right client group seems to be targeted. Completion rates are on a par with other similar programs in Australia, and findings suggest that the program is meeting its objective of reducing

participant drug use, at least while involved in the program. Although long-term outcomes, offending outcomes and client views have not been investigated in the current report, based on evidence presented here the program appears to be having a positive impact on the lives of clients, especially those who complete the program. Attention to issues raised in the recommendations would make for an even more successful and efficient program.

## References

Ziersch E & Traeger M 2010. *6-Months Drug Treatment Program: Final Evaluation Report*. Adelaide: Office of Crime Statistics and Research.

Ziersch E & Marshall J 2012. *The South Australian Drug Court: A Recidivism Study*. Adelaide: Office of Crime Statistics and Research.

Weatherburn D, Jones C, Snowball L & Hua J 2008. *The NSW Drug Court: A re-evaluation of its effectiveness*. Bureau of Crime Statistics and Research (BOCSAR) Crime and Justice Bulletin No. 121.

[http://www.bocsar.nsw.gov.au/lawlink/bocsar/ll\\_bocsar.nsf/vwFiles/CJB121.pdf/\\$file/CJB121.pdf](http://www.bocsar.nsw.gov.au/lawlink/bocsar/ll_bocsar.nsf/vwFiles/CJB121.pdf/$file/CJB121.pdf).

Payne J 2008. *The Queensland Drug Court: a recidivism study of the first 100 graduates*. Australian Institute of Criminology (AIC) Research & Public Policy Series No 83.

<http://www.aic.gov.au/documents/7/C/C/%7B7CCCCFD2-FFF6-4DAB-B17F-49700902BC1D%7Dhpp83.pdf>