



**Tasmania's Court
Mandated Drug
Diversion Program**

**Evaluation
Report**

November 2008

Executive Summary

Success Works was commissioned by the Tasmanian Department of Justice to evaluate the pilot Court Mandated Drug Diversion Program (CMD). CMD commenced in July/August 2007 and the pilot period expired at the end of June 2008.

CMD is unique amongst court diversion programs in Australia in that it is:

- Positioned after a finding of guilt
- Focussed on addressing 'criminogenic needs' and targeted towards offenders who are at a high risk of reoffending
- Available to family violence related offenders as well as non-violent offenders.
- An option for all Magistrates in all Tasmanian Magistrates Courts

In its first year of operation 250 offenders were referred for screening for suitability for CMD (almost 30% higher than the funded target of 196) and 157 offenders commenced CMD orders. Over half were placed on Category One 'Bail Diversion' orders (53%) with the next most common order type being Category Three 'Drug Treatment Order' (21%) followed by Category Two 'Probation Order or Suspended Sentence with CMD component' (11%). Remaining orders were a cocktail of DTO, Bail and Probation orders combined.

CMD adopted a service structure that reflects international best practice. In its first year, contracted service providers for CMD were:

- Anglicare Tasmania, for the provision of assessment, development of individual management plans and individual and group counselling services

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- Salvation Army for the provision of detoxification, pharmacotherapy, residential rehabilitation and drug testing services (of which only residential rehabilitation and drug testing were able to be provided)
 - Community Corrections for the provision of case management for adult offenders undertaking CMD
 - Youth Justice for the provision of case management for young offenders undertaking CMD
 - Turning Point Alcohol and Drug Services for the provision of accredited and non accredited training programs
 - Success Works for this evaluation.

At the end of the first year, one service provider (Community Corrections) opted out of the program altogether and another (Salvation Army) reduced its involvement to residential rehabilitation services only. A new service model has now being introduced in which Anglicare Tasmania is responsible for both case management and drug testing (as well as retaining responsibility for individual and group counselling) and assessment and the development of individual management plans is undertaken by Court Diversion Officers attached to the Department of Justice.

The Department of Justice pursued four strategies in the implementation of CMD:

1. Service delivery
2. Capacity building
3. Quality improvement
4. Service integration

Implementation of CMD has been in the context of a recognised incapacity of the existing alcohol and drug service system in Tasmania to meet the client needs.

In relation to service delivery, the major findings from the first year of operation were:

- Higher than expected take up of CMD by the courts
- Significant proportions of offenders assessed as high or very high risk
- High levels of polydrug abuse and low levels of prior drug treatment
- Significant levels of additional need for services outside CMD
- Higher than expected referrals to individual counselling as part of CMD
- Lower than expected participation in group counselling and residential rehabilitation
- Inability to establish ambulatory detoxification or pharmacotherapy programs within CMD
- Higher than expected take-up of urine analysis

In relation to capacity building, CMD has made a significant contribution to the improvement of Tasmania's drug treatment capacity through the provision of access to a range of accredited and non accredited training.

In relation to quality improvement, national standards have been largely achieved for urine testing and the assessment tools for the program reflect world's best practice.

In relation to service integration there is evidence that most of the building blocks for effective service integration are now in place

CMD has been largely successful in achieving the following short term outcomes:

- Relapse prevented or delayed
- Offenders address criminogenic drug treatment needs
- Services work together effectively
- Services achieve best practice
- Courts have more options to respond appropriately to drug using offenders

While reduced level of offending is a long term aim that is influenced by a range of other factors, the data for reappearances at court indicates that 43% of all CMD offenders had reappeared in court for a further matter (39% of offenders on bail). It is unknown whether the further offending took place before or after the commencement of CMD. This level of reoffending is similar to those of similar programs in other jurisdictions.

CMD remains a work in progress. A changed service model was introduced at the end of the first twelve months which should deliver improved services. There is evidence that the new service model will be more effective in terms of local service integration and more responsive to the courts as the separation between screening and assessment is removed.

Given the change in service model no recommendations are made in relation to service delivery. Recommendations are as follows.

- That a further evaluation of the outcomes of CMD be conducted in the next two to three years
- That the CMD database be maintained and monitored for accuracy on a regular basis
- That CMD work together with the Alcohol and Drug Service Sector and DHHS to expand the range of treatment options for offenders
- That brokerage funding or other arrangements be provided to allow case managers to facilitate access to non-CMD services for high risk offenders
- That CMD provide regular feedback on the achievements and directions of the program to Magistrates, police and defence counsel as a means of ensuring their continued support for the program

Much has been achieved in a short period of time in implementing CMD and the Project Implementation Group in the Department of Justice and the various service providers should be acknowledged and congratulated for their efforts.

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1. Introduction

Success Works was commissioned by the Tasmanian Department of Justice to evaluate the pilot Court Mandated Drug Diversion Program (CMD).

The goal of CMD is to break the drug-crime cycle by involving offenders in treatment and rehabilitation programs and providing alternative pathways for offenders through increasing their access to drug, alcohol, or other welfare services.

CMD also aims to:

- Provide offenders with an opportunity to acknowledge and address offending behaviour caused by drug abuse, thereby improving physical and psychological well being
- Help eligible offenders abstain from illicit drug use
- Reduce drug related offending behaviour
- Provide offenders with the tools to recognise and prevent relapse into substance abuse and criminal behaviour
- Develop a shared approach to and a commitment to a 'joined up' service delivery system between Government and the NGO sector.

The program commenced in July/August 2007 and the evaluation period expired at the end of June 2008.

This evaluation considers the first twelve months of the pilot program. Two progress reports were prepared by Success Works (in October 2007 and March 2008) addressing the progress of the program and identifying key formative issues. This final report brings together all of the data about the first twelve months of CMD.

Data provided by the Department of Justice indicates that in its first year of operation 250 offenders were referred for screening for suitability for the program and 157 offenders commenced the program¹.

¹ 65 offenders were ruled ineligible, not suitable or withdrew their consent prior to the CMD order being made and 19 were awaiting an assessment or the Court's determination on an assessment at the time the data was supplied. Insufficient data was provided to determine the status of 9 offenders identified for an initial screening.

2. The Court Mandated Drug Diversion Program

Overview

CMD is part of Tasmania's response to the National Illicit Drug Diversion Initiative. The objectives of the National Illicit Drug Diversion Initiative are to:

- Increase incentives for drug users to identify and treat their illicit drug use early
- Decrease the social impact of illicit drug use within the community
- Prevent a new generation of drug users committing drug-related crime in Australia, therefore leading to safer environments for all Australians.

While Tasmania was the first state to introduce police diversion², it was the last state to introduce a court based drug diversion program.

The pilot program has been implemented by the Department of Justice using a tendered service delivery approach. In its first year, contracted service providers were:

- Anglicare Tasmania, for the provision of assessment and individual and group counselling services
- Salvation Army for the provision of detoxification, pharmacotherapy, residential rehabilitation and drug testing services

² Police diversion has been in place in Tasmania since March 2000 allowing cannabis cautioning for first offenders; 'brief interventions' for second time cannabis users and referral to treatment for third time cannabis users and people found in possession of small quantities of other illicit drugs including heroin, amphetamines, ecstasy.

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- Community Corrections for the provision of case management for adult offenders undertaking CMD
 - Youth Justice for the provision of case management for young offenders undertaking CMD.
 - Turning Point Alcohol and Drug Centre or the provision of a training needs analysis and relevant training
 - Success Works for the provision of this evaluation.

Funding for the pilot program allowed for up to 196 offenders to participate in CMD in the first twelve months.

The program model chosen by the Department of Justice is based on current Australian and world's best practice research in relation to the diversion of drug using offenders into treatment programs using a therapeutic jurisprudence approach.

CMD Program Model

CMD is available to adult and juvenile offenders who plead or are found guilty of committing certain drug possession or use crimes, or non-violent crimes in order to support or pay for illicit drug use, or who [as an result of drug use] have committed certain family violence crimes. CMD operates within all of Tasmania's Magistrates Courts. It is not available to offenders appearing in the Tasmanian Supreme Court.

CMD has three categories:

- Category One – provided as a condition of bail following a plea or finding of guilt and prior to sentence. Category one is designed to have a maximum duration of 12 weeks. Offenders' compliance and success with a Category One order is taken into account at the point of sentencing. For some offenders, this may mean a further court direction to undertake a Category Two or Three order.
- Category Two – provided as a condition of probation or suspended sentence. Treatment is determined by the Court after consideration of an

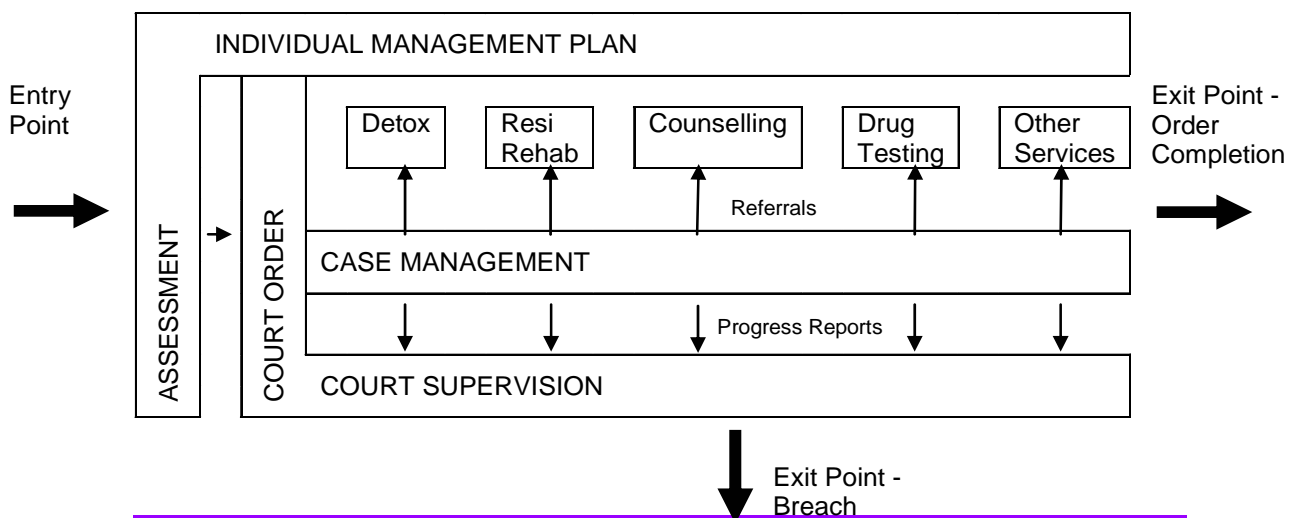
assessment report and may be for the period of the court order but is generally for less than 12 months.

- Category Three – provided as a sentencing option in its own right. The Drug Treatment Order (or DTO) is for offenders who would otherwise be subject to imprisonment. The term of imprisonment is held in abeyance, subject to satisfactory progress in the treatment program. This order includes regular court review and sanctions for minor levels of non-compliance which can also be suspended as an incentive for improved engagement. This level of diversion is available to offenders with complex needs who might benefit from extensive, longer term treatment, up to 18 months.

Offenders are assessed for CMD according to their drug treatment, general health and welfare and criminogenic needs. Individual Management Plans are developed based on the assessment which then guides the delivery of integrated intervention and treatment approaches through a case management approach.

Offenders on CMD orders may be directed into individual counselling, group counselling, and/or residential rehabilitation. They may also be subject to periodic urine testing. Referrals to non-CMD services may be included in the individual management plans (eg to mental health, housing or disability services). Case Managers are responsible for the implementation of the individual management plans.

The program model for CMD is as follows:



The five main components of CMD are assessment; individual management plans; court orders; case management and court supervision. All CMD offenders experience these program components. Other program elements such as counselling, residential rehabilitation and drug testing are secondary with offender's participation based on their specific needs and circumstances.

During the first year Court Diversion Officers (CDOs) coordinated the delivery of CMD in each region. Their role has been to liaise directly with the courts, conduct screening interviews for offenders and generally manage the interface between the assessors (Anglicare), case managers (Community Corrections and Youth Justice) and the courts. The role of the CDOs has now changed considerably in the light of the new service model (see below).

CMD Program Approach

Tasmania's approach to drug diversion differs from other jurisdictions in a number of key ways.

- While it has been condition of Commonwealth funding in every jurisdiction for the diversion option to be available to non-violent offenders only, Tasmania has successfully negotiated for family violence offenders to be eligible for CMD when their family violence offending is drug related
- Tasmania has positioned the availability of CMD after a finding of guilt. In a number of other jurisdictions, a pre-determination of guilt is not required to access bail based diversion programs
- CMD has developed a program model which clearly divides the assessment and case management functions and aims to build service capacity as a lasting outcome of the pilot program funding

The separation of assessment from case management is a departure from usual practice in community corrections settings. However, separating assessment from case management overcomes potential conflicts of interest for assessors who may otherwise put the financial or workload demands of their agency ahead of the needs of the client

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- CMD has a focus on addressing 'criminogenic needs' (ie. those factors which generate or engender criminal behaviour) rather than being based solely on harm minimisation (where the focus is on developing strategies to limit harm rather than changing behaviours). By prioritising 'criminogenic needs' the program is primarily targeted towards offenders who are at risk of reoffending rather than expending resources on people who may never come into contact with the criminal justice system again.

New Service Model

While it will not be subject to the evaluation process it is important to note the changes that were made to the service model for CMD at the end of its first year of operation.

Community Corrections (who were providing case management services) decided to withdraw from CMD and the Salvation Army decided to reduce their involvement to residential rehabilitation services only. As a result the following new responsibilities were put in place:

- Assessments and individual management plans are now prepared by the Court Diversion Officers (CDOs) within the Department of Justice
- Case management of adult offenders will be managed by Anglicare Tasmania
- Urine testing will also be managed by Anglicare Tasmania
- Case management of young offenders remains the responsibility of Youth Justice
- Residential rehabilitation services will be shared by Salvation Army and a possible second provider.
- Individual and group counselling remains the responsibility of Anglicare Tasmania
- Pharmacotherapy and detoxication services are no longer contracted in the CMD service model.

3. Evaluation

The evaluation of CMD has been designed not only to provide advice to the Department of Justice and CMD project implementation group about the progress and outcomes of the initiative, but to contribute to the implementation of the pilot program through a strong formative component which has detailed and reflected upon the learnings from the initiative as it has been implemented.

Two progress reports were prepared by Success Works during the evaluation period (in October 2007 and March 2008). These reports were primarily focused on formative issues. A two day evaluation workshop was held in April 2008 to consider the findings from the evaluation and make recommendations for the future. A third report was developed by Success Works based on this workshop.

This final evaluation report presents both the formative evaluation findings from the first year of operation as well as the summative evaluation³ findings.

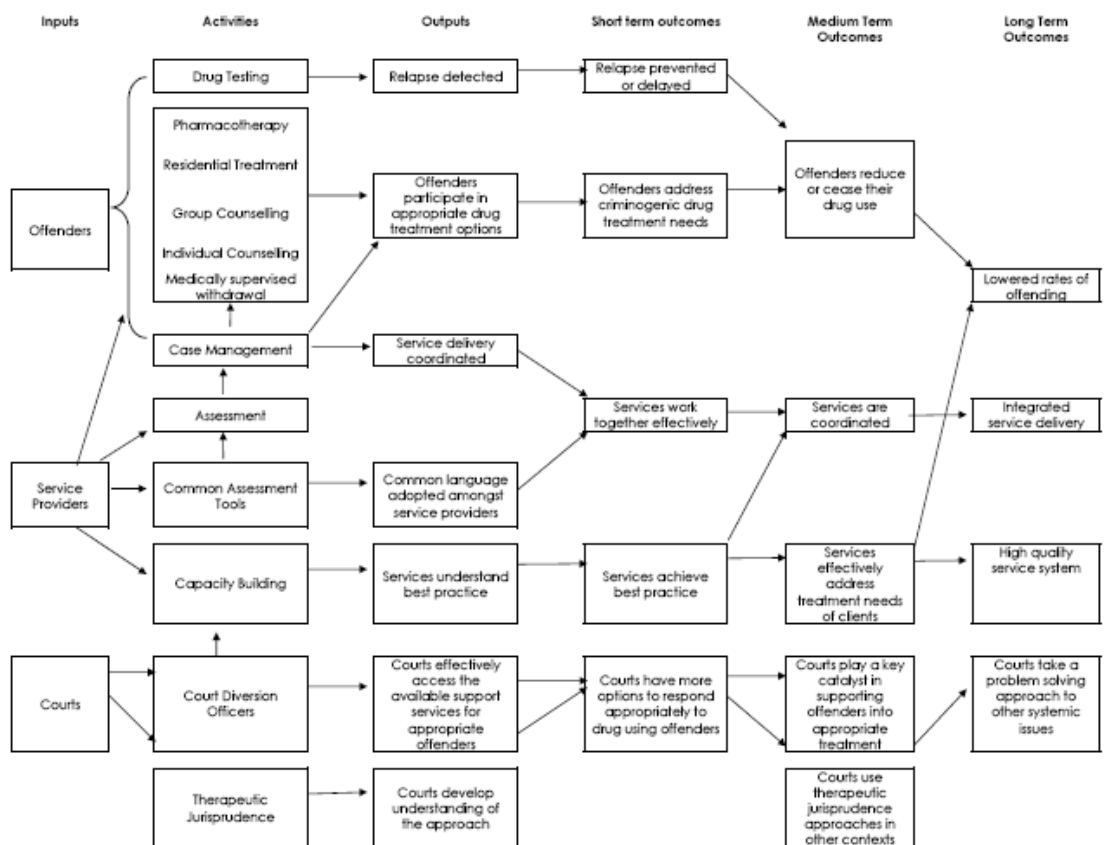
Project Logic

A 'Project Logic' model provides a summary of the logic underpinning an initiative. Evaluators use a project logic model to unpick the thinking behind the initiative and identify where their data collection efforts should be focused. A project logic model is a visual representation of the relationships between the various components of the program. The components include the program

³ Summative evaluation determines what has been achieved by the initiative and the overall relevance of those achievements given the research findings. It is generally carried out when the program has been in place for some time in order to study its effectiveness and judge its overall value. The primary audience is usually external, such as another government department or funding body (eg the Commonwealth Department of Health and Ageing) or the general public. The objectivity and overall reliability of findings is important in summative evaluation.

inputs, the program activities (i.e. what is being funded through the initiative), the outputs of the program and the outcomes expected in the short, medium and long term. The project logic is a schematic representation highlighting the logic by which a program is expected to work. The outputs and short-term outcomes identified in the logic model become the evaluation questions which in turn drive the data collection tools.

The CMD project logic is as follows:



Project logic allows the evaluators to focus on the areas that are within the control of the initiative. Long term outcomes are usually impacted by a range of other factors. Recidivism (or reoffending) is a case in point. While the project logic identifies 'lowered rates of offending' as a long term outcome; this outcome will be impacted by a range of factors which are outside the scope of CMD (eg socio-demographic issues, other non drug treatment related criminogenic needs, negative peer groups, age, gender etc). The project logic indicates that the long term outcome of 'lowered rates of offending' is related to the medium term outcome of 'offenders reduce or cease drug use' and the short-term outcome of 'offenders address criminogenic drug treatment needs' which is achieved through offenders participating in appropriate drug treatment options (the relevant program output). The project logic model allows the evaluators to look for evidence that the output has been delivered and, depending on the time allowed for the evaluation, whether the short term outcomes have been achieved and then theorise the impact that will have been made by the initiative on the achievement of the long term outcomes.

Data Collection Tools and Processes

In accordance with the project logic, data collection tools were developed to gather the data that forms the evidence of the evaluation. The following data has been collected:

Quantitative Data:

- Intake Data for all offenders referred to the CMD program, whether or not they are eligible or suitable
- Court Appearance Data for each court appearance involving CMD offenders (to monitor the processes of CMD and the supervision of the offender by the court as well as the workload for the court and CDO).
- Assessment Data for each offender to determine the assessment outcomes in terms of needs, risks and treatment requirements.

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- Service Provision Data for each offender to determine what services and programs he or she has participated in, service gaps and barriers and goals achieved.
 - Completion Data for each offender to determine the outcomes of the order (ie successful completion or breach) and any outstanding issues.
 - Recidivism Data based on returns to court in order to determine the occurrence of further offending following the imposition of a CMD order.

This data has been collated by the Department of Justice. It should be noted that Success Works has not been able to independently assess the accuracy or content of the data. Our role has been to analyse the data provided to us by the Department.

Qualitative Data:

- Interviews with Magistrates
- Interviews with CMD project team
- Interviews with Court Diversion Officers
- Interviews with Service Providers
- Interviews with Lawyers/ Prosecutors
- Observation of courts and CMD meetings
- Interviews with External Agencies
- Case Studies of a sample of offenders participating in CMD orders.

It should be noted that further case studies will be completed of offenders undertaking CMD orders in the next six to eight months.

Success Works has conducted all of the qualitative interviews directly.

4. Literature Review

As part of the design of the evaluation of CMD, Success Works prepared a detailed review of the relevant literature. A summary of the literature is provided in this chapter.

Tasmania's drug use and drug crime profile

The drug use and drug-crime profile of Tasmania differs from that of mainland Australian states. Based on the Australian Institute of Health and Welfare's (AIHW) 2004 *National Drug Strategy Household Survey* and the National Drug and Alcohol Research Centre's *Illicit Drug Reporting System*, Stojcevski (2006) found that:

- the proportion of Tasmanians who admitted to using illicit drugs in the previous twelve months was higher than in Victoria and New South Wales
- cannabis was the most widely used illicit drug
- use of analgesics for non-medical purposes was the second highest rate nationally
- alcohol misuse was the second highest rate nationally
- Tasmania is experiencing increased availability of and increased use of methamphetamines
- there is significant illicit use of methadone and injection of benzodiazepines
- the use of heroin and cocaine remains low in Tasmania (Stojcevski, May 2006: 3-4).

Stojcevski concludes that 'there is an illicit drug-using culture of consequence in the state' (4) and that there is a relatively high and increasing rate of property crime (in particular) associated with this drug use profile. Stojcevski notes that, in

Tasmania, drug users are twenty times more likely to be arrested for property crime than for drug crime (5). He also found that forty percent of people in Tasmania's prisons associate their offending with alcohol or illicit drug use (9).

Key Conceptual Issues

CMD has been based on a number of key concepts.

Therapeutic Jurisprudence and problem-solving courts

CMD is underpinned by the principles of therapeutic jurisprudence (defined by the International Network of Therapeutic Jurisprudence as a perspective that 'regards the law (rules of law, legal procedures, and roles of legal actors) ... as a social force that can produce therapeutic or anti-therapeutic consequences').

Therapeutic jurisprudence positions the court as a problem-solving institution with a whole of community rehabilitative and restorative focus.

Professor Arie Freiberg distinguishes between 'therapeutic jurisprudence' (which is the study of law as a therapeutic agent), and 'problem-solving courts' which deploy therapeutic jurisprudence concepts. Freiberg says that 'problem-oriented courts'

... represent a move away from a focus on individuals and their criminal conduct to offenders' problems and their solutions. Their attempt to deal with the problems which may have contributed to an offender's criminal behaviour reflects a realisation by courts and legislators that social problems may require social, rather than legal solutions (Freiberg 2001, quoted in Stojcevski 2006: 31)

In problem-solving courts the judges' willingness to divert clients to treatment and to deploy the resources of the court to broker a set of support services

around the offender is aimed at ending the cycle of crime and return 'offenders' to pro-social living.

Therapeutic jurisprudence and problem solving courts are driven by the recognition that 'recidivism, where caused by underlying physical, psychological, social or economic circumstances is better, and probably more economically, dealt with by effective social interventions than by harsher sentences' (Freiberg 2001: 4).

Problem solving courts seek 'to use the authority of the courts to address the underlying problems of individual litigants, the structural problems of the justice system, and the social problems of communities' (Freiberg 2004: 2, quoting Berman and Feinblatt 2001). They also seek to 're-engineer how government systems respond to problems like addiction, mental illness and child neglect' (Freiberg 2001: 5).

A problem solving court approach aims to replicate the motivational effect a first court appearance has for a first offender in those with a more regular experience of the court process. The personal interest of the Magistrate or Judge and the individualised attention of the court is, at least in part, aimed at personalising the court experience for the offender so that it is clear to them that the court does have an interest in them and has not just 'written them off'.

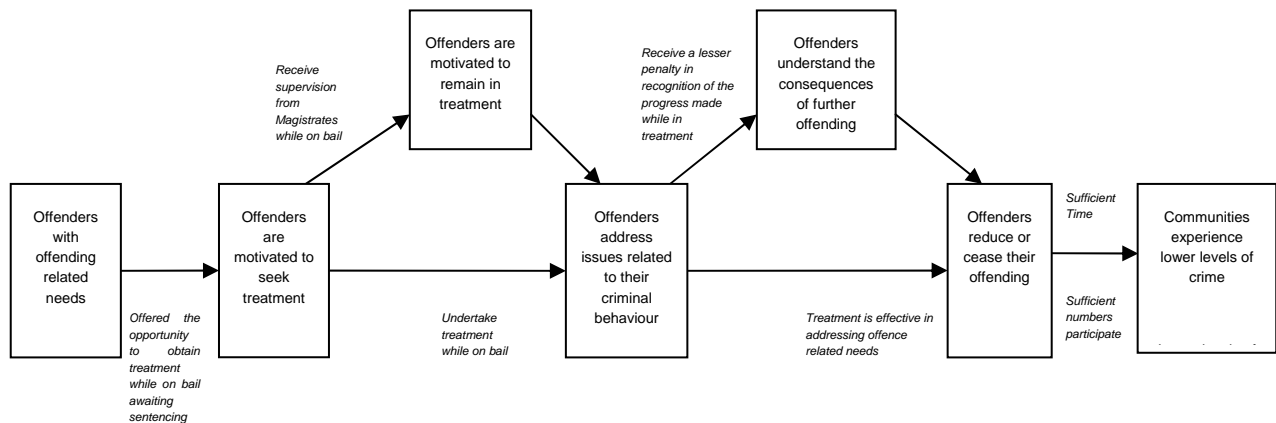
Problem solving courts have a number of key features. They offer:

- An approach by the judicial officer which moves away from the immediate questions of guilt or innocence towards broader issues of improvements in the health and wellbeing of the offender, of public safety and amenity and of the social and communal problems which may be conducive to criminal behaviour.
- An ability to tailor responses and approaches to justice based on informed decision-making. Judicial officers require more in-depth information about the individual case and the impact of such offending on the community than in other cases.

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- On-going judicial supervision. The court monitors the progress of the offender by requiring the offender to report back to the court. Accountability is achieved through judicial monitoring.
 - Direct engagement with defendants. Judicial officers talk directly to the defendant, making the court more meaningful for participants and exploiting the powerful role of the court as enforcer, mentor and supervisor.
 - A non-adversarial approach. Problem solving courts encourage participants to resolve cases and issues by collaboration rather than confrontation. This may require an admission of guilt.
 - Integration of service provision. The court and the court building provides a focus for the assessment of offenders needs for social, welfare and health services and is involved in coordinating their access to these services.
 - A focus on results (hence formal evaluations need to be conducted to test their efficacy).
 - Community outreach (Farole and others 2005: 57, 61, 62-65; King 2006:2; Freiberg 2004: 2-3).

Judicial leadership and commitment is considered critical to the effectiveness of problem solving courts (Farole and others 2005: 59, 61). Embedding a problem solving approach relies on active leadership of judicial officers committed to a non-adversarial approach, who ask more questions, seek more information (eg, about previous treatment history, mental health issues) and explore or entertain a greater range of rehabilitative, restorative and therapeutic solutions (ibid).

Success Works has developed the following project logic model to describe the processes that occur in a therapeutic jurisprudence approach to bail-based programs:



Assumptions:

- A pending court appearance is a strong motivator for change
- Offenders who participate in pre-sentence treatment understand the chance they have been given and are motivated to sustain the changes they have made and/or remain in treatment
- A personal relationship with the Magistrate increases the motivation for offenders to avoid further criminal behaviour

This project logic highlights the interplay between the supervision of the court and the motivation for offenders to first of all seek and then maintain their involvement in treatment during the bail period. Matters out of the hands of the court (such as the effectiveness of the treatment offered and the offenders' understanding of the consequences of their further offending) are then vital in achieving the longer term aims of reduced levels of offending and less crime overall.

Criminogenic Needs

CMD is focussed on addressing the criminogenic needs of offenders with drug issues appearing before Tasmania's Magistrates Courts.

Criminogenic needs are those needs presented by an individual that directly generate their criminal behaviour. Addressing these needs reduces their levels of criminal activity. Examples include antisocial attitudes, antisocial feelings, drug or alcohol dependencies, and poor parental affective and supervision skills.

Non criminogenic needs may also be dynamic but changes in them will not reduce criminality: examples include self-esteem, literacy and numeracy and emotional/person problems unrelated to criminal activity.

Based on the "What Works" literature in the rehabilitation of offenders (Andrews, et al, 1990), effective rehabilitation programs must adhere to the four principles of risk, need, responsiveness and human service:

- Risk - the level of treatment services must be matched to the risk level of the offender. Higher risk offenders should receive more intensive and extensive services whereas lower risk offenders should receive minimal or no intervention at all.
- Need - Effective programs should target the criminogenic needs of offenders.
- Responsivity - program styles and modes of delivery should be based on recognised successful approaches with the client groups such as cognitive behavioural and social learning approaches.
- Human Service - programs should be delivered within institutional and community settings that understand and respect the individual (Dowden and Andrews 2000: 451-3, p.453 cites Andrews et al 1990).

In addition Day, Howell and Rickwood identify the need for programs to promote professional flexibility and discretion in their design enabling individual approaches to client needs.

A focus on criminogenic needs and the 'what works' literature means that the client group for CMD is a higher risk (and therefore more recidivist) group of offenders than an early intervention program targeting people just becoming involved with the criminal justice system.

Diversion

Diversion is generally perceived as involving the 're-direction of offenders away from conventional criminal justice processes, with the aim of minimising their level of contact with, or extent of penetration of, the formal system' (Wundersitz, 2007: 31). These forms of diversion generally involve the provision of alternatives to

appearing before a court (eg police cautioning for cannabis use), sometimes in return for an agreement that the person will undertake some form of education or treatment.

In the context of CMD, however, diversion is related to the concept of '*any* processing option that offers what is perceived to be a different and less punitive response from that which would otherwise have applied' (ibid). For some CMD offenders, diversion also means providing them with an alternative to imprisonment.

While police diversion programs for low level drug offenders are generally aimed at ensuring that diverted offenders are removed from the criminal justice system, with the hope that they never return; court based diversion program, such as CMD, can, in the short to medium term, actually increase the level of involvement with and scrutiny by the criminal justice system (Wundersitz, 2007: 33). In fact, the level of criminal justice intervention can be so intense that court diversion options for drug users can be perceived to be significantly more intrusive and potentially more punitive than the normal processing options (ibid).

This is an important concept to understand in relation to CMD. By agreeing to participate in CMD, offenders (with the exception of those who would otherwise have been remanded in custody or imprisoned) have generally accepted a much higher level of involvement with the criminal justice system and intrusion into their personal lives than they would have experienced on an 'ordinary' bail or probation order or other sanctioning arrangement.

Other Australian Court Based Diversion Programs

All other jurisdictions in Australia offer some form of court based diversion to treatment for illicit drug using offenders.

Victoria

Victoria provides a number of court based diversion options including:

- Court Referral & Evaluation for Drug Intervention & Treatment (CREDIT)
- Deferred sentencing
- Rural outreach diversion workers
- Post sentence treatment services
- Drug Court

CREDIT is a bail program available from eleven of Victoria's Magistrates Courts. Like CMD, CREDIT is open to all age groups and stages of drug use. CREDIT is open to first time and low risk offenders along with those with some previous criminal and/or drug use history. To be eligible for CREDIT the offender must be charged with a non-violent offence, have an illicit drug problem, be released on bail, be initially bailed to a court where the CREDIT program operates and not subject to any other court order with a drug treatment component.

Deferred sentencing allows Magistrates to defer sentence for up to six months with a specific condition to attend drug treatment. To be eligible for a deferred sentence, the offender must be aged between 17 and 25, have a drug problem and be found guilty of an offence. Deferred sentencing is available in every Magistrates Court in Victoria.

The Rural Outreach Diversion Worker (RODW) provides a service to rural courts which do not have access to CREDIT. The RODW provides a link between the community, police, courts and the drug treatment service system and is primarily

targeted towards young offenders aged below 25 years. The target group is offenders who are apprehended for a non-drug related offence and thus not eligible to receive a caution and participate in the pre-court Drug Diversion Program, but whose drug use is a clear factor in their criminality.

Post sentence drug treatment is provided through the Community Offenders Advice and Treatment Service (COATS) operated by the Australian Community Support Organisation (ACSO).

Offenders receiving community based dispositions or a Combined Custody and Treatment Order (CCTO) may be referred to COATS for assessment. COATS will develop an alcohol and drug treatment plan based on the assessment and then purchase the necessary treatment services from a range of accredited community-based alcohol and drug treatment agencies across Victoria. In exceptional cases, COATS can undertake pre-sentence assessments for the Court, particularly where the Court is considering a CCTO. Over 6,000 offenders are either assessed or referred to treatment by COATS per annum. The majority of these are men aged in their twenties who are subject to Community Based Orders.

Victoria also operates a Drug Court at the Dandenong Magistrates Court. The Drug Court is responsible for sentencing and supervising the treatment of offenders with drug or alcohol dependency, who have committed an offence under the influence of drugs or alcohol or to support a drug or alcohol habit.

Offenders appearing at the Drug Court are sentenced to a 2 year Drug Treatment Order (DTO). The DTO consists of two parts, a custodial part and a treatment and supervision part. The custodial sentence is suspended to allow for the treatment of the offender. The treatment and supervision involves conditions which are intended to address the offender's drug and alcohol dependency. Sanctions and rewards are used to support compliant behaviour and sanction non-compliant behaviour. The Drug Court Magistrate has the responsibility for the supervision of offenders placed on the Drug Court program and is assisted by a multi-disciplinary team consisting of a case manager, clinical adviser, specialist community correction officers and a dedicated police prosecutor and defence lawyer. If offenders breach the DTO, the DTO can be cancelled and offenders sentenced to serve the unexpired portion of their sentence.

South Australia

South Australia has the Court Assessment and Referral Drug Scheme (CARDS) as well as a Drug Court.

CARDS operates in six Magistrates Courts and the Youth Court and is designed to provide an opportunity for offenders who use drugs to receive access to drug treatment as part of the court process.

Referrals for an assessment can be made prior to the court hearing by the offender or someone acting on their behalf. Referrals can also be made by the Magistrate during the court hearing. To initiate an assessment for CARDS, the offender telephones the CARDS team for a 10-minute phone interview. If the offender meets preliminary criteria for participation, an appointment is made for further assessment. Following the assessment a written report is prepared that includes recommendations about the offender's suitability for the scheme. This report is provided to the lawyer or made available to the court at the hearing by the CARDS Assessor.

CARDS is available pre-plea. If the offender is suitable the matter can be adjourned for three months while the offender participates in treatment. CARDS may also be made a condition of bail. At the end of three months, the defendant re-appears in court and the Magistrate finalises the CARDS matter, taking into account their participation in the scheme.

After the offender has pleaded and/or been found guilty of the charges, the Magistrate may place the offender on a supervised bond with the condition that they attend drug treatment (supervised by Correctional Services). The matter is resolved when the period of the bond expires. If referral to treatment is linked to a condition of bail or a bond, failure to attend treatment appointments may be considered to be a breach and could result in arrest and having the matter brought back to court.

To be considered for the scheme the offender must have either committed the offence to support an illicit drug habit or whilst under the influence of an illicit or licit drug, or be charged with possession or use of an illicit drug. The offender must also be assessed as:

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- having a treatable drug problem
 - having been charged with summary or minor indictable offence(s) in the Magistrates Court or a minor or major offence in the Youth Court
 - being suitable for release into the community
 - providing informed consent to participate in the scheme
 - living in an area serviced by the treatment agency
 - not on any other court-ordered drug treatment program
 - not currently charged with a sexual offence
 - not currently charged with an offence of violence that precludes them from CARDS
 - not currently charged with a major indictable offence.

CARDS treatment involves at least four counselling sessions with a specialist clinician. Offenders may voluntarily engage in more intense and ongoing treatment. Voluntary treatment can include:

- Withdrawal management, including inpatient detoxification if necessary
- Pharmacological treatment such as methadone and buprenorphine
- Relapse prevention programs such as counselling and group therapy
- Residential rehabilitation
- Referral to Narcotics Anonymous and other abstinence-based support groups
- Support with physical and mental health issues
- Support to access education or vocational training
- Support with accommodation, family relationships and financial issues

SA also offers the Drug Court. The SA Drug Court is only available through the Adelaide Magistrates Court. It combines intensive judicial supervision, mandatory drug testing and case management, involving three phases of sanctions, over a 12-month period including home detention bail with electronic

monitoring. Offenders appearing at the drug court are required to plead guilty prior to their acceptance onto the program. They are required to attend weekly court appearances. Offenders appearing at the drug court are facing a potential prison sentence.

Western Australia

WA offers a number of diversion options, several of which are available at the court stage.

The Young Person's Opportunity Program (YPOP) is an early intervention diversion program targeting young people aged 10 to 18 who have been identified by their Juvenile Justice Team (JJT) Coordinator as having either an emerging or significant drug issue. In Perth, young people in the Court Conferencing process can participate in YPOP. The offences do not have to involve drugs.

The Pre-sentence Opportunity Program (POP) aims to direct offenders with no or minimal criminal record but with a drug use problem into treatment. Participants in the program would normally expect to receive a fine or community based order on a plea of guilty.

The Indigenous Diversion Program (IDP) directs Indigenous people who have committed relatively minor offences and that have an alcohol and/or other drug problem. While similar to POP, IDP provides a culturally secure regional service.

The Supervised Treatment Intervention Regime (STIR) directs moderate level offenders with a greater drug use problem into treatment. Unlike POP, STIR provides ongoing case management of offenders and requires a strong partnership between drug treatment services, correctional services and the judiciary.

The Perth Drug Court provides adult and young people with substance abuse problems into appropriate treatment and supervision programs tailored to their specific needs.

Northern Territory

The NT government provides the Court Referral and Evaluation for Drug Intervention and Treatment Program (CREDIT NT), overseen by the Department of Justice. CREDIT NT is a pre-sentence bail program, where eligible offenders are bailed for up to four months to attend drug treatment services as identified during a comprehensive assessment by a qualified court clinician. Treatment progress is monitored through reviews by the court, and attendance and participation in the program is taken into account during final sentencing by the magistrate.

Queensland

Queensland offers the Illicit Drugs Court Diversion Program (IDCDP). The IDCDP targets both adult and juvenile offenders who appear in any Queensland Magistrates or Children's Court charged with possession of small amounts of illicit drugs for personal use.

The program diverts minor level offenders to an approved service provider for appropriate intervention (assessment and education session). Attendance and completion of the intervention session results in the original offence ending without a conviction. Where an offender does not attend the session, a warrant can be issued and the offender returned to court to be dealt with again for the original offence.

Queensland also operates drug courts in five locations. The Drug Courts offer offenders an intensive drug rehabilitation order (IDRO) as an alternative to prison. The courts provide supervision of the offenders as they progress through their order. Offenders must have pleaded guilty to drug-related offences and have no outstanding charges for offences involving sexual or other types of physical violence. Failure to comply with an IDRO will result in the person being returned to court for sentencing.

Queensland also offers the Queensland Indigenous Alcohol Diversion Program. This program is operating on a pilot basis in three communities: Cairns/Yarrabah; Townsville/Palm Island and Rockhampton/Woorabinda⁴. This program provides Indigenous offenders with the option of intensive alcohol treatment for up to 20 weeks as a condition of bail. After care support services are also provided to support offenders following sentencing. Most of the treatment services are residential.

New South Wales

New South Wales Magistrates Court offer the Magistrates Early Referral Into Treatment (MERIT) program. MERIT operates in 60 courts and is a pre-plea program under which arrested defendants, with illicit drug use problems, may be bailed to undertake drug treatment and rehabilitation. MERIT is available to adults aged 18 years and over. MERIT case workers assess potentially eligible offenders for program suitability at the court, develop and monitor progress against the treatment plan and report to the court on progress.

The program generally runs for three months. Participation, or otherwise, is reported back to the court at the sentencing hearing. The impact of participation in MERIT on the final sentence is at the discretion of the magistrate.

NSW also operates a number of other programs:

- Wellington Options. This pilot program operating out of the Wellington Local Court is directed towards both juvenile and adult offenders and provides holistic case management through a dedicated case worker. Offenders are engaged for up to 12 months and access intensive drug treatment, family support and case management services. At completion participation in the program is taken into account when determining the final sentence.
- Young Offenders' Residential Rehabilitation (YORR) program provides residential units in Coffs Harbour and Dubbo for young offenders who are

⁴ Success Works is currently evaluating the QIADP initiative for the Queensland government.

either within the juvenile justice system, or at risk of being so because of their drug and/or alcohol misuse. The program is available to young offenders aged between 10 and 18 years, and involves the young person committing to a three-month intensive residential rehabilitation program. The program is designed to support clients in later stages of detoxification, and also offers outpatient programs and aftercare planning.

- Young Offenders' Rural and Regional Counselling (YORRC) program provides young offenders with the option of being referred to specialist counsellors employed by the NSW Department of Juvenile Justice. The program uses a case management model incorporating alcohol and drug counselling and referral to other relevant services.

NSW operates a Drug Court at Parramatta which aims to assist drug-dependent offenders to overcome both their drug dependence and their criminal offending. To be eligible for the Drug Court a person must:

- be highly likely to be sentenced to full-time imprisonment if convicted
- have indicated that he or she will plead guilty to the offence
- be dependent on the use of prohibited drugs
- reside within the catchment area (specified areas of Western Sydney)
- be referred from a court in the catchment area
- be 18 years of age or over
- be willing to participate.

Offenders charged with violent or sexual offences or who have a mental illness are not eligible for the Drug Court.

The NSW Drug Court is able to sentence offenders to periods of incarceration in a Compulsory Drug Treatment Correctional Centre (CDTCC) based near the Parklea Correctional Complex (approximately 40km north-west of the Sydney). The CDTCC houses up to 70 offenders who have been sentenced to a Compulsory Drug Treatment Order by the Drug Court. The CDTCC specialises in abstinence-based treatment and in the rehabilitation for offenders with 'long

term illicit drug dependency and an associated life of crime and constant imprisonment' (New South Wales Government 2007).

ACT

ACT provides the Court Alcohol and Drug Assessment Service (CADAS) as a pre-sentencing treatment option for offenders charged with alcohol and other drug-related offences. The program is available in adult and children's courts.

The CADAS clinician, who is located at the Court, provides an immediate assessment, and recommends an appropriate treatment plan. If the offender is released on bail to comply with the treatment plan, the CADAS clinician monitors attendance, and reports outcomes to the Court. Non-compliance is taken into account by the Magistrate at sentencing.

ACT also provides a Treatment Referral Program as a post sentencing option. The magistrate or judge may, as part of the sentence imposed, instruct a client to undergo a treatment order rather than receive a custodial sentence or as an option to reduce their custodial time. The treatment is overseen by a Treatment Assessment Panel, and conducted by an approved treatment agency. The treatment can be for a period of 6 months up to 2 years. Offenders who fail to complete their treatment order may revert to a custodial sentence.

Evaluations of court based diversion programs

Victoria's CREDIT and Drug Court Programs

Two evaluations of CREDIT have been undertaken including a pilot stage evaluation (Heale and Lang 2001) and a full program evaluation (Alberti, King and others December 2004; King, Fletcher and others November 2004).

The pilot program evaluation found that 52% of participants had completed their treatment program and that 24% of participants had re-offended during the period of bail. This rate of recidivism was similar to the rate for a comparison

non-CREDIT group. They also found that almost 30% of re-offending by each group occurred within seven days of setting bail. The evaluators found that Aboriginal and Torres Strait Islander Victorians had a low participation rate in CREDIT and that, while some ethnic communities were overrepresented (11% of participants were of Vietnamese descent), other groups were underrepresented (Heale and Lang 2001: 227).

The full evaluation of CREDIT found that:

- The initial target of 2068 referrals per year was not reached in any period during the evaluation
- Three quarters of participants were males with males aged 20-29 years accounting for 45% of all participants
- Most participants had significant offending histories prior to referral to CREDIT with an average of 21.9 prior convictions per participant
- Over 76 per cent of participants used heroin
- Two thirds of participants spent less than 90 day in the program while one third spent more than 90 days in the program
- Almost one in ten remained with the program for over 160 days where the bail period was extended
- Magistrates encourage participants to continue in treatment by extending bail periods to maximise the benefits of the program
- Treatment professionals 'reported excellent results for CREDIT participants and stated that their success rates with such participants generally exceeded those where treatment was not mandated'
- Treatment completion rates⁵ for CREDIT participants of 80%

⁵ 'Completion' was defined as 'attended treatment and engaged well in treatment throughout the entire period of bail', 'made significant positive progress', 'attended scheduled reviews with clinician', 'attended all court hearings'.

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- Ninety-two per cent of participants received a non-custodial sentence when they returned to court while thirty per cent of non-completing participants received a custodial sentence
 - 2.5 percent of those who did complete treatment also received a custodial sentence
 - 38 percent of offenders reoffended within 12 months of commencement of the program at an average rate of 263 offences per 100 CREDIT participants (Alberti King, 2004).

The evaluation of the drug court found that:

- Most offenders were males aged 26-35, which accounted for 47% of participants
- Just over half (54%) of participants were born in Australia with the next most commonly reported background being Vietnamese (12%)
- On average, participants had 40 prior convictions, 50% of which were for property-related offences and 19% for drug related offences
- The major offences that led to their being placed on a DTO were predominantly property-related (68% of cases), with drug-related offences being the major offence in 15% of cases
- The average time taken to progress through all stages of the program was 173 days (range 105-289 days), slightly more than double the anticipated duration of 12 weeks (or 84 days)
- Cancellations were made after an average 183 days (within a wide range of 55-349 days)
- An attendance rate for drug testing of 78% with 76.3% of tests producing positive results. Of participants, 63% had negative (i.e. clean) test results for 10% or less of their urine samples, 23% were clean in 11-50% of tests, 8% were clean in 51-90% of tests, and 6% were clean in 91% of tests or more
- Projected re-offending rates of approximately 72% of the participant reoffending within 12 months, for a total of 365 offences per 100 participants in that period.

NSW MERIT (Magistrates Early Referral into Treatment)

An evaluation of MERIT (Passey et al, 2007) followed up all participants who were accepted into the Lismore MERIT Pilot Program in the initial 18 months of operation (between July 1, 2000 and December 31, 2001).

To measure recidivism, the NSW Bureau of Crime Statistics and Research provided data from the police database on the offences allegedly committed by Lismore MERIT Pilot Program participants between the date of referral to the program and December 31, 2002. Police charges were used as a proxy measure of recidivism (rather than finalised offences) because court processes can be protracted, and data recording, cleaning and processing require additional time. The evaluators recognise that only detected offences are measured in this way and some charges may not lead to a conviction.

The evaluators found that of the 178 people accepted to the Lismore program in the first 18 months:

- 53 percent completed the program
- The average time on the program was 119 days for completers, and 57 days for noncompleters.
- Most were male, unemployed, and users of multiple different classes of illicit drugs with a median age of 29 years. 15 percent identified as Aboriginal
- Heroin (58%) was the most frequent 'principal drug of concern' (the drug identified by the participant as their greatest concern), with cannabis (23%) and amphetamines (16%) also common
- Most were recidivist with 57% reporting previous imprisonment, and 79% having at least one prior criminal conviction
- 25% of people who had completed the program and 50% of those that did not complete the program had reoffended within 3 months of being referred to the program

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- 53% of people who had completed the program and 69% of those that did not complete the program had reoffended within 12 months of being referred to the program
 - The average time taken before committing a further offence was 375 days for completers and 247 days for noncompleters.

ACT CADAS (Court Alcohol and Drug Assessment Service)

CADAS provides a diversion option for around 250 clients a year. A 2003 evaluation found that limited data was available on the program making quantitative evaluation difficult. The evaluation fell back on 'feedback from stakeholders' who reported that the program 'does achieve the stated objective of engaging clients in treatment and offering options clients may not be aware of prior to contact with CADAS'. The limited data 'suggested' a degree of success in linking clients to treatment, and some success in completion of programs and reduced drug use (Morgan Disney 2003: 42-4). 'However it is difficult to assess the extent of success on the third objective of diverting offenders from future involvement in the criminal justice system in the absence of good quality data' (43).

The evaluation found that the program was under-utilised by magistrates largely because magistrates perceived a lack of understanding on the part of drug treatment services about 'the justice context in which the service is located' (Morgan Disney 2003: 7, 47). Magistrates expressed some concern as to 'whether alcohol and drug workers generally appreciated the importance of addressing the criminal behaviour of their clients through CADAS' (p.47). In other words there was a perceived lack of agreement between the courts and treatment services over 'accountability' (Morgan Disney 2003: 8) in relation to mandated clients. Indeed, some treatment workers 'argued that their intervention was health related' and a post-court intervention (p.47). This attitude, or understanding contrasted with the clear understanding of MERIT and CREDIT staff who 'stated that, in their view, understanding this justice context was

integral to their service and they confronted the issue “head on” (Morgan Disney: 47).

Morgan Disney also identified a need to educate ACT police to ensure more referrals, for closer integration with mental health forensic workers, and for changes be made to the physical infrastructure of courts to ensure that CADAS offices adjoin court rooms.

They also noted a need to clarify the meaning of ‘early intervention’ in regard to CADAS since some offenders had substantial histories of criminal activity, although they had not necessarily been previously referred to treatment (Morgan Disney 2003: 38).

South Australia’s CARDS (Court Assessment and Referral Drug Scheme)

Evaluators of CARDS found that in the two years from June 2004 to June 2006, 332 referrals were made to CARDS comprising 300 individuals, of whom 207 were accepted on to the program. Of these offenders, they found that:

- 60 percent successfully completed the program
- 75 percent were male and 86 percent were aged under 40. The mean age was 30.7 years and the median 30. 12% were Aboriginal
- The number of criminal events reduced from an average of 2.55 per week per offender in the six months prior to participation to 1.7 per week in the six months following referral
- 60% were not charged with further criminal offending while participating on the program (meaning that 40% were).

Queensland's Court Diversion Program

Queensland court diversion program is a low level diversion program providing education rather than 'treatment'.

An evaluation of the pilot stage (Irwin 2006: 16-20) found that

- 5202 offenders were assessed as eligible for diversion and diverted, of whom 190 were juvenile,
- Diverted offenders had a compliance rate (attendance) of 91%
- Only 385 diverted offenders returned to court for non-compliance
- There were below average completion rates amongst females, Aboriginal clients, young clients (especially high for 14-16 year olds) and for those in rural locations.

A study of recidivism, based on a sample of 200 diversion pilot program participants in the two years of the pilot, found that:

- 67% of diverted adults without previous criminal history did not re-offend.
- 37% of adults with a criminal history did not re-offend (63% did re-offend)
- 28% of juveniles (with or without criminal history) did not re-offend (72% did re-offend) (Irwin 2006: 19-20).

A recent evaluation of the Queensland drug court (Payne, 2008) found that:

- Most offenders were male (86%), married or living in a de facto relationship (82%), non-Indigenous (90%) and aged 29 years on average
- 70 percent of program graduates committed a new offence while participating in the drug court program – mainly breach-related offences resulting from minor non compliance with the order
- 43 percent of program graduates committed at least one new property offence while on a drug court order, 15 percent committed a violent offence and 31 percent committed a drug offence while on the program.

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- 92 percent of people who left the program prior to graduation (terminates) reoffended
 - For program graduates offending declined by 86 percent from an average of 2.9 offences every six months prior to participation to 0.4 offences every six months during participation
 - Program terminates also showed a reduction in reoffending – down from 3.6 offences every six months prior to participation to 2.1 offences every six months following participation – a 42 percent reduction

The evaluation found that after leaving the drug court program:

- 59 percent of program graduates were reconvicted of a new offence within two years. The first post-graduation offence occurred after an average of 379 days
- 77 percent of program terminates were reconvicted within two years of their release from prison – the average time to first offence was 139 days
- Program graduates committed an average of 0.61 offences every six months after their graduation, down by 80 percent compared with the 12 months prior to their entry into the drug court program
- Program terminates committed an average of 1.38 offences every six months after being released from prison – 63 percent lower than their rate of offending in the 12 months prior to drug court participation
- No real differences between people who had left the program (terminates) and a prisoner comparison group in both their pre and post-drug court/imprisonment offending rates.

Evidence of Success

According to Freiberg, program evaluations in general have 'not been satisfactory because time scales have been short and the sample sizes small' (Freiberg 2004: 13). For example, the 2001 Victorian evaluation of CREDIT took place when the pilot had been operating for only nine months (Heale and Lang 2001: 223). Turning Point's Diversion Outcomes Study was able to recruit only

twenty-three participants for interview against a two state (Tasmania and Victoria) target of 350 (Bull 2003: 77-8). Evaluators for CADAS (Morgan Disney 2003) found the data sources inadequate to identify successes and issues with the program. King reports that in Western Australia, despite the development of a number of significant innovative programs, the courts lacked the resources and the statistical data to accurately establish the effectiveness of its programs (King, Feb 2006: 1). Klag and others also found 'little solid empirical data on the effectiveness of legal coercion [to treatment], calling into question the evidence-based claims made by researchers that coerced treatment is effective in the rehabilitation of substance users' (Klag and others 2004: 1782). They also found that 'empirical evaluations of the nature and efficacy of mandated treatment have been seriously impeded by methodological and conceptual problems' (Klag and others 2004: 1782) and conclude that much of the literature is based on assertion rather than evidence.

Stevens, Berto and others (2005) found a similar ambiguity when they reviewed English, German, Dutch, French and Italian sources. They found that whereas Anglophone sources tended to report positive benefits from what they call 'Quasi-Compulsory Treatment (QCT) interventions, the non-Anglophone material 'shows a wider range of outcomes including negative effects'. They also found that strong motivation on the part of the diverted offender is a key success factor regardless of whether the offender is a mandated or a voluntary participant in treatment (Stevens and others 2005: 269, 275). Quasi-coercion may not necessarily be inconsistent with high motivation.

When evaluations have occurred, the key performance indicators against which programs have been measured include:

- The relative proportion of referrals by police, magistrates, prosecutors and self-referral of the offender
- Client uptake of diversion to treatment
- Retention and satisfactory completion of treatment programs
- The extent of re-offending while on bail

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- The extent of recidivism in the 6-12 months following completion of treatment (Heale and Lang 2001: 223).

In relation to reoffending (recidivism) evaluations to date suggest that 'the effects of programs on recidivism have been minimal if not non-existent, though performance of offenders during the program[s] has been better' (Freiberg 2004: 13). This is consistent with the Project Logic adopted for this evaluation which places 'reduced levels of reoffending' as a long term outcome; acknowledging that its achievement will also be impacted by a range of other factors outside the control of the court diversion program.

The literature does confirm, however, that diversion programs do appear to have resulted in improved health and wellbeing outcomes for offenders, better relationships between the courts and drug treatment service providers and have delivered 'more procedural justice to the participants who feel that they have been listened to and that the process is relatively fair' (Freiberg 2004: 13).

Wundersitz (2007) notes the lack of an holistic approach to evaluation of drug diversion initiatives which examine the relationships, interactions and composite outcomes of all types of initiatives within one jurisdiction (Wunderstitz, 2007: 36). Unfortunately this lack of an holistic approach is repeated in this evaluation given the focus is on court diversion rather than considering the interaction between CMD and the Tasmanian Police drug diversion initiative.

Wundersitz also notes that, like this one, most evaluations have taken place at the commencement of the program or at an early stage. While these evaluations are 'critical to identify and respond to any implementation and process-related issues' (Wundersitz, 2007: 111), she notes that 'all programs evolve over time, as initial teething problems (often identified by the evaluations themselves) are rectified, as understanding of participant needs is more fully developed and as political imperatives change' (ibid)). She advocates follow-up studies some years after program inception as being more important in terms of measuring program outcomes, because, as she says 'by that stage, the number of participants is much larger and sufficient time has elapsed to assess long term impacts on reoffending and drug use patterns' (Ibid).

Follow up evaluation of CMD is recommended later in this report.

5. Implementation of CMD

The Department of Justice has pursued four distinct strategies in the implementation of CMD:

1. Service delivery
2. Capacity building
3. Quality improvement
4. Service integration

Following an overview of the implementation process, this chapter outlines what has been achieved in each of these areas during the first year. Where appropriate, quantitative and qualitative data obtained through the evaluation process is included.

However, prior to the consideration of the implementation process, a summary is provided of the complex and difficult pre-implementation history of CMD.

Pre-implementation history

Tasmania is the last jurisdiction in Australia to implement a court based drug diversion program. Prior to the commencement of the pilot program and this evaluation, Success Works met with a range of key informants in order to obtain an understanding of the reasons for the delayed commencement.

Based on these interviews it is apparent that CMD is the result of the third attempt to establish a drug diversion program in Tasmania. The history of the implementation of CMD is as follows:

- The first attempt to establish a court based drug diversion option occurred in 2001/02 led by Tasmania Police and the Department of Premier and Cabinet with some involvement from the Department of

Justice. The recommendation was to establish a bail based program similar to MERIT (NSW) and CREDIT (Victoria). This option was rejected by the State Government after it became apparent that there had been insufficient consultation with the Chief Magistrate and that he and others held major concerns about positioning the diversion option prior to a finding of guilt.

- The second attempt was in 2003/04 led by the Department of Justice. This attempt addressed the Chief Magistrate's concerns by positioning drug treatment diversion after a finding of guilt. This option involved Youth Justice and Community Corrections providing the case management and also having the capacity to purchase treatment support from Alcohol and Drug and other non-government services. This model was rejected by the Commonwealth who continued to advocate for a pre-plea based bail programs based on MERIT in NSW and had concerns that the funding could be used to supplement underfunded parts of the State Government. There was also a perception that this option did not adequately address the lack of capacity and resources in the AOD and non-government sectors in Tasmania.
- The third (and ultimately successful) attempt did not commence immediately after the failure of the second attempt. After the failure of the second attempt, there was a deterioration in relationships on the Commonwealth/State Reference Group with perceptions that the NGOs were not providing an adequate service for Police diverted clients, that DHHS was not resourcing the sector adequately and that the Commonwealth were seeking to drive a capacity building agenda for the NGO sector at the expense of the state's diversion capacity. Also at this time, at the Commonwealth's insistence, NGOS were appointed to the Commonwealth/State Reference Group. This changed the dynamics of the committee and rendered it ineffective, at least for a while. There was no clear agreement on what the principle issues were or what the priorities should be.
- Sometime after the appointment of a new Director in the local office of the Department of Health and Ageing (DOHA) in 2004, it was agreed to

have one last attempt to develop a diversion program acceptable to all stakeholders. To facilitate this, the DOHA Director arranged a special meeting between the Commonwealth/State Reference Group and the Acting Chair of the Australian National Council on Drugs (ANCD) to discuss the capacity for Tasmania to have its own unique approach to drug diversion.

- Following this meeting, a working group was established with just the major players (Department of Justice, Tasmania Police, Department of Health and Human Services, the Alcohol, Tobacco and Drugs Council and the local member of the ANCD). The working group established a set of principles that then drove the development of the third model during 2005/06. Central to these principles was the concept of therapeutic jurisprudence. The working group made a number of compromises in order to develop the preferred model. There is an understanding now that no one department or organisation was able to get everything their own way. Rather, the model in place now is based on a series of agreements – that the NGO sector needed to gain additional resources and capacity as part of the initiative; that funding for this program should not supplement underfunded parts of the state budget; that the initiative be positioned after a finding of guilt and that the program be offered in all courts and regions.

Implementation Process

Project Implementation Team

The implementation process has been managed by a central team led by the Principal Consultant, Strategic Policy and Projects in the Department of Justice (who is also responsible for the implementation and ongoing management of the Tasmanian Government's *Safe at Home* Strategy⁶).

⁶ Safe at Home is an integrated statewide service response to family violence.

At the commencement of the implementation process, the implementation team comprised the Principal Consultant, the Coordinator of Special Programs, the Senior Consultant - Business Processes (responsible for a number of projects), two head office based Project Officers and an administration officer (both solely CMD focused). Prior to implementation three Court Diversion Officers (one per court region) were appointed and provided a regional presence for the implementation team.

Part way through the year the positions of Project Officer ceased and one part-time incumbent transferred to a new position in courts to support the implementation of therapeutic jurisprudence within the courts as part of the CMD response.

The Court Diversion Officers (CDOs) have been members of the implementation team as well as providing services within the CMD program itself. At the commencement of CMD there were three CDOs; one per region. By March 2008 an additional part-time CDO had commenced in the South as well as a part-time administrative officer. By the end of the evaluation period the two CDO positions in the North and North West had been reduced to one position in the North and 0.6 EFT position in the North-West. There were still two CDOs in the South.

In the first year, the CDOs service delivery role was to liaise with the courts in relation to CMD, conduct screening interviews, refer offenders to Anglicare Tasmania for assessment and ensure that the Assessment Reports, Individual Management Plans and Progress Reports were provided to the court in a timely manner. The CDO's have become increasingly involved in court review processes and fulfilled an essential linking role between the Courts and the treatment service providers. The CDO role changed significantly at the end of the first year of operation to accommodate the new service model.

Context

CMD has been implemented in the context of a recognised incapacity of the existing alcohol and drug service system in Tasmania to meet the needs and expectations of clients, families, other service providers and the community in general (DHHS, Alcohol, Tobacco and Other Drug Services: Discussion Paper, 2007).

During the period in which CMD has been in operation, the Department of Health and Human Services commissioned a review to “take a closer look at the service system within Tasmania and to determine whether the capacity of the sector is sufficient to meet the needs of clients both now and into the future” (DHHS, 2007).

This review was completed in January 2008 and found:

- The size of the alcohol and drug workforce treatment sector in Tasmania is significantly lower than the national per capita average
- Considerable strain on the available workforce to manage people with alcohol and drug problems
- People with drug issues have not been able to access suitable treatment services
- Increasing rates of accidental deaths due to opioid use
- Significantly increasing rates of prescriptions for benzodiazepines to levels 300% higher than the national rate (Healthcare Management Advisors, 2008).

In order to be effective, CMD has had to position its twelve month pilot program within this broader context of inadequate service capacity and many and various service gaps.

Key strategies to address this context have included:

- The strong focus on capacity building for both the government and non government sectors

- The sharing of CMD funding between government and non government providers
- The commissioning of this evaluation to document learnings, service gaps and barriers as well as outcomes.

Funding

The funding provided to the Tasmanian Government by the Commonwealth for CMD by the Department of Health and Ageing was a little over \$2.4 m.

The Tasmanian Government also contributed about \$200,000 to CMD in its first year of operation (\$110,000 to project management and \$90,000 to program coordination).

Further, as a result of CMD the Tasmanian Magistrates Court absorbed a significantly increased workload with no increase in funding.

Based on data provided by the Department of Justice, the breakdown of the CMD Commonwealth funding component by program was as follows:

Table 1: CMD Funding by Program Component

Program	Total
Project Management ⁷	253.8
Program Coordination (Coordinator plus CDO's etc)	449.5
QA & Capacity Building	373.5
Assessment	264
Case Management	424.5
Treatment Services (Counselling and Res. Rehab.)	230.1

⁷ Includes funding for program implementation staff, the court diversion officers, admin support, accommodation, equipment, communications, travel and internal training plus a small amount of funds for urine testing and other costs to be allocated to service providers as required

Drug testing	225
Evaluation	234.7
TOTAL	2,455.0

A competitive tendering and contracting approach was used to identify appropriately qualified and experienced service providers. Expressions of Interest for the provision of key components of the program (including the evaluation) were called for in October 2006. Short-listed organisations were then asked to submit detailed tenders for submission in early 2007. Aside from the evaluation contract which was awarded in March 2007, service contracts were awarded in June 2007.

Contracts were awarded as follows:

Table 2: Contracts

Service Provider	Contracted Service(s)	Projected Amount
Anglicare Tasmania	Assessment Individual Counselling Group Counselling	\$241,000
Community Corrections, Department of Justice	Case Management – adult offenders	\$375,000
Youth Justice Services, Department of Health and Human Services	Case Management – juvenile offenders	\$97,250
Salvation Army	Residential Rehabilitation Detoxification Pharmacotherapy Drug Testing	\$288,590
Success Works	Evaluation Services	\$217,600
TOTAL		\$ 1,219,440

Source: tenders.tas.gov.au

Based on interviews with key informants, the use of a contracted service delivery model was more familiar to the non-government agencies involved in CMD. Community Corrections and Youth Justice were not as familiar with the process and did not necessarily feel that this was an appropriate model for government agencies to undergo.

Model of Implementation

The contracting model represents a 'top-down' approach to implementation. Rather than seeking to build consensus and negotiate with service providers as equal partners from the beginning (the 'bottom-up' method), the requirements for service delivery were clearly specified in the tender and interested organisations asked to develop their approach accordingly.

A top down approach comes with a number of well documented potential drawbacks:

- There can be a lack of ownership by key stakeholders with the result that they actively or passively resist the change process and/or undermine the implementation process (Pressman and Wildavsky, 1973, Bardach, 1977, O'Toole, 2000)
- Staff at the 'street level' responsible for delivering the program may not understand program goals and priorities and so institute their own which fundamentally shift the dynamics of the program (Lipsky, 1980)
- Staff designing the program may not understand the need for flexibility at the 'street level' and fail to allow the required latitude for local staff and managers to make local level modifications required for program success (Schneider, 1999)

The consequences of these potential pitfalls would be, in the worst circumstance, the undermining of the whole initiative, or, more likely, the expenditure of considerable time and energy as those responsible for implementation need to deal with the lack of 'ownership' of the initiative by key stakeholders.

The CMD has endeavoured to overcome the disadvantages of the initial top down approach through the establishment of inclusive governance arrangements.

Governance

Since the awarding of the contracts, the implementation of CMD has been guided by a State Coordinating Committee. The Principal Consultant, Strategic Policy and Projects has been the chair of this committee which has also involved other project implementation team members plus each of the CDOs and management level representatives from the Courts, Anglicare Tasmania, the Salvation Army, Community Corrections and Youth Justice. This group has been responsible for ongoing decision making in relation to the implementation of CMD.

This governance arrangement has aimed to establish shared responsibility for the on-going development and rollout of the program more aligned to a 'bottom-up' implementation approach.

The State Coordinating Committee met weekly for the first six months of the implementation period and has met fortnightly since then.

Informants to the evaluation have described the committee as effective and useful although there has also been a perception from some participants that the meetings have been overly frequent (particularly when they were weekly) and not always well targeted towards strategic issues. Nevertheless, attendance at these meetings has been consistent and the agendas indicate that a range of policy and practical issues have been discussed.

As a result of the April evaluation retreat, Regional Integrated Case Coordination (RICC) meetings were established within the new operational models to undertake case monitoring processes.

It took some time for these meetings to commence and they were less than regular initially. By the end of the evaluation period they were operating regularly in all regions. RICCs are important in the formation of local level

relationships that will drive the achievement of an integrated service delivery model.

Program Manuals

Program manuals detailing the requirements for program delivery were developed as a key tool supporting the roll-out of CMD. The manuals were developed alongside the commencement of the program with the first drafts of the Bail and Sentencing Into Drug Treatment (Categories One and Two) Manuals released on 9 July (the same day the program commenced in Hobart) and the Category Three (Drug Treatment Order) Manual released on 22 August 2007, the same day the legislation came into effect. Both manuals had been circulated to stakeholders as consultation drafts prior to their release.

A first draft of a consolidated program manual for CMD was circulated on 30 November 2008 and the final consolidated program manual was circulated on 7 March 2008. The consolidated manual contains all of the information originally contained in the three separate program manuals plus amendments approved by the State Coordinating Committee since the original manuals were developed.

The manuals are designed to be dynamic documents that will be amended over time as systems requirements change. The manuals set out the goals of the program and the roles of all key services at each point in the diversion process. They also set out the requirements for each service provider and staff member at each stage in the process.

Most informants were generally positive about the manuals. Some expressed concerns, however, about the number of times the manuals had been changed.

Service Delivery

As mentioned earlier, in its first year, contracted service providers for CMD were:

- Anglicare Tasmania, for the provision of assessment, development of individual management plans and individual and group counselling services
- Salvation Army for the provision of detoxification, pharmacotherapy, residential rehabilitation and drug testing services
- Community Corrections for the provision of case management for adult offenders undertaking CMD
- Youth Justice for the provision of case management for young offenders undertaking CMD.

This section looks at what has been achieved in relation to each service component. To start with, however, data in relation to the level of take up by the courts and the use of the various court orders is provided.

Take Up by the Courts

Unlike other jurisdictions, CMD has been an option for all Magistrates in all of Tasmania's Magistrates Courts. The take up of the CMD program by individual courts and Magistrates has therefore been of interest to the evaluators.

The data provided by the Department of Justice indicates that 250 offenders were referred for screening for CMD in its first year of operation.

The overwhelming majority of these were referred by Magistrates (96.8%) with Defence Counsel referring just 2.4% and the remaining 0.8% being referred by either Youth Justice or Community Corrections.

Table 3: Source of Referral

Source	Number	Percent
Magistrate	242	96.8
Defence Counsel	6	2.4
Community Corrections	1	0.4
Youth Justice	1	0.4
Total	250	100

Approximately 94.4% of referrals were heard in the Adult's Magistrate Court (n=236). The remaining complaints were heard in the Children's Division of the Magistrate Court (n=14, 5.6%).

Table 4: Level of Court

	Number	Percent
Adult MC	236	94.4
Children's MC	14	5.6
Total	250	100

The majority of referrals were heard initially in the Hobart court (n=157; 63%), followed by the Launceston court (n=48; 19%), the Devonport court (n=36; 14%) and the Burnie court (n=9; 4%).

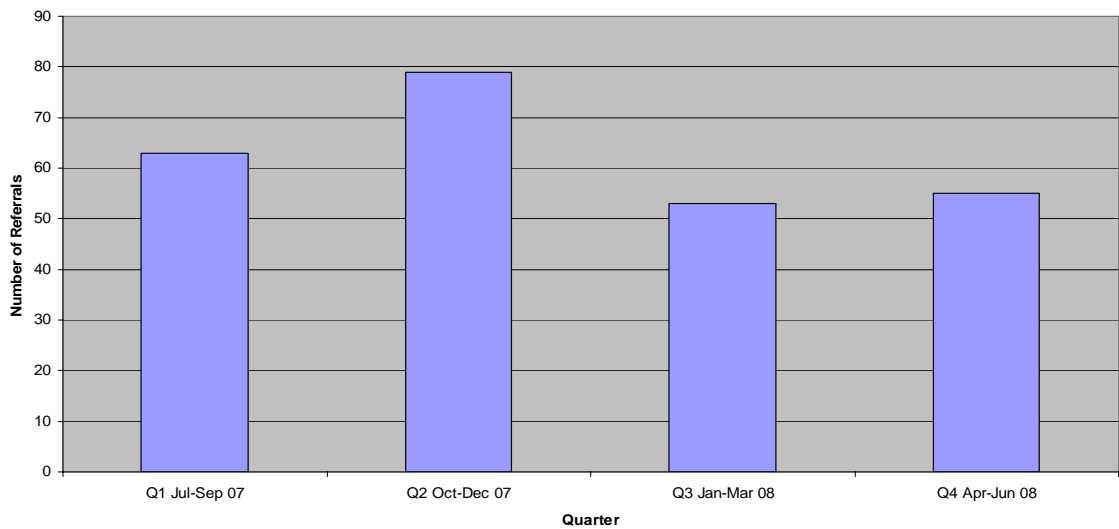
Table 5: Court Location

Court Location	Number	Percent
Hobart	157	62.8
Launceston	48	19.2
Devonport	36	14.4
Burnie	9	3.6
Total	250	100

Comparing referral numbers to the number of Magistrates at each court indicates ratios of one Magistrate to every 36 referrals at Devonport; one to 22 at Hobart; one to 16 at Launceston and one to nine at Burnie. The average number of referrals per Magistrate was 13.6 (SD ± 9.8).

Referrals were reasonably consistent during the year with the highest number of referrals in the second quarter (October to December 2007) as all Magistrates Courts came fully on line and started to use the program.

Figure 1: Number of Referrals per Quarter



There was a decline in referrals in the final quarter in the South Region from a maximum of 51 screenings in the second quarter to 24 screenings in the fourth quarter. This may be due to a variety of reasons including the Courts’ sitting patterns, the absence of the Deputy Chief Magistrate on extended leave for a period during the final quarter, or a reduction in Magistrates’ or defence counsels’ confidence in the program. Whatever the reason, the decline indicates that attention may be required to ensure that Magistrates and others remain confident that the program has beneficial effects.

Table 6: Number of Screenings for each Region

	Q1	Q2	Q3	Q4	Totals
South	49	51	33	24	157
North	6	14	14	16	50
North West	8	14	6	15	43
Totals	63	79	53	55	250

This data indicates that CMD has been taken up by almost all Magistrates in Tasmania. However the data indicates some variability in the level of take up between individual courts. Based on interviews, the lower level take up at Burnie, for instance, reflects the concerns of the local Magistrate and others in relation to the lack of CMD funded support services in the North West, particularly local access to residential rehabilitation or detoxification support.

Court Diversion Officers

During the first year of CMD, the role of the Court Diversion Officers (CDOs) was to manage the interface between the courts and the CMD program. This included the following functions:

- Conduct screening assessments at the request of the court (may take place at the court or in prison or elsewhere)
- Refer offenders who have been screened as eligible for CMD to the assessor for an assessment appointment (involves making an appointment time for the offender or arranging for the assessors to visit the offender in prison)
- Collect and photocopy relevant paperwork from the court and police prosecutors for all offenders referred for assessment and deliver this material to the assessors as quickly as possible
- Liaise with the assessor during the assessment process as required
- Attend court with the assessment report and provide advice to the Magistrates in relation to the contents of the assessment report and the proposed IMP
- Collect and photocopy relevant court orders and any other documentation from the court.
- Prepare a full package of documents (including court orders, assessment reports, IMPs and any other documentation) and provide this to the Case Managers (Community Corrections or Youth Justice) as quickly as possible

-
- Maintain a diary of court review dates and liaise with Case Managers to ensure progress reports are prepared and deliver these to the court (including prosecutors and defence counsel) on time
 - Where possible, attend progress hearings for offenders and answer questions about the CMD program from the court
 - Maintain data records for all offenders referred for initial screening, assessment and who are directed to the CMD program.

The workload of CDOs has been high and distributed unevenly between the three regions. Consequently, the allocation of CDOs changed from one per region to two CDOs in the South, 1 CDO in the North and 0.6EFT CDO in the North West.

It is important to note that the Coordinator, Special Programs in the Department of Justice has retained a quality assurance role in relation to the screening interviews, the timeliness of the response, the content and timeliness of assessment reports and the content and relevance of IMPs.

As noted earlier, the role of the CDOs has now changed substantially to include the undertaking of assessment and the preparation of IMPs as well as their presentation back to the court. The Coordinator, Special Programs quality assurance role remains in place.

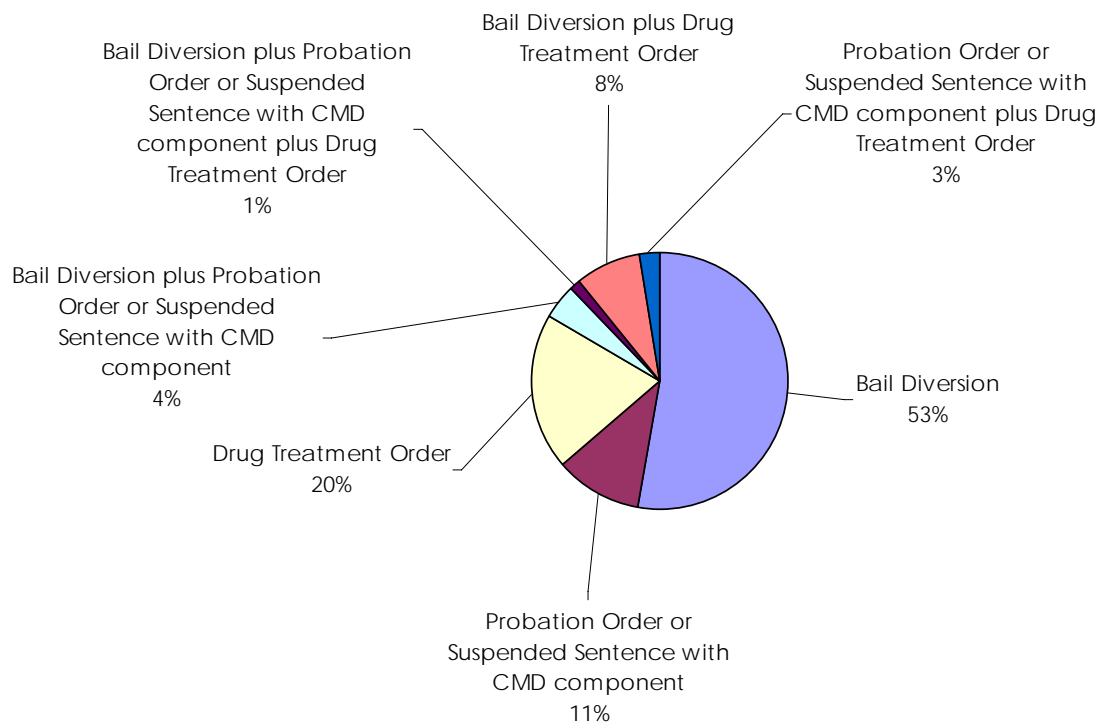
Court Orders

Courts have the option of three different categories of CMD orders. Category One is provided as a condition of bail following a plea or finding of guilt and prior to sentence and was originally designed to have a maximum duration of 12 weeks. Category Two is provided as a condition of probation or suspended sentence where the treatment components can have the same duration as the overall order but generally would not exceed 12 months and Category Three is a sentencing option in its own right (the Drug Treatment Order) which may have a duration of up to 18 months.

The Department of Justice dataset contains 157 cases where the category of order is recorded. The majority of orders were Category One 'Bail Diversion'

(n=83, 52.9%), the next most common category was Category Three 'Drug Treatment Order' (n=31, 19.7%) and then Category Two 'Probation Order or Suspended Sentence with CMD component' (n=17, 10.8%). The remaining orders are made up of a cocktail of the previous three orders such as 'Bail Diversion plus a Drug Treatment Order' (n=13, 8.3%), 'Bail Diversion plus a Probation Order or Suspended Sentence with CMD component' (n=7, 4.5%), 'Probation Order or Suspended Sentence with CMD component plus a Drug Treatment Order' (n=4, 2.5%) and lastly 'Bail Diversion plus a Probation Order or Suspended Sentence with CMD component plus a Drug Treatment Order' (n=2, 1.3%).

Figure 2: Categories of Orders



The Department of Justice data indicates that on 30 June 2008 there were 115 offenders still actively participating in the program with the status of another 26 offenders unclear.

Commencement and completion dates were recorded for 51 offenders with the average duration of their orders being 120 days.

Table 7: Duration of Orders Completed successfully and unsuccessfully

Category	Average Duration (Days)
1	118.3
2	72.3
3	134.0
1 and 2	143.5
1 and 3	149.5
2 and 3	187.0

Information on start and completion dates and whether the offender successfully completed the order was recorded for 47 offenders. The average duration of offenders successfully completing the order (n=7) was 146 days while the average duration of offenders unsuccessfully completing the order (n=40) was 111 days.

Assessment

Assessments are conducted with the offender in a face to face interview using the Level of Service Case Management Inventory (LS/CMI™). This tool was developed by Andrews, Bonta, and Wormith in 2004 and has been validated in the United States, Canada, the United Kingdom, and Singapore. LS/CMI™ is both an assessment tool and a case management tool for use in justice, forensic,

correctional, prevention, and related settings. It provides specific norms (risk levels) for both male and female offenders. The main assessment section of the LS/CMI™, Section 1, consists of 43 questions completed from a semi-structured initial interview with the offender. The aim of these questions is to identify which of the following eight areas in the offender's backgrounds and current situation puts them at greatest risk of reoffending:

- Criminal History
- Leisure / Recreation
- Alcohol / Drug Problems
- Education / Employment
- Companions / Peers
- Pro-Criminal Attitude / Orientation
- Family / Marital
- Antisocial Pattern

Sections 2-5 of the tool identifies additional risk factors and sections 6-7 provide a summary of risks and needs and allows for clinical override of assessment recommendations based on atypical situations and clinical judgement. Section 8 provides tools for program and placement decisions for institutional and community offenders, indicating which areas, when treated are most likely to reduce offenders' risk levels overall (Source: Justice System Assessment and Training -J-Sat.com))

In addition to collating data in relation to the offender's background and current situation that puts them at greatest risk of reoffending the tool collects demographic information such as age, gender, indigenous status (a summary of this demographic data for referred offenders is included at **Appendix A**)

In the first year of CMD, assessments were conducted by Anglicare Tasmania. A number of issues arose during the year in relation to the assessment processes including:

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- Higher than expected numbers of offenders remanded in custody for assessment
 - Difficulties in achieving the required timelines for assessments (within a two week adjournment period) with the result that this timeline was extended to three weeks in the South
 - The need for additional assessors to be trained as demand and workload levels were higher than expected, again mainly in the South
 - Variable quality in assessment reports, particularly initially, as staff in Anglicare Tasmania learnt what was expected in a court report.

Data provided by the Department of Justice indicates that as at 30 June 2008 242 offenders had been referred for assessment⁸. Of these, 43 were found to be unsuitable for CMD, 16 assessments had not taken place prior to the data cut off date (30 June 2008) and 1 withdrew consent prior to the assessment taking place. There were another 6 for whom insufficient data is recorded to determine whether an assessment took place or not.

Very few offenders received a LSCMI™ score indicating that they are of very low or low risk (n=3, 1.6%). Over 80% of the offenders received a score indicating they were high risk (n=105, 55.0%) or very high risk (n= 60, 31.4%). This result is consistent with the 'What Works' literature (based on Andrews et al, 1990) which recommends that criminal justice programs be targeted towards those at the highest risk of reoffending.

⁸ While there were 250 offenders referred for screening, eight were screened and ineligible for the program of whom six were not willing to participate (n=6, 75.0%), one was ineligible due to alcohol being the principal drug of concern (n=1, 12.5%) and one had an ineligible offence type (n=1, 12.5%).

Table 8: LS/CMI™ score

Risk Level	Score	No. of Offenders	Percent of assessed Offenders
Very Low	0-4	0	0.0%
Low	5-10	3	1.6%
Medium	11-19	23	12.0%
High	20-29	105	55.0%
Very High	30+	60	31.4%
Total		191⁹	100%

Based on revised requirements, CMD assessments must now take place within a two week (North and North West) or three week (South) adjournment period. While there is substantial missing data or unreliable data in relation to this area in the dataset provided to Success Works by the Department of Justice, the available data indicates that all regions have struggled with these timelines. The best performing region is the South where over 47% of reports are prepared within the timeframe.

⁹ Not all of the assessed offenders will have been accepted onto CMD hence the higher number of assessments than offenders commencing CMD orders.

Table 9: Days between Court request for assessment and report being received by CDO

	North	N-West	South	Total
Total recorded requests	37	18	123	178
Within Time	7	3	58	68
Percent within time	18.9%	16.7%	47.2%	38.2%

As noted above, the proportion of assessments undertaken with prisoners on remand has been higher than anticipated by the project implementation group and has had an impact on the costs associated with the assessment process. Based on the data supplied, three-fifths of assessments (n=125, 60.7%) took place in the office of the assessor while two-fifths took place in prison (n=81, 39.3%)¹⁰.

Individual Management Plans

Individual Management Plans (or IMPS) are developed for offenders by the assessors based on the outcome of the assessment process. The IMP forms part of the report back to the Magistrates when they are considering CMD and provides an indication of what is required for the offender to address their substance abuse and criminal behaviour. The IMPs are intended to be a guide for the case manager in relation to the interventions that may be required to address the offender's criminogenic needs and risks. The case manager is able to modify and amend the IMP based on the offender's progress and changing circumstances.

There were some initial difficulties in relation to the content and status of IMPs that were resolved during the year. These difficulties included:

¹⁰ There were 44 instances (17.6%) where the place of assessment was not recorded.

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- Some initial confusion about the status of IMPs with the result that several CMD orders included compliance with the IMP as a specific condition on the CMD order meaning that any modifications to the IMP would have required a formal change to the court order and any lack of compliance would have formed a potential breach of the order.
 - A tendency for some early IMPs to be over-specific in terms of the interventions required to address the offender's criminogenic needs creating difficulties for case managers unable to access the recommended services or who may favour alternative options based on their knowledge of the offender and the offenders changing circumstances
 - Unrealistic expectations in terms of the range of programs available in Tasmania for drug using offenders and the number of interventions offenders are capable of participating in within the timeframe available. This was particularly significant for offenders on Category 1 Bail Orders who are meant to complete their CMD intervention requirements within 12 weeks.

Data collated by CDOs during screening assessments has provided an indication of the level of criminogenic needs presented by the referred offender group.

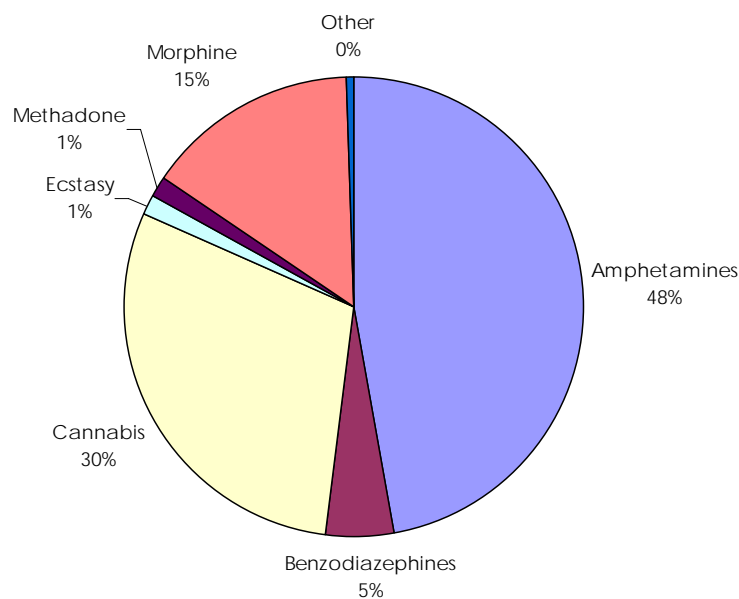
In summary, this data indicates:

- A high level of polydrug abuse with amphetamines, cannabis, morphine and benzodiazepines being the most significant drugs used by the offender group
- Low levels of prior drug treatment with less than half of offenders referred for CMD having participated in any form of drug treatment prior to CMD
- Significant levels of need for additional services outside CMD with over 54% of offenders with recommended external referrals requiring three or more services

In relation to the type of drug used, the CMD data indicates a different drug use pattern to mainland court diversion programs which still show a dominance of opioid dependence together with increasing levels of amphetamine and

methamphetamine abuse. For referred offenders to CMD the 'principle drug of concern' for nearly half (n=97, 47.1%) was amphetamines followed by cannabis (n=61, 29.6%) and morphine (n=31, 15.0%)¹¹. These three drug types were the 'principle drugs of concern' for over 91% of referred offenders.

Figure 3: Principle Drug of concern

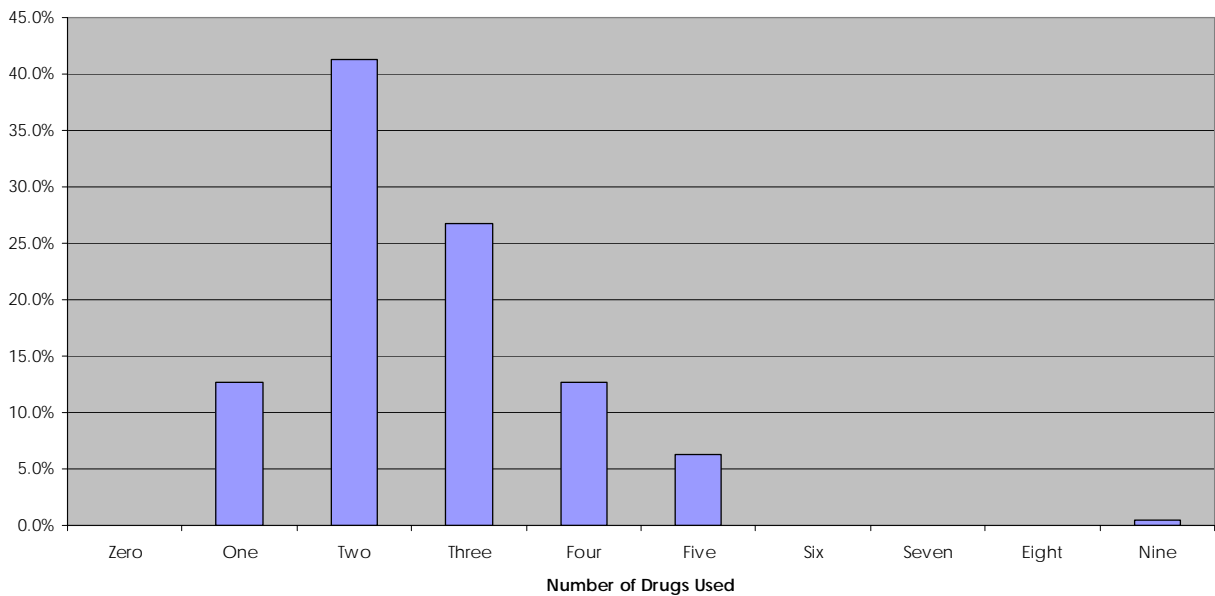


The data also indicates that most offenders referred for screening had more than one 'drug of concern' (n=180, 87.4%) and nearly a half had three or more 'drugs of concern' (n=95, 46.1%). One offender had nine 'drugs of concern' including amphetamines, benzodiazepines, cannabis, cocaine, ecstasy, heroin,

¹¹ This item was recorded for 206 offenders, data was not recorded for 44 offenders (17.6%).

methadone, morphine and alcohol¹². The following table indicates the level of polydrug use by the referred offender group.

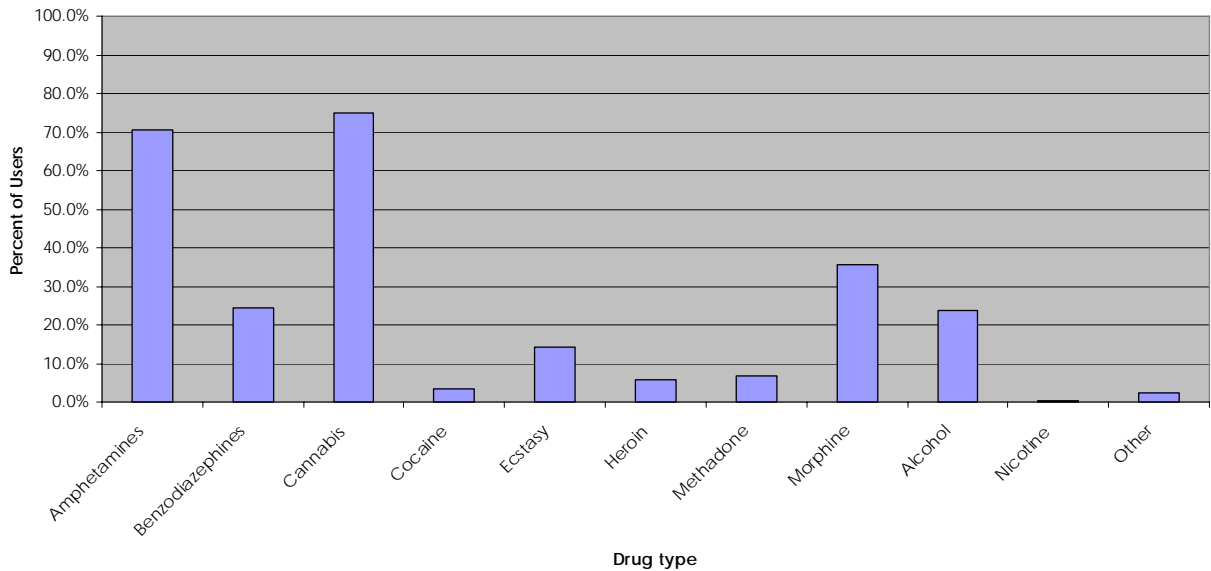
Figure 4: Number of drugs used



When all 'drugs of concern' are considered nearly three-quarters of referred offenders used cannabis (n=145, 74.8%) and nearly as many used amphetamines (n=142, 70.4%). Morphine was used by 73 offenders (35.4%) and benzodiazepines by 50 offenders (24.3%). The high level of benzodiazepine abuse in Tasmania overall (Healthcare Management Advisors, 2008) is apparent in this data.

¹² The reporting rate for alcohol misuse (n=49, 23.8%) and nicotine misuse (n=1, 0.5%) would appear to be considerably less than expected and may well have been underreported.

Figure 5: Types of drugs used



As noted above, the screening data provided by the Department of Justice indicates that, despite their high risk status and chronic drug use histories, less than half of the offenders referred to the CMD program reported having ever previously participated in any drug rehabilitation program (n=90, 43.9%)¹³. This indicates the significance of CMD in offering drug treatment opportunities to this high risk group: for over half of the offenders referred to the program, CMD has been their first ever opportunity to confront their need for treatment and to gain support to deal with their addiction related issues. This finding confirms the overall lack of alcohol and drug treatment services in Tasmania (as found by Healthcare Management Advisors, 2008) and is, in itself, is a significant achievement.

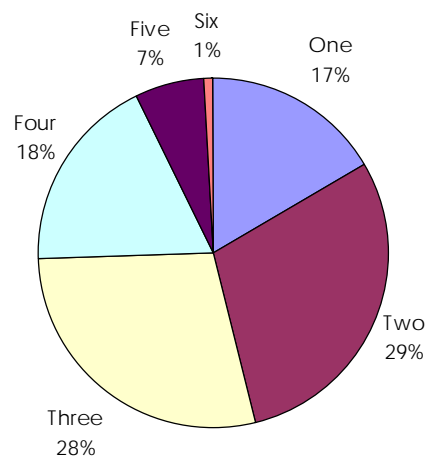
¹³ This item was not recorded for 18% (n=45, 18.0%) of the dataset.

In addition to information about drug use and previous treatment participation, assessors have recorded the non CMD services that the offenders should access to address criminogenic needs related to their drug use.

Data provided by the Department of Justice indicates a higher level of reporting of non-CMD services for offenders in the South. This may relate to differences in assessment processes or data reporting or may relate to the overall lack of services in the North and North West to which offenders can be referred.

Of the 137 cases where offenders were recorded as requiring non CMD Services 23 (16.8%) required one other service, 40 (29.2%) required two other services, 39 (28.5%) required three other services, 25 (18.2%) required four other services, 9 (6.6%) required five other services and 1 (0.7%) required six other services. This indicates a high level of additional need amongst a significant proportion of CMD offenders. It is important to note that many or all of these additional needs may also be 'criminogenic' (i.e. directly contributing towards offending behaviour) and, unless adequately addressed, have the potential to undermine CMD's achievement of 'lowered rates of offending'. This is particularly important to remember in considering the reoffending data later in this report and points to the need for CMD to have access to brokerage funds or other ways of accessing services for offenders in mainstream agencies.

Figure 6: Number of Non CMD Services required



The following table indicated the type of non-CMD services required -

Table 10: Type of non-CMD services required

Service	No.
Employment Services	88
Education/Training Services	85
Other Counselling Services	66
Income Support	62
Independent Housing Services	53
Mental Health Services	14
Disability Services	2
Supported Accommodation	1
FVOIP Assessment	0

Percent is not provided as missing data means that the total number of offenders who require no non-CMD services is not known.

It is also important to note in relation to criminogenic needs that when Success Works prepared the second Progress Report based on the Department of Justice dataset as at 31 December 2007 a large proportion (n=63, 40.4%) of individuals referred to CMD also had a "Safe at Home" reference number indicating a history of family violence. From 1 January to 30 June 2008 only six new individuals (5.6%) were recorded as having "Safe at Home" reference number and no individual screened since late February 2008 has had a "Safe at Home" reference number. This dramatic shift in representation of family violence offenders is likely to reflect a change in the method of data collection used for this variable. As the safety of the offender's family and the integrity of the program are of significant importance it is recommended that this issue is investigated as a matter of priority.

Case Management

During the first year of operation case management of CMD offenders was the responsibility of Community Corrections for adult offenders and Youth Justice for young offenders. Responsibility for case management for adult offenders has subsequently transferred to Anglicare Tasmania.

In the first year, issues in relation to case management included:

- An initial lack of understanding of the need to separate case management from the assessment process and some resistance to 'external' assessments by case managers¹⁴
- Differences in understanding about the role of the case manager with Community Corrections and Youth Justice having experience as correctional case managers (in which offenders are told what is expected of them and the consequences of non compliance and then expected to make their own choices about their participation and engagement with the IMP) and the non-government agencies which had an expectation of a more pro-active and positive role for case managers akin to the case manager role in the health and welfare sectors
- Some initial difficulties in meeting the required frequency of weekly face to face case management contact meetings
- Some difficulties in separating the case management role from a counselling role for community corrections staff.

According to the Case Management Society of Australia (CMSA), case management is 'a client-focused process that supports clients to reach their

¹⁴ Separation of assessment from case management makes sense in a multiprovider system where there is the potential for the case plan to be made to fit what the service provider can deliver, rather than being focused on what the offender needs. As the aim of CMD has been to lift the quality of service delivery to drug using offenders, there is a valid justification in the separation of the assessment and case planning function from case management.

optimal level of health and well-being'. They define case management as 'a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost effective outcomes' (CSMA, 2004: 6)

The CSMA has produced a set of National Standards of Practice for Case Management (CMSA, 2004) which Success Works has reviewed as part of this evaluation. However as the standards are copyright it is not possible to include the full set of standards in this report. They are able to be purchased from <http://www.saiglobal.com>.

In summary, the National Standards developed by CMSA provides six Standards of Practice as follows:

- Case identification and assessment: clients who meet the eligibility criteria for case management are identified and an assessment is completed
- Needs identification: in conjunction with the client, the case manager documents identified client needs
- Planning: client goals are documented reflecting the priorities and plan for action agreed upon between the client and the case manager
- Monitoring: planned services, supports and resources are monitored against the goals documented in the client's individualised care plan
- Evaluating: periodic reassessment and evaluation of the client's outcomes is conducted against the expected outcomes and available evidence
- Outcomes: case management actions are outcome oriented.

They also provide eight standards of performance:

- Quality of Practice: clients receive an appropriate level of case management that is client focussed, promotes cost-effective outcomes, and enhances client independence wherever possible

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- Education/Preparation/Certification Qualifications: Case management outcomes reflect the skills and knowledge that case managers develop through practice and formal education
 - Collaboration: the case manager will foster collaborative relationships to generate care plans which address client needs and optimise outcomes
 - Legal: clients receive care that is within the constraints / protection of all relevant legislation
 - Ethical: case management will be delivered within an ethical framework
 - Advocacy: case managers advocate for client-oriented solutions to identified needs at the service delivery level and at the policy-making level
 - Resource utilisation: resources which are safe, efficient and cost effective to meet client care needs are applied and monitored
 - Research: case management practice is based on valid research findings including plans and interventions that result in high quality, cost-effective outcomes.

The case management approach of community corrections is broadly as follows:

- Intake Assessment for all new clients (Client Identification and Assessment/Needs Identification)
- Development of an individual management plan (Planning)
- Implementation of the individual management plan including referrals to other organisations for specialist assistance (Planning / Monitoring)
- Ongoing supervision by the probation officer at a frequency determined by the risk assessment. This may involve counselling in relation to offending related needs (Monitoring / Evaluating)
- Supervision of the probation officer by a professional supervisor to ensure the required intensity and quality of intervention (Evaluating)

-
- Case reviews and risk reassessment at predetermined intervals to determine progress against goals and the need for new goals to be set. Reviews may also determine a change in the frequency of contact (Evaluating)
 - Case exit at the end of the order with referral for additional support if required (Outcomes).

This model of case management broadly reflects the National Standards of Practice, however there are several key differences between correctional case management and standard models of case management that relate to the mandated nature of the client group.

These differences include the continued provision of informal guidance and intervention by correctional case managers even when professional services have been brokered; a reliance on the threat of sanctions and close monitoring to keep the client involved with case management rather than aiming for their positive engagement with the case plan; and different expectations about the aim of interventions between case managers (reduced offending) and brokered service providers (individual growth and change) (Healey, 1999). Healy notes that these differences in approach mean that correctional case managers must make efforts to maintain rapport and open dialogue with external services working with offenders in order to ensure positive outcomes. He notes that failure to develop and maintain rapport can result in increased paperwork, lack of managerial control of cases and poor supervision of client progress through treatment and court ordered sanctions (ibid).

Case management by Community Corrections in the first year of operation continued to apply a standard correctional case management approach¹⁵. However a more active 'health-focussed' case management approach may constitute a significant intervention in its own right. In the change to a new case management provider (Anglicare Tasmania) a different case management

¹⁵ It is noted that Community Corrections provided case management in accordance with their original submission.

approach may be possible which moves from an approach driven by the threat of sanctions as the underlying tool for engagement to one that is based on the positive involvement of offenders who are motivated by their involvement in CMD to address their addiction related issues. This will be an interesting evaluation focus for the future.

It is important to note that, while the numbers have been small, the philosophy of Youth Justice has always been to work in positive and active way to engage young people. If the CMD numbers in the Youth Justice area increase, they too, will have the opportunity to further their learnings in relation to effective case management for drug using young offenders.

Related to the role of the case manager in CMD is the time taken for treatment components of the CMD order to commence. While there were large amounts of missing or dubious information for this item in the Department of Justice dataset¹⁶, the available data indicated the average length of time between CMD commencing and the first recorded treatment was 52 days (SD ± 54.8).

The highest recorded rate of commencing treatment was Individual Counselling where less than 40% of offenders were recorded as commencing counselling. Group counselling and residential rehabilitation had less than 19% of commencement dates entered.

It should be noted however, that while 'treatment' may have taken some time to commence, there is no evidence that the process of case management did not commence immediately following the court order.

¹⁶ Only 49.0% of the data from South was usable (n=73), less than 38% from North-west (n=16, 37.2%) and only 16.0% of the data from North was usable (n=8).

Table 11: Reporting rates for Treatments

Treatment	No. recommended for treatment	No. recorded as commenced treatment	Percent recorded as commenced treatment
Individual counselling	146	62	42.5%
Group counselling	37	8	21.6%
Detoxification	1	0	0.0%
Residential rehabilitation	33	8	24.2%

Individual Counselling

Individual counselling was provided by Anglicare Tasmania in the first year of CMD and will continue to be provided by them in the new service model.

Of the 157 CMD offenders who started CMD in its first year, 146 (93.0%) were required to undertake individual counselling as part of their IMP. Issues raised during the year in relation to individual counselling included:

- The high proportion of offenders referred to individual counselling indicating either a potential over use of this condition on IMPs and/or the lack of other intervention options (or both)
- The need to develop relationships with non CMD agencies in relation to offenders with pre-existing counselling arrangements at the time of their commencement on CMD
- The efficacy of different counselling approaches and the potential for learning about what forms of counselling are most effective with this client group. Anglicare Tasmania are undertaking longer-term research to monitor their learnings about counselling approaches and their impact on client outcomes. The literature would suggest that cognitive behavioural therapy and social learning approaches will be the most effective with the offending client group (Andrews et al 1990).

In relation to this latter point, Anglicare Tasmania staff provide counselling in a number of different frameworks. Those nominated most frequently to the evaluators were:

- Cognitive behavioural therapy (CBT) – this form of counselling is based on modifying cognitions, assumptions, beliefs and behaviours. The particular therapeutic techniques commonly include keeping a diary of significant events and associated feelings, thoughts and behaviours; questioning and testing cognitions, assumptions, evaluations and beliefs that might be unhelpful and unrealistic; gradually facing activities which may have been avoided; and trying out new ways of behaving and reacting. Relaxation and distraction techniques are also commonly included. The use of CBT is strongly endorsed as an effective strategy for use with offenders.
- Solution Focused Counselling – this form of counselling is focuses on what clients want to achieve through counselling rather than on the problem(s) that made them seek help. This approach does not focus on the past, but instead, focuses on the present and future. The counsellor invites the client to envision their preferred future and then the counsellor and client work out what will help them get to that place in small or large increments.
- Motivational Interviewing – developed specifically for people with alcohol or drug addictions, motivational interviewing is directive, client-centred counselling aimed at eliciting behaviour change by helping clients to explore and resolve their ambivalence towards change.
- Strengths Based Counselling – similar to solutions focused counselling, this approach starts with an understanding that individuals have capacities and resources and that these should be the starting point for resolving issues rather than problems or pathologies. Practicing from a strengths orientation means helping to discover and embellish, explore and exploit clients' strengths and resources in the service of assisting them to achieve their goals. Beginning with identification of strengths leads the plan for work in a different direction than using the problem definition.

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- Narrative – this form of counselling starts with the client telling his/her story; then, together with the client, the counsellor deconstructs the assumed realities within the story and assists the client to create a new story which solves the problems inherent in the original story. Seeing the problem as outside of the individual, allows the client to more clearly define the problem and find solutions. Narrative counselling involves intentional change to one's story and supports clients to create new stories that challenge underlying patterns and assumptions.

While the number of offenders recommended to undertake counselling was extremely high, the data provided by the Department of Justice records that only 62 offenders (42.5%) commenced individual counselling and that only 18 offenders completed their counselling program, involving, on average, 8.1 appointments over 94.6 days of which 6.4 appointments were actually attended. This data is presumed to contain substantial missing records as the level of demand on individual counsellors has been said to be very high during the year.

The Department of Justice data also records that only one offender achieved their individual counselling goals, however it is noted that 4 offenders who received individual counselling were recorded as successfully completed the whole CMD program (including the offender who achieved their individual counselling goals). It is assumed that the four offenders who completed the CMD program had also successfully completed their individual counselling program.

Table 12: Reason for finishing Individual Counselling Program

Reason	No.
Successfully completed program	4
Failed to attend for Treatment	7
Attended but did not change behaviour	1
Subsequently determined to be ineligible	1
Withdrew consent	1
Not recorded	4
Total	18

It is recommended that data records held by the Department of Justice be maintained in a more up-to-date fashion as further evaluation of the impact of counselling on CMD outcomes is not possible without accurate data recording.

Group Counselling

Group counselling is also the responsibility of Anglicare Tasmania and remains so in the new service model. In its first year, the only group counselling program funded through CMD was SAINTOC (Substance Abuse Is Not The Only Choice) which was developed by the Cognitive Centre Foundation in the UK.

Issues raised during the year in relation to group counselling included:

- The delays in establishing the group counselling program
- The lack of access to group counselling for offenders in the North and North West
- The lack of access to group counselling for offenders with employment or educational commitments during the day
- The intensity and duration of the program

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- The 'closed group' nature of the program which has meant that Anglicare Tasmania have needed to wait to accumulate a critical mass of offenders prior to commencing the program in order to ensure that the group nature of the program can be sustained to the end given the inevitability of absenteeism and drop outs.

To date only one group counselling program has been provided. This program was provided in the South and took place during the day.

The data provided by the Department of Justice indicates that 37 out of the 157 offenders given CMD orders (21.7%) were directed to undertake group counselling as part of their IMP. The records indicate that eight offenders commenced the group counselling program and four offenders finished the program after 91 days (13 weeks). Two offenders were recorded as not completing the program as they failed to attend and one offender withdrew consent. One offender was neither recorded as completing nor as failing the program. The program consisted of 14 sessions, those completing the program (n=4) attended between 9 and 13 appointments with an average of 11.25.

Success Works met with four offenders attending the group counselling program at their last session. The offenders were universally positive about the experience of the group counselling program and felt that they had benefited from their participation. One offender said that the group program was the first time they had been able to really confront their drug use and that previous experiences in individual counselling had been no where near as helpful. One offender on the program had been abstinent for the entire period and while it had been difficult to participate when others were still using from time to time, they had found the program to be of assistance. This offender had also provided an inspiration to the others.

Residential Rehabilitation

During the first year, residential rehabilitation was provided by The Salvation Army at their existing therapeutic community program 'The Bridge'. Access to the residential rehabilitation program was limited to two beds at a time with a maximum of 15 participants in a full year. It is understood that access to at least

one bed at The Bridge forms part of the new service model for CMD and that additional residential treatment places may be sought from an alternate provider.

Issues raised in relation to residential rehabilitation during the first year included:

- Concern at the lack of places for CMD offenders at the Bridge
- An ongoing lack of understanding of the purpose of residential rehabilitation by Magistrates, lawyers and others
- Some initial difficulties in relation to the suitability of referrals to The Bridge with the result that the Salvation Army were supported to introduce a 'gateway' assessment to determine the readiness for participation of offenders referred for participation.

Access to residential rehabilitation remains a contentious issue in CMD. Magistrates and defence lawyers persist in a belief that participation in residential rehabilitation should take place at the beginning of a CMD order and that the lack of beds at The Bridge is therefore a barrier to participation for some offenders.

However, residential rehabilitation is not a form of imprisonment nor detoxification. Residential rehabilitation is based on a therapeutic community model. In a therapeutic community, residents and staff participate in the management and operation of the community, contributing to a psychologically and physically safe learning environment where change can occur. In a therapeutic community, there is a focus on the biopsychosocial, emotional and spiritual dimensions of substance use, with the use of the community to heal individuals and support the development of behaviours, attitudes and values of healthy living (Australian Therapeutic Communities Association).

Offenders are able to participate in the residential rehabilitation program at any stage during their CMD order with the timing of participation related more to their individual stage of change (precontemplative, contemplative, preparing, active, maintaining, relapse) than the administration of their CMD order.

Based on the Department of Justice data there were 33 offenders from the 157 granted CMD orders (19.7%) who had 'residential rehabilitation' as part of their IMP. Eight offenders were recorded as commencing residential rehabilitation and six were recorded as ending the program. The duration of the six finished residential rehabilitation periods ranged from 7 to 64 days with an average of 29.2 days. All six offenders failed to successfully complete the residential rehabilitation, two attended but did not change their behaviour and four breached the conditions of their residency.

Detoxification

The Salvation Army were contracted as part of CMD to develop and deliver a detoxification service. Detoxification is a short-term intervention that deals with the physical withdrawal from drugs of dependence. Most withdrawal experiences are uncomfortable and some can be life threatening. The type of drug, the amount used, the frequency of use, the length of use and pre existing health conditions can affect the process of withdrawal. Detoxification services to support withdrawal can be offered in a residential setting, at home or on an outpatient basis (also known as ambulatory detoxification).

The Salvation Army developed a proposed model of service for the provision of an ambulatory detoxification service which was not approved by the Department of Health and Human Services. As a result no detoxification service has been available as part of CMD.

The Department of Health and Human Services operates a residential detoxification service in Hobart. CMD clients are now able to access this program although there were some difficulties in gaining access earlier in the year. Other forms of detoxification support are nonexistent in Tasmania with the exception of individual programs undertaken by individual GPs.

Only one offender was recorded as being required to undertake a detoxification program. The offender was not recorded as commencing the program.

Pharmacotherapy

The Salvation Army were also contracted to provide pharmacotherapy as part of CMD. To date no pharmacotherapy services have been made available, although CMD offenders are able to access pharmacotherapy via their own GP (if they are licensed) or from one of the small number of existing GP pharmacotherapy services in Tasmania.

Pharmacotherapy is generally related to opioid dependence (of which there is little in Tasmania) with two main drugs available for substitution therapy: methadone and buprenorphine. Doctors and pharmacists administering methadone or buprenorphine must be accredited by the state health authorities. Tasmania has few participating general practitioners and pharmacists currently accredited.

Pharmacotherapy may also involve the use of palliative medication to deal with the psychological and physical effects of withdrawal (rather than providing a substitute for the drug).

The Salvation Army was unable to locate a doctor willing to be involved in the CMD program and a decision was taken not to proceed with pharmacotherapy as part of the CMD program.

There were no offenders recorded as being required to attend a pharmacotherapy program.

Urine testing

Urine testing was also provided by the Salvation Army in the first year of CMD. Urine testing remains a feature of CMD but responsibility has now transferred to Anglicare Tasmania.

In the first year demand for urinalysis far exceeded expectations in terms of both budgetary forecasts and the frequency with which the Courts would order its use. There were 1,312 episodes of urinalysis state-wide conducted across 149 offenders. While this figure is substantially larger than predictions, it is indicative of the importance of urinalysis as both a regulator and reinforcer.

As well as a higher level of frequency than expected, the cost of each individual urine test has been considerably higher than budgeted for initially. The resources not able to be applied towards pharmacotherapy and detoxification services have been redirected towards urine testing.

Anecdotal feedback to CDOs and the evaluators from offenders and Magistrates indicate that access to urinalysis is one of the key attractions of CMD. Offenders report that access to regular urine testing provides a strong incentive for them to remain drug free and a reason to refuse offers of drugs from peers. Offenders report that the positive reinforcement they receive upon producing a clean sample is akin to what has been described as the 'Weight-watchers' effect. Magistrates appreciate the 'concrete' feedback provided by an urinalysis report and the fact that its results allow for a realistic understanding of the status of the offender and their efforts to change.

It has been important for offenders to be tested on a regular basis during the early phases of their Order. CDOs assert that there is no way to assume that an offender is drug free or making real efforts to reduce their drug use without their being tested regularly and that testing frequency should be maintained until the offender has demonstrated that they are making the required efforts.

While urine testing has been a feature of most CMD orders, the frequency of testing has varied according to the level of the order and the benefit of testing for the individual. Those undertaking the Category One Bail Diversion option of CMD are typically required to produce urine samples for analysis once at the beginning of their order, and once at the end of the 12-week diversionary period. Offenders subject to a Category Two Community Based Order typically undergo one urinalysis per month for the duration of their order. Those on a Category Three Drug Treatment Order are expected to present for urinalysis twice a week in the first 3-month phase of their order, once per month for the second phase, and twice (in total) in phase three. It should be noted however that the frequency of drug testing has been the subject of considerable discussion during the year and that, while the above requirements are included in the program manual; Magistrates, Case Managers and the offenders themselves have often requested more frequent testing.

The Department of Justice dataset does not record the outcome of urine tests which means it has not been possible to determine the impact of CMD in terms of offenders reducing or ceasing drug use (the medium term outcome identified in the project logic leading to the ultimate aim of reduced levels of offending).

It is noted that there are difficulties in obtaining useful data in relation to urine testing. The following chart gives approximate detection periods for each illicit substance via urinalysis. The ranges depend on amount and frequency of use, metabolic rate, body mass, age, overall health, drug tolerance, and urine pH.

SUBSTANCE * denotes drugs tested under the Australian Standard	DETECTION PERIOD IN URINE
Amphetamine*	1-4 days
Barbiturates	1-21 days
Benzodiazepines*	1-42 days
Cannabis (single use)*	2-3 days
Cannabis (weekly use)*	3-9 days
Cannabis (habitual use)*	up to 12 wks
Cocaine*	4-5 days
Codeine/Morphine*	2-4 days
Opium*	24-48 hrs
Heroin*	2-4 days
Methamphetamine*	3-5 days
PCP	3-7 days

This chart indicates that while urine testing offers a strong disincentive for individual drug use, the aggregated results from the testing process may not be representative of the actual level of drug use by offenders. Other data sources are also required in order to validate the degree to which CMD has impacted on the reduction of drug use.

Service Delivery Summary

As mentioned above, service delivery was one of four key strategies in the first year of operation of CMD. The results of this strategy have been mixed. In summary the major findings from the first year of operation of CMD in relation to service delivery are as follows:

- Higher than expected take up of CMD by the courts with 250 referrals (expected 196) and 157 commencements
- Highest level of take up of Bail Orders (Category One) followed by DTOs (Category Three)
- Higher than expected proportions of assessments undertaken in prison with offenders on remand
- Longer time periods than expected required for assessments
- Significant proportions of offenders assessed as high or very high risk
- High levels of polydrug abuse and low levels of prior drug treatment
- Significant levels of additional need for services outside CMD
- Different drug use patterns to mainland court diversion programs
- Higher than expected referrals to individual counselling as part of CMD
- Lower than expected participation rates in group counselling and residential rehabilitation
- Inability to establish ambulatory detoxification or pharmacotherapy programs within CMD
- Higher than expected use of urine testing.

Capacity Building

As mentioned earlier, there is an acknowledged lack of capacity in the alcohol and drug treatment sector in Tasmania (Healthcare Management Advisors, 2008; DHHS, 2007). The Department of Justice therefore adopted capacity building as one of their key strategies in the first year of CMD.

CMD provided access to a range of training opportunities for CMD services providers and the broader service sector. In particular, access to accredited training was provided by Turning Point Alcohol and Drug Services following a training needs assessment involving responses from all CMD agencies.

CMD provided seven preparatory information and training programs prior to the commencement of CMD.

Table 13: Seven preparatory information and training programs provided by CMD

Program	Speakers	Date	Attendance
Statewide CMD Conference	Liz Little, Principal Consultant Prof Arie Freiberg (Monash University) Dr Nick Crofts (Turning Point) Jelena Popovic, Dep Chief Magistrate, Vic Deen Potter, Magistrate WA Sgt Wes Lawson, Neighbourhood Justice Centre, Collingwood, Vic Debbie King, Success Works	8 May 2007	150+
CMD Providers Orientation Day	Liz Little, Principal Consultant Robyn Bogle, Coordinator, Special Programs Tony Jacques – Senior Consultant Kieran Connolly and Wendy Dodd – Turning Point Victor Stojcevski – Project Officer (CMD) Debbie King – Success Works	15 June 2007	30 approx

Program	Speakers	Date	Attendance
Lawyers Information Session	Victor Stojcevski – Project Officer (CMD) Debbie King – Success Works	13 July 2007	25 approx
Regional Information Forum - NW	Representatives from each service provider plus CMD project team representative	23 July 2007	30 approx
Regional Information Forum - South	Representatives from each service provider plus CMD project team representative	25 July 2007	Unknown
Regional Information Forum	Representatives from each service provider plus CMD project team representative	6 August 2007	Unknown
Magistrates Conference Information Session	Malcolm Doreian – Turning Point Debbie King – Success Works Gael Vizard - Community Corrections Jon Morrison – Anglicare Jacqueline Steele - Youth Justice Ronda McIntyre -Salvation Army	26 – 27 July 2007	16 approx (All Magistrates plus senior Court staff)

The following training programs held after the commencement of CMD:

Program	Speakers	Date	Attendance
Working With Mandated Clients	Dr Chris Trotter	12-13 July	25
LSCMI Accreditation Training	Prof Jim Ogloff	18-19 July	24
SAINTOC	Cognitive Centre Foundation, UK	24-28 Sept	Unknown
The What, Why and How of Aboriginal Wellbeing: Building Cultural Safety and Cultural Ease to Improve Outcomes	Dennis McDermott	22 Nov 2007 (half day public seminar)	30 approx

All Charged Up: Building Cultural Safety and Cultural Ease to Improve Outcomes for Aboriginal and CALD clients	Dennis McDermott & Di Gabb	22-23 Nov 2007 1.5 days (CMD only)	16 approx
Relapse Prevention, Court Report Writing and Providing Professional Supervision	Prof Jim Ogloff	18-19 February 2008	Unknown

In addition, Turning Point Alcohol, and Drug Service provided the following accredited and non accredited programs:

Training Program	Enrolment
Perspectives in Drug Use: A six-day graduate certificate subject.	45 (16 non CMD)
Introduction to Counselling and AOD Counselling: A six-day graduate certificate subject.	40 (12 non CMD)
AOD Treatment, Assessment and Planning: A six-day graduate certificate subject.	39 (8 non CMD)
Working with aggression and intoxication: A two-day non accredited professional development course	21 (9 non CMD)

The overall enrolment levels per course were as follows:

Subject	Total Number of Enrolments	CMD	Community Corrections	Youth Justice	Anglicare	Salvation Army	Enrolments from non CMD participants
Perspectives in Drug Use	45	4	8	6	6	5	16
Introduction to Counselling and AOD Counselling	40	5	9	4	5	5	12
AOD Treatment, Assessment and Planning	39	5	6	10	9	1	8
Working with aggression and intoxication	21	3	1	5	2	1	9
TOTALS	145	17	24	25	22	12	45

CMD has therefore made a significant contribution to the improvement of Tasmania's drug treatment capacity through the provision of access to accredited and non accredited training. It is expected that this will have contributed towards improved quality of service delivery within and outside CMD and to the sustainability of the outcomes.

Quality Improvement

In addition to building capacity in the alcohol and drug sector in Tasmania, a major aspect of the CMD initiative has been to improve the quality of AOD service delivery.

Significant quality improvement activities have included the development of standards for urine testing commensurate with Australian National Standards (prior to CMD, urine testing in both community corrections and the AOD sector had generally not been in accordance with national standards) and the introduction of the LS/CMI™ assessment tool.

Future quality improvement activities are likely to focus on the learnings to be obtained by Anglicare Tasmania in relation to the efficacy of various individual counselling models and the change in case management approach from the traditional community corrections approach to one that is more reflective of the model in mainstream health and welfare sectors.

It is also important to note the quality assurance role of the CDOs and the Coordinator, Special Programs who have maintained a watchful eye over the quality of assessments reports and IMPs.

This section details the two major quality improvement activities achieved to date.

Australian National Standards for Urinalysis

An analysis of the Salvation Army's compliance with the Australian National Standards for Urinalysis was reported on in Success Works' March 2008 Evaluation Progress Report.

In summary, this analysis found that the Salvation Army's urine testing regime was fully compliant with the Australian Standards with the exception of the following:

Table 14: Australian Standards

Standard	Variation in Compliance
<p>3.2.2 Procedures for collecting urine specimens should allow for individual privacy. This Standard does not exclude the option to observe the collection of urine under strictly controlled medical conditions. Observation is to be carried out by a medical practitioner or paramedical staff under the direction of a medical practitioner</p>	<p>Observation is carried out by non medically qualified staff in the North West. Supervision is carried out by qualified nurses in the North and South. There is no medical practitioner available to supervise or direct the collecting of urine samples</p>
<p>3.3.3 (b) The donor shall provide the specimen in a stall or otherwise partitioned area that allows for individual privacy.</p>	<p>Offenders provide the urine sample under direct observation</p>
<p>4.2 The approved method shall be one of the following:</p> <ul style="list-style-type: none"> (a) Gas chromatography (GC). (b) Gas chromatography/mass spectrometry (GC/MS). (c) High pressure liquid chromatography (HPLC). (d) Immunoassay. (e) Liquid chromatography/mass spectrometry (LC/MS). 	<p>Salvation Army employs Point of Care testing for some tests.</p>

It was noted, however, that the level and approach to urine testing carried out by the Salvation Army represented a vastly improved level of service compared with previous arrangements for offenders. In fact, several interviewees, including

Magistrates, indicated that the capacity to refer offenders for urine testing had been one of the most significant improvements achieved by CMD.

Assessment Tools

CMD has adopted the Level of Service Case Management Inventory (LS/CMI™). This tool was developed by Andrews, Bonta, and Wormith in 2004 and has been validated in the United States, Canada, the United Kingdom, and Singapore.

The development of assessment tools in correctional services has followed a particular history (Andrews, Bonta & Wormith, 2006). The first generation relied on professional judgement alone and applied up until the 1970s. The second generation saw the development of actuarial approaches to risk assessment. These were able to distinguish between low and high risk offenders however they were ‘atheoretical’ and static in nature (i.e. they were over reliant on past history and did not allow for offender’s status to change) (Andrews et al, 2006). The second generation applied from the mid 1970s through to the mid to late 1980s. The third generation built in dynamic risk factors as well as information that allowed correctional officers and others working with offenders to know where to target their efforts. This generation emerged in the late 1980s and 1990s. Since then, a fourth generation has commenced (Andrews et al, 2006) which integrates risk assessment with systematic intervention and monitoring. LS/CMI™ is an example of a fourth generation risk assessment tool.

The use of the LS/CMI™ represents a best practice approach to risk/need assessment in criminal justice settings and is an overall quality improvement. It is notable that the LS/CMI™ is now being implemented in both Community Corrections and Youth Justice Services.

Service Integration

As one of the four overall strategies, the achievement of service integration has been a key feature of the first year of CMD. Service integration is achieved when effective links are created between individuals and organisations at governance, management and case worker levels (Voydanoff, 1995).

Factors that support the achievement of a coordinated service model include local level delegation and discretion to improve the match between needs and service delivery; flexibility in service planning and funding at the local level (Waldfoegel, 1997) (Voydanoff, 1995) and effective leadership at all levels (Huxham and Vangen, 2000).

Barriers to effective service integration are based within the actions, attitudes and constraints on 'street level' staff (Meyers, 1993, Sandfort, 1999, Huxham and Vangen, 2003), silo-based funding arrangements (Waldfoegel, 1997), the pressures staff are working under (Huxham and Vangen, 2003) and the negative relationships that can form between individuals and between organisations (Markoff et al., 2005).

The following is an analysis of the degree to which the factors supporting service integration are in place within CMD at the end of its first year:

Table 15: Factors supporting service integration

Factor	In place	Evidence
Links at Governance level	Yes	Relationships have formed between members of the SCC.
Links at Management levels	Yes	Protocols have been developed between service providers. Managers are engaged in local level Coordinatng Committees
Links at Case Worker levels	Yes	Increasing evidence of contact between case workers in relation to specific cases

Local Level Delegation	Yes	Decisions about the operation of the program have been increasingly delegated to the Regional Coordinating Committees
Flexible Service Planning and Funding	No	Funding for the program is fixed in accordance with contractual arrangements. There is very little capacity for differential funding for offenders based on need, risk or circumstances
Leadership	Yes	While the Principal Consultant has been the clear leader during the implementation of CMD there is evidence of increased leadership at local and service provider levels as individuals become more familiar with the program

Mattessich et al (2001) identified *20 Success Factors for Collaborations* based on a meta analysis of the literature. The 20 factors are identified below along with an assessment as the degree to which the factor was in place in the Tasmanian CMD program at the end of the first year. The descriptions relate to the collaborative entity or group, which in the case of CMD refers to the combined efforts of the Implementation Project Group, Community Corrections, Youth Justice Services, Anglicare and the Salvation Army:

Factor	Description	Relevance to CMD
1. Factors Relating to the Environment		
A. History of collaboration or cooperation in the community	A history of collaboration or cooperation exists in the community and offers the potential collaborative partners an understanding of the roles and expectations required in collaboration and enables them to trust the process	Partially in place While the partners in CMD were new partners who had not worked together previously, the Department of Justice had prior relevant experience through Safe at Home and other agencies also had some relevant experience. However, there are few role models in place in Tasmania in relation to collaborative effort
B. Collaborative group seen as a legitimate leader in the community	The collaborative group (and by implication, the agencies in the group) is perceived within the community as reliable and competent – at least related to the goals and activities it intends to accomplish	In place There is support within the broader community for the CMD project
C. Favourable political and social climate	Political leaders, opinion makers, persons who control resources and the general public support (or at least do not oppose) the mission of the collaborative group	In place There is political support for CMD at State and Commonwealth levels
2. Factors relating to Membership Characteristics		
A. Mutual respect, understanding and trust	Members of the collaborative group share an understanding and respect for each other and their respective organisations; how they operate, their cultural norms and values, their limitations and their expectations	Partially in place There was some level of antagonism between CMD organisations during the first year which should be largely overcome within the new service model

Factor	Description	Relevance to CMD
B. Appropriate cross section of members	To the extent that they are needed, the collaborative group includes representatives from each segment of the community who will be affected by the activities	Partially in place Links made at the SCC and management levels. Links were still being created at operational levels
C. Members see collaboration as in their self interest	Collaborating partners believe that they will benefit from their involvement in the collaboration and that the advantages of membership will offset costs such as loss of autonomy and turf.	Partially in place Not all partners were convinced of the benefits of involvement and two have now ceased or reduced their involvement accordingly
D. Ability to compromise	Collaborating partners are able to compromise, since the many decisions within a collaborative effort cannot possibly fit the preferences of every member perfectly	Partially in place There has been some evidence of the SCC making compromise decisions (such as in relation to the frequency of urine testing and the length of time for assessments)
3. Factors relating to Process and Structure		
A. Members share a stake in both process and outcome	Members of the collaborative group feel 'ownership' of both the way the group works and the results or products of its work	Partially in place The SCC has been generally been centrally driven and led. Greater levels of ownership should be achieved in the new service model
B. Multiple layers of participation	Every level (upper management, middle management, operations) within each partner organisation has at least some representation and ongoing involvement in the collaborative initiative	Partially in place Links made at the SCC and management levels. Increasing levels of participation at local levels as the Regional Coordinating Committees have commenced

Factor	Description	Relevance to CMD
C. Flexibility	The collaborative group remains open to varied ways of organising itself and accomplishing its work	In place The SCC and the Implementation Project Group have changed their ways of operating and the rules and requirements as the initiative has progressed. The service model changed substantially at the end of the first year
D. Development of clear roles and policy guidelines	The collaborating partners clearly understand their roles, rights, and responsibilities, and they understand how to carry out those responsibilities	In place The initial contracting arrangements; cross agency protocols and the CMD program manual made roles and responsibilities clear. These have been updated in light of the new service model
E. Adaptability	The collaborative group has the ability to sustain itself in the midst of major changes, even if it needs to change some major goals, members, etc, in order to deal with changing conditions	In place The changed service model is evidence of the capacity for the collaboration to adapt to changed requirements
F. Appropriate pace of development	The structure, resources and activities of the collaborative group change over time to meet the needs of the group without overwhelming its capacity, at each point throughout the initiative	In place While the take up of CMD meant that the pace of development was faster than anticipated, the collaborative effort was able to cope through flexible approaches.
4. Factors relating to Communication		
A. Open and frequent communication	Collaborative group members interact often, update one another, discuss issues openly and convey all necessary information to one another and to people outside the group	In place The SCC meets regularly and attendance is reasonably consistent. There is evidence of good relationships in the regional groups

Factor	Description	Relevance to CMD
B. Established informal relationships and communication links	In addition to formal channels of communication, members establish personal connections – producing better, more informed and cohesive group working on a common project	Partially in place Some evidence of productive relationships forming between some collaborative group members
5. Factors relating to Purpose		
A. Concrete, attainable goals and objectives	Goals and objectives of the collaborative group are clear to all partners and can realistically be attained	In place
B. Shared vision	Collaborating partners have the same vision, with clearly agreed upon mission, objectives and strategy. The shared vision may exist at the outset of collaboration or the partners may develop a vision as they work together	In place The initial 'vision' was set out by DOJ in contract documents. This is not necessarily shared (except to the extent that organisations entered into the contracts). These difficulties have been overcome in the new service model
C. Unique purpose	The mission and goals or approach of the collaborative group differ, at least in part, from the mission and goals or approach of the member organisations	In place CMD is a unique program and does not overlap with any existing program or organisation
6. Factors relating to Resources		
A, Sufficient funds, staff, materials and time	The collaborative group has an adequate, consistent financial base, along with the staff and materials needed to support its operations. It allows sufficient time to achieve its goals and includes time to nurture the collaboration	In place CMD is adequately funded. However its pilot status for the first year tended to undermine the degree of commitment some organisations gave to it

Factor	Description	Relevance to CMD
B. Skilled leadership	The individual who provides leadership for the collaborative group has organising and interpersonal skills, and carries out the role with fairness. Because of these characteristics (and others) the leader is granted respect or 'legitimacy' by the collaborative partners	In place Leadership for the initiative is clearly with the Principal Consultant, DOJ. Legitimacy is attached to this by virtue of the contracting relationship with partner organisations.

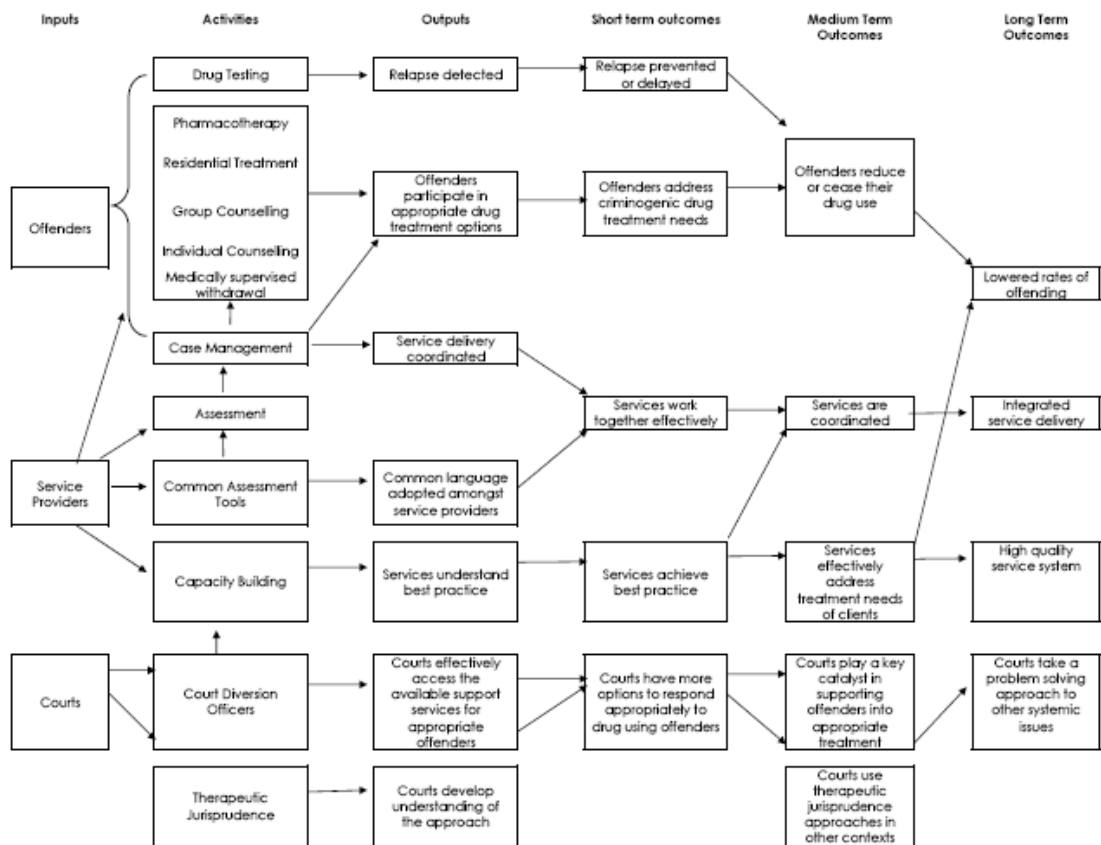
Reference: Mattessich P W, Murray-Close M, and B R Monsey (2001) *Collaboration: What Makes It Work (2nd Edition)*, Wilder Research Center, Fieldstone Alliance, St Paul Minnesota

It is evident that most of the building blocks for effective service integration are in place with the exception of flexible service planning and funding. This will be a challenge for the program into the future.

It is also apparent that the new service model provides improved opportunities for service integration to be achieved. The achievement of service integration is a process which takes time and consistent effort. Its achievement will be an interesting ongoing feature of CMD.

6. Outcomes

In considering the outcomes of CMD it is important to note the Project Logic developed for this evaluation:



The project logic indicates that CMD has the following short term outcomes:

-
- Relapse prevented or delayed
 - Offenders address criminogenic drug treatment needs
 - Services work together effectively
 - Services achieve best practice
 - Courts have more options to respond appropriately to drug using offenders

The evidence from the first year of CMD in relation to these outcomes is presented in this Chapter.

At the end of the chapter information is also provided in relation to the reoffending of offenders on CMD. It should be noted that lowered rates of offending is identified in the project logic as one of the four long term outcomes for CMD. The achievement of each of these long term outcomes will be influenced by a range of other factors outside of the control of CMD, hence the use of the project logic to identify the short and medium term outcomes that are more directly attributable to CMD.

Relapse Prevented or Delayed

As mentioned earlier in this report, it has not been possible to obtain aggregated data in relation to the results of urine testing. This is understandable given the harm minimisation focus of CMD and the inability to accurately determine *actual* levels of drug use based on relatively infrequent urine tests. However the lack of aggregated data on the use of drugs on CMD means that it is not possible to provide quantitative data in relation to the achievement of this short-term outcome.

It is notable that that qualitative data obtained from offender interviews (see **Appendix B**) indicates that some offenders have made substantial efforts to

cease or reduce their level of drug use while on CMD. For some this has been the first occasion on which they have ever attempted such a reduction.

Staff involved in the delivery of CMD also confirm that many offenders have used the opportunity presented by CMD to make considerable efforts to cease or reduce their drug use.

The literature on drug addiction confirms that ceasing drug use is a complex process that takes time, and may only be achieved after many interventions (Hser et al, 1998).

A major study in the United Kingdom (Gossop et al, 2003) found that a cohort of 650 problem drug users in the UK achieved marked, and statistically significant, reductions in frequency of use of illicit and non-prescribed drugs over an extended period after receiving one of four different treatment modalities. The most marked change in drug use tended to occur in the first year after treatment with subsequent change occurring more gradually as individuals maintained or gradually increased their likelihood of ceasing drug use altogether. The same study found that crime rates fell during the first year and then remained reasonably static for the entire follow up period. In summary this study found evidence of reduced drug use and reduced criminal activity following treatment but not to the point of abstinence or no criminal activity at all.

In a study on substance abuse treatment outcomes for adolescents, Latimer et al (2000) found that drug-abusing adolescents who receive sufficiently long treatment, participate in aftercare, and possess at least one individual or interpersonal protective factor during their recovery process have the best chance to maintain gains made during treatment. They point out that there is a multiplicity of factors that will determine post treatment success including the mix of risk and protective factors presented by the individual and the level of drug use or support for drug use in their family and social networks. These factors (well outside the control of treatment providers) accounted for at least half of the variance in treatment outcome.

A 1998 study (Hser et al, 1998) examined factors related to drug treatment program entry among 276 drug users seeking treatment referral. The analyses

found that being mandated by the courts and a prior positive treatment experience was significant in terms of drug users seeking admittance to drug treatment programs. The study found that those with more severe problems (drug related and others) were less likely to enter treatment, indicating that psychological distress and family problems may undermine motivation to follow through on treatment referral. This study validates the provision of mandated drug treatment program through the courts and the importance of the drug treatment experience being positive even if it is not 'successful' in the first instance.

All of these findings reinforce the complexity of addressing drug treatment in a criminal justice setting and the need for courts, governments and program critics to be patient in seeking the achievement of the long term outcomes from drug treatment.

Offenders address criminogenic drug treatment needs

This outcome has been achieved to the extent that offenders have participated in programs as part of CMD that address their needs.

Achievement of this outcome is likely to have been impeded by the lack of all program components during the first year (eg ambulatory detoxification and pharmacotherapy which, while planned, were not able to be provided) as well as the lack of referral services in Tasmania to address non-drug related issues.

An expanded role for case management should have a strong impact on the capacity for offenders to address their full range of criminogenic needs. Brokerage support for case managers (allowing them to purchase additional services when required) would also assist.

Services work together effectively

As discussed earlier in this report under the heading of Service Integration, there is evidence that most of the building blocks for effective service integration are now in place with the exception of flexible service planning and funding.

In particular it has been noted that the reduction in service agencies involved in CMD in the new service model will also be conducive to the achievement of service integration.

Services achieve best practice

As noted earlier, national standards (representing best practice) have already been substantially achieved in relation to drug testing as a result of CMD. As well, it is evident that the LS/CMI™ assessment and case planning tool represents current world's best practice.

Other developments signalled by Anglicare Tasmania to research effective counselling models for offenders and implement national case management standards should also ensure that CMD represents a best practice approach.

Remaining areas to address the degree to which best practice has been achieved include the court supervision process itself (i.e. the operation of problem solving courts); access to non-CMD services for offenders with multiple needs (eg through the effective use of brokerage funds and/or existing and new service networks); residential rehabilitation programs; group counselling and providing access to medical and psychosocial supports.

Courts have more options to respond appropriately to drug using offenders

There is no doubt that this outcome has been achieved. Courts have made use of CMD at a level that was higher than anticipated. All Magistrates and all courts have made use of CMD to at least some extent.

There is also evidence that the two related medium term goals (Courts play a key catalyst in supporting offenders into treatment and Courts use therapeutic approaches in other circumstances) have also been substantially achieved.

Qualitative evidence has been obtained from offenders and from staff involved in CMD in relation to the vital and central role played by Magistrates in motivating offenders to take part in CMD. Several offenders spoke of the significance of the apparent personal interest the Magistrate was taking in them and the fact that 'they didn't want to let the magistrate down' by failing to make the most of the opportunities presented to them by CMD.

This is an important finding for CMD as many Magistrates are sceptical that the still minimal amount of time they are able to spend on CMD matters in court makes any particular difference at all. While it does require further evaluation, early evidence would suggest that the magistrates' personal attention to the individual is strongly motivating and a key aspect in the success of CMD to date.

Interest in therapeutic jurisprudence and problem solving courts would also seem to be increasing in Tasmania. A long time convert to this approach, the deputy chief magistrate, has set up a Mental Health List at the Hobart Court which uses a similar problem solving approach. This, along with the fact that all Magistrates have used CMD to at least some extent, would seem to indicate that Magistrates are 'voting with their feet' and seeing value in the problem solving approach at least as an alternative for highly problematic and complex high risk offenders.

Reoffending

While reducing the level of reoffending is one of the objectives of CMD, the literature acknowledges that this is a complex objective. As mentioned above the project logic identifies 'reduced levels of offending' as a long term outcome of the program that will be influenced by a variety of other factors outside the direct control of CMD.

In considering the reoffending data, it is important to note that there has only been a short period of time in which to follow up CMD offenders. As the

reoffending data was supplied by the Department of Justice at the end of June 2008, all offenders will have had less than 12 months at the most since the commencement of their CMD order and the majority will have had considerably less time.

It should also be noted that the data provided by the Department of Justice only relates to reappearances in court. It does not include rearrest, and we are not able to determine whether the matter for which the offender is reappearing in court was committed before or after the commencement of CMD. We also don't have access to the dates of the reoffending in order to determine whether participation in CMD increased the time taken between offending (as has been found in other evaluations, eg Payne, 2008) or whether the alleged reoffending occurred prior to the offender commencing the CMD program.

Nevertheless the following data provides some insight into the level reoffending for CMD offenders.

Of the 157 offenders who commenced a CMD order, 68 (or 43.3%) had reappeared before court for a further matter by the end of June 2008.

Of those that reappeared before court, 57 were men and 11 were women:

Table 16: Gender

	No. commenced CMD	No. re-appeared before Court	Re-appearing rate
Male	134	57	42.5%
Female	23	11	47.8%
Total	157	68	43.3%

There was no significant difference between Indigenous and non-Indigenous offenders in terms of the likelihood of reappearing in court on a further matter while on CMD:

Table 17: Indigenous Status

	No. commenced CMD	No. re-appeared before Court	Re-appearing rate
Aboriginal	22	10	45.5%
Torres Strait Islander	4	0	0.0%
Neither Aboriginal nor TSI	111	49	44.1%
Not stated	20	9	45.0%
Total	157	68	43.3%

Key differences in the likelihood of the offender reappearing in court on a further matter are evident when the offenders are differentiated into the different categories of CMD:

Table 18: Category

	No. commenced CMD	No. re-appeared before Court	Re-appearing rate
Category One - Bail Diversion	88	34	38.6%
Category Two - Probation Order or Suspended Sentence with CMD component	17	7	41.2%
Category Three - Drug Treatment Order	31	15	48.4%
Bail Diversion plus Drug Treatment Order	13	8	61.5%
Bail Diversion plus Probation Order or Suspended Sentence with CMD component	7	1	14.3%
Probation Order or Suspended Sentence with CMD plus Drug Treatment Order	4	2	50.0%

Bail Diversion plus Probation Order or Suspended Sentence with CMD component plus Drug Treatment Order	2	1	50.0%
Total	162	67	41.4%

Those on DTOs alone or in combination with other order types were the most likely to have reappeared in court on a further matter (between 48.4% for DTO alone and 61.8% for DTO plus Bail). Based on the design of the program, these offenders are the highest risk and therefore most likely to reoffend.

This finding is even more evident when the LS/CMI™ scores are compared with the likelihood of reappearing in court on a further matter:

Table 19: LS/CMI™ Score

Risk Level	Score	No. commenced CMD	No. re-appeared before Court	Re-appearing rate
Very Low	0 to 4	0	0	0.0%
Low	5 to 10	1	0	0.0%
Medium	11 to 19	8	1	12.5%
High	20 to 29	89	39	43.8%
Very High	30+	54	28	51.9%
Not recorded		5	0	0.0%
Total		157	68	43.3%

Offenders who completed the CMD program successfully (although small in number) were less likely to reappear in court on a further matter than offenders who had not completed CMD. While a lot of data is missing, this result would indicate that CMD does have some impact on reducing the level of reoffending.

Table 20: Successfully Completed Program

	No. commenced CMD	No. re-appeared before Court	Re-appearing rate
Completed Successfully	7	2	28.6%
No - Referred back to Court for action	38	24	63.2%
No - Referred back to Supervisor of community based orders	2	0	0.0%
Not recorded	110	42	38.2%
Total	157	68	43.3%

Regional differences are also particularly significant and point to possible gaps in the data provided by the Department of Justice:

Table 21: Regions

	No. commenced CMD	No. re-appeared before Court	Re-appearing rate
North	21	8	38.1%
North-West	23	0	0.0%
South	113	60	53.1%
Total	157	68	43.3%

It is highly unlikely that no offenders from the North West will have reappeared in court on a further matter.

Also of interest are the age categories of those who have reappeared in court on further matters. While one might expect the rates of reappearances to be higher in the young age groups (given the literature about the level of adolescent offending), this data shows a more consistent pattern across all age groups with 26-29 year olds the most likely to have reappeared in court.

Table 22: Age Group

Age Group	No. commenced CM Program	No. re-appeared before Court	Re-appearing rate
16-20	20	9	45.0%
21-25	35	13	37.1%
26-30	47	23	48.9%
31-35	33	16	48.5%
36-40	14	5	35.7%
41-45	5	2	40.0%
46-50	2	0	0.0%
51-55	1	0	0.0%
Total	157	68	43.3%

Analysed according to their principle 'drug of concern' indicates that those using methadone, amphetamines and morphine were significantly more likely to have reappeared before the courts on a further matter than those using other drug types. Those whose principle 'drug of concern' was benzodiazepines, ecstasy or cannabis were less likely than others to have reappeared in court on a further matter.

Table 23: Principle Drug of Concern

	No. commenced CM Program	No. re-appeared before Court	Re-appearing rate
Amphetamines	82	38	46.3%
Benzodiazepines	8	2	25.0%
Cannabis	28	10	35.7%
Ecstasy	3	1	33.3%
Methadone	2	2	100.0%
Morphine	34	15	44.1%
Total	157	68	43.3%

It is therefore evident that a number of offenders involved in CMD have reappeared in court on further matters. The complexity in achieving reductions in recidivism levels are discussed elsewhere in this report. In summary the findings from this evaluation would suggest the following in relation to the recidivism of the participants:

- Reducing reoffending is a long term outcome of the program which will be influenced by a range of factors outside the control of the program, including a range of personal and family/peer related factors which will be different for each individual
- Tasmania has an overall lack of drug treatment services with the result that less than half of CMD offenders have undertaken any previous drug treatment. The literature would suggest that entrenched drug users may

require multiple treatment episodes before achieving a substantial reduction in their drug use

- Reoffending levels of CMD offenders are commensurate with other court based drug diversion programs (see final chapter)
- CMD has been specifically designed to provide an option for high risk offenders who, by definition, are more likely to reoffend than lower risk and less complex offenders but who also pose the greatest level of ongoing risk without any access to treatment.

In considering the reoffending findings, it should also be noted that CMD does not represent a lesser penalty for most offenders. With the exception of those who would otherwise have been remanded in custody instead of being bailed, or imprisoned instead of being granted a DTO, offenders participating in CMD have generally accepted a higher level of involvement with the criminal justice system and intrusion into their personal lives than they are likely to have experienced on an 'ordinary' bail or probation order or other sanctioning arrangement. For those who would otherwise have been imprisoned, the opportunity has been for them to access treatment to break this cycle and so reduce the risk they pose into the future.

7. Conclusion and Recommendations

The goal of CMD is to break the drug-crime cycle by involving offenders in treatment and rehabilitation programs and providing alternative pathways for offenders through increasing their access to drug, alcohol, or other welfare services.

CMD also aims to:

- Provide offenders with an opportunity to acknowledge and address offending behaviour caused by drug abuse, thereby improving physical and psychological well being
- Help eligible offenders abstain from illicit drug use
- Reduce drug related offending behaviour
- Provide offenders with the tools to recognise and prevent relapse into substance abuse and criminal behaviour
- Develop a shared approach to and a commitment to a 'joined up' service delivery system between Government and the NGO sector.

This final section of the report summarises the findings outlined in the previous chapters in terms of the goals and aims for the program. It also sets out some recommendations for the consideration of the Department of Justice based on the evaluation findings.

In setting out the findings to date, Success Works asks readers to note that twelve months is a short period of time with which to evaluate a court diversion program. Many of the medium and long term outcomes of the program have not had time to be realised. Further evaluation is required to determine actual performance against these criteria.

Goals

The goal of CMD has been broken into the following components:

- Breaking the drug-crime cycle
- Involving offenders in treatment and rehabilitation programs
- Providing alternative pathways for offenders.

Breaking the Drug-Crime Cycle

Not unsurprisingly, given its focus on high risk offenders, CMD can not be said to have 'broken' the drug-crime cycle. Of the 157 offenders who commenced CMD orders, 68 (or 43.3%) reappeared in court on a further matter prior to the end of June 2008.

Demonstrating the accuracy of the system, rates of reoffending were highest for those assessed as highest risk and for those participating on Drug Treatment Orders.

This level of reoffending is similar to those of similar programs in other jurisdictions.

The following table compares the reoffending rates for bail based programs (i.e. Category One in Tasmania, CREDIT (Vic), MERIT (NSW) and CARDS (SA). It should be noted, however, that all of these rates have been calculated using different data, different time periods and different criteria for determining what constitutes further offending.

Table 24: Reoffending on Bail Orders by Jurisdiction

	Tas CMD	CREDIT (Vic)	MERIT (NSW)	CARDS (SA)
Reoffending Rate	38.6%	38%	53% ¹⁷	40%

CMD is therefore broadly similar to other jurisdictions in terms of the impact of the program on reoffending (noting that, based on these figures, it is more aligned to the lower end of the spectrum of reoffending than the higher end, at least in relation to bail orders).

The literature suggests that reducing levels of reoffending is an extremely complex objective which will be impacted by a variety of factors outside the control of the criminal justice system.

Involving Offenders in Treatment and Rehabilitation Programs

The evidence from this evaluation of CMD is that 250 offenders were offered the opportunity to participate in CMD during its first year and that 157 offenders took up that opportunity. As CMD has not previously existed, it is possible to conclude that CMD has offered the chance for a significant number of offenders to be involved in treatment and rehabilitation programs as part of their involvement in the criminal justice system. It is notable, in this regard, that less than half of this mainly high risk group of offenders had ever undertaken any form of drug treatment before in the past. CMD has therefore been successful in the achievement of this objective.

¹⁷ Reoffending within 12 months of people who had completed the MERIT program

Providing alternative pathways for offenders

CMD has had some success in establishing alternative pathways for offenders. 'New' programs on offer during the first year of CMD were assessment, case management, urinalysis and individual and group counselling. Residential rehabilitation at The Bridge was a preexisting program available to Tasmanian drug users on a voluntary basis. No particular changes were made to The Bridge's program to accommodate CMD offenders.

In addition, while new in concept, case management of adult offenders did not offer anything different to traditional probation supervision during the first year of operation¹⁸. This may change now that responsibility has transferred to Anglicare Tasmania.

It is noted that some new treatment or rehabilitation programs were slow to start (group counselling) or non existent (detoxification and pharmacotherapy).

While it is not a 'treatment program' *per se*; access to urine testing has been a successful feature of CMD which has supported offenders to at least try to break the cycle of dependence.

Aims

In addition to the above goals, CMD has established a number of aims that underpin the achievement of the goals. The following table sets out the current level of achievement against each of the aims.

¹⁸ It is acknowledged that Community Corrections did not offer anything other than their existing case management approach in response to the original tender.

Table 25: Current level of achievement against each of the goals

Aim	Achievement
Provide offenders with an opportunity to acknowledge and address offending behaviour caused by drug abuse, thereby improving physical and psychological well being	250 offenders have been provided with the opportunity and 157 offenders have participated in CMD.
Help eligible offenders abstain from illicit drug use	Urine testing has been used extensively as a supportive approach to ensure offenders are able to maintain or achieve abstinence and to allow case managers to have a factual base on which to assist offenders to deal with continued drug use and relapse. It has not been possible to obtain data in relation to the outcomes of urine testing.
Reduce drug related offending behaviour	Reoffending levels are commensurate with those in other jurisdictions. It is not known whether the further offending has been drug related or occurred before of after involvement with CMD.
Provide offenders with the tools to recognise and prevent relapse into substance abuse and criminal behaviour	Offenders participating in individual counselling or group counselling have been provided with tools and insights to recognise their own cycle of abuse. However, maintenance programs are only now being put into place to assist offenders to deal with the prospect of relapse.

Aim	Achievement
Develop a shared approach to and a commitment to a 'joined up' service delivery system between Government and the NGO sector	Service integration remains a priority for CMD with evidence of improving relationships and the development of robust local governance arrangements.

Recommendations

CMD remains a work in progress. A changed service model was introduced at the end of the first twelve months which should deliver improved services. There is evidence that the new service model will be more effective in terms of local service integration and more responsive to the courts as the separation between screening and assessment is removed.

Given the change in service model it is not possible or useful for the evaluation to make recommendations relating to the service delivery model. As a result of the formative evaluation process recorded in the two previous reports, service delivery has already changed and it would be pointless for Success Works to make recommendations which relate to the old model and are, in effect, redundant.

Recommendations based on this evaluation relate more to the evaluation itself. As this evaluation was only ever designed to focus on the first twelve months of the program, it is suggested that that the process be repeated again in the next few years in order to determine what has changed in the intervening period. Recommendation one is therefore:

- 1. That a further evaluation of the outcomes of CMD be conducted in the next two to three years**

To support that evaluation, it is recommended that data collection processes in the Department of Justice be improved. Success Works has had to manage large amounts of missing data and sort through a number of obvious data anomalies such as commencement dates that precede screening dates. A sound database is a fundamental component for evaluation and for effective monitoring of the program by the Statewide Coordinating Committee and the Department of Justice. Our second recommendation is therefore:

2. That the CMD database be maintained and monitored for accuracy on a regular basis

CMD is making progress in establishing new treatment options and pathways for offenders. As the target group for CMD is high risk offenders (and should remain so) efforts are needed to expand the range of treatment approaches to this group of offenders. They represent the highest need (and priority) group of drug using individuals in the state. Further efforts to draw together the two service sectors (CMD and mainstream Alcohol and Drug Services) should be a priority in order to ensure that CMD offenders and others at risk of offending receive access to a full range of service options.

The third recommendation is:

3. That CMD work together with the Alcohol and Drug Service Sector and DHHS to expand the range of treatment options for offenders

It is also notable that assessments of CMD offenders have identified significant additional needs that are outside the capacity and skills of the drug treatment sector. Access to non-CMD support services are required if offenders are going to be able to address other factors related to their offending behaviour and drug use. To facilitate this case managers require access to brokerage funds or other arrangements which will allow non-CMD services to be accessed in a timely way by offenders. The fourth recommendation is:

-
- 4. That brokerage funding or other arrangements be provided to allow case managers to facilitate access to non-CMD services for high risk offenders**

It CMD is to be successful, priority must be given to maintaining Magistrates' belief in the benefits of the program as well as building support amongst defence counsel and police. Efforts to educate the court community about CMD and its achievements are therefore vital. A final recommendation is:

- 5. That CMD provide regular feedback on the achievements and directions of the program to Magistrates, police and defence counsel as a means of ensuring their continued support for the program**

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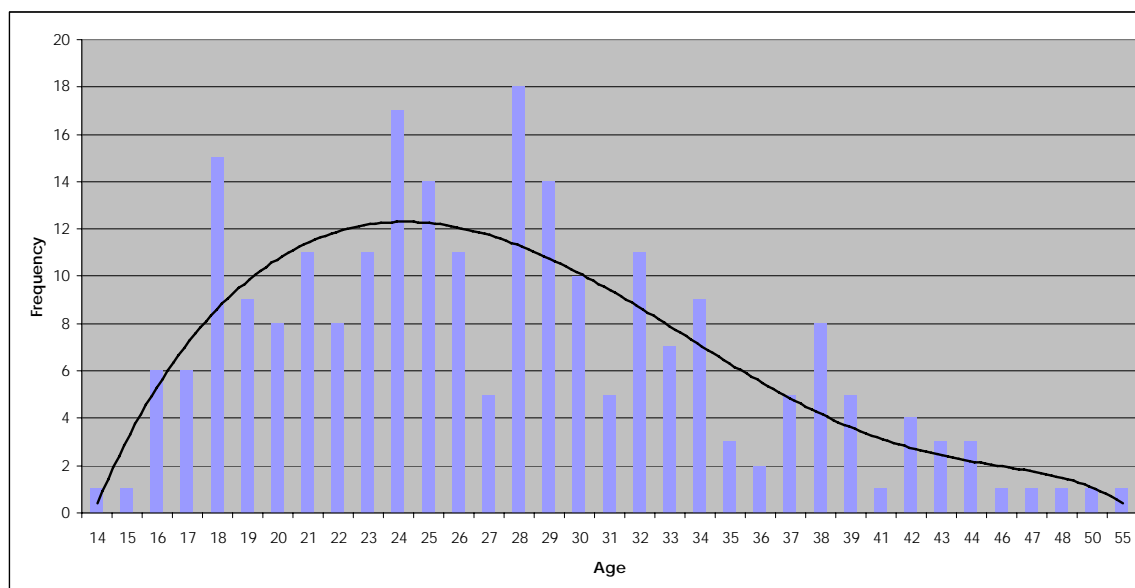
APPENDIX A - Demographics

Demographic information is provided for the 250 individuals who were identified as potentially suitable for the program and referred for screening.

Age

Offenders ranged in age from 14 to 55 years old with an average age of 27.5 years (SD \pm 7.6). The median age (50% above this age and 50% below) was 27 years while the mode (most common age) was 28 years.

The distribution of ages across the entire dataset is depicted below.



There were only minor differences in age according to gender with females tending to be slightly younger.

Table 26: Age and gender of people referred to CMD

	Males	Females
Average age	27.6	27.3
Mode age	28.0	26.0
Median age	27.0	26.0
Standard Deviation	7.8	7.0

Gender

The ratio of males to females indicates substantially more males than females are identified as being potentially suitable for screening. Specifically, 214 (86%) of individuals identified were male, and 36 (14%) were female.

Indigenous status

As the program has progressed an increasing proportion of participants have identified themselves to be of Aboriginal (14%) or Torres Strait Islander (2%) decent. The majority of participants in the CMD program were non-Indigenous (66%). A large proportion (18%) of the dataset did not record indigenous status.

Table 27: Indigenous Status

	Number	Percent
Aboriginal	36	14.4
Torres Strait Islander	4	1.6
Neither Aboriginal nor Torres Strait Islander	164	65.6
Not stated	46	18.4
Total	250	100

Preferred Language of Offender

All offenders indicated that they preferred to communicate in English (n=250; 100%).

Postcode of residence

Table 28: Postcode of residence

Postcode	Suburbs	No of Assessments
7000	Glebe, Hobart, Mount Stuart, North Hobart, West Hobart	13
7004	Battery Point, South Hobart	3
7005	Dynnyrne, Sandy Bay, University Of Tasmania	2
7007	Mount Nelson, Tolmans Hill	1
7008	Lenah Valley, New Town	4
7009	Derwent Park, Lutana, Moonah	17
7010	Dowsing Point, Glenorchy, Goodwood, Montrose, Rosetta	10
7011	Austins Ferry, Berriedale, Chigwell, Claremont	15
7015	Geilston Bay, Lindisfarne, Rose Bay	3
7016	Risdon Vale	2
7017	Grasstree Hill, Honeywood, Old Beach, Otago, Tea Tree	3
7018	Bellerive, Howrah, Montagu Bay, Mornington, Rosny, Rosny Park, Tranmere, Warrane	15
7019	Clarendon Vale, Rokeby	10
7020	Clifton Beach, Sandford	1
7021	Lauderdale	2
7025	Dulcot, Richmond	1
7030	Apsley, Bagdad, Bothwell, Bridgewater, Brighton, Broadmarsh,	25

Postcode	Suburbs	No of Assessments
	Dromedary, Dysart, Elderslie, Gagebrook, Granton, Interlaken, Jericho, Kempton, Lower Marshes, Mangalore, Melton Mowbray, Miena, Pelham, Pontville, Shannon, Steppes, Waddamana	
7050	Kingston, Kingston Beach	5
7052	Blackmans Bay	1
7053	Bonnet Hill, Tarooma	1
7109	Crabtree, Cradoc, Glaziers Bay, Glen Huon, Glendevie, Grove, Hastings, Huonville, Judbury, Lonnavaile, Lower Longley, Lucaston, Lune River, Lymington, Mountain River, Petcheys Bay, Raminea, Ranelagh, Southport, Strathblane, Waterloo, Wattle Grove, Woodstock	1
7112	Abels Bay, Cygnet, Deep Bay, Eggs And Bacon Bay, Garden Island Creek, Gardners Bay, Nicholls Rivulet, Randalls Bay, Verona Sands	2
7116	Cairns Bay, Castle Forbes Bay, Geeveston, Police Point, Port Huon, Surges Bay	1
7140	Black Hills, Boyer, Bradys Lake, Bronte Park, Bushy Park, Butlers Gorge, Dee, Derwent Bridge, Ellendale, Fentonbury, Fitzgerald, Glenfern, Glenora, Gretna, Hamilton, Hayes, Hollow Tree, Karanja, Lachlan, Lake St Clair, Macquarie Plains, Magra, Malbina, Maydena, Molesworth, Moogara, Mount Field, Mount Lloyd, National Park, New Norfolk, Osterley, Ouse, Plenty, Rosegarland, Sorell Creek, Strickland, Tarraleah, Tyenna, Uxbridge, Victoria Valley, Wayatinah, Westerway	7
7150	Adventure Bay, Allens Rivulet, Alonnah, Barnes Bay, Dennes Point, Gordon, Great Bay, Kaoota, Killora, Longley, Lunawanna, Oyster Cove, Pelverata, Sandfly, Simpsons Bay, Upper Woodstock	2
7171	Midway Point, Penna	1
7172	Nugent, Orielton, Pawleena, Sorell, Wattle Hill	2
7173	Carlton, Connellys Marsh, Dodges Ferry, Forcett, Lewisham, Primrose Sands	2
7176	Kellevie	1

Postcode	Suburbs	No of Assessments
7178	Murdunna	2
7210	Campbell Town, Lake Leake	1
7212	Blessington, Burns Creek, Deddington, Evandale, Nile, Western Junction	1
7248	Invermay, Mayfield, Mowbray, Newnham, Rocherlea	8
7249	Kings Meadows, Punchbowl, South Launceston, Youngtown	2
7250	East Launceston, Launceston, Newstead, Norwood, Prospect, Prospect Vale, Ravenswood, Riverside, St Leonards, Summerhill, Travellers Rest, Trevallyn, Waverley, West Launceston	27
7252	Beechford, Dilston, Hillwood, Lefroy, Lulworth, Mount Direction, Pipers River, Swan Bay, Weymouth, Windermere	2
7253	Bell Bay, George Town, Low Head	1
7268	Lilydale, North Lilydale, Underwood	1
7275	Blackwall, Deviot, Exeter, Frankford, Glengarry, Holwell, Lanena, Loira, Notley Hills, Robigana, Winkleigh	1
7291	Carrick	2
7304	Breona, Caveside, Chudleigh, Dairy Plains, Deloraine, Dunorlan, Elizabeth Town, Golden Valley, Jackeys Marsh, Kimberley, Mayberry, Meander, Mersey Forest, Mole Creek, Moltema, Montana, Needles, Parkham, Red Hills, Reedy Marsh, Weegenana, Weetah, Western Creek	3
7305	Merseylea, Railton, Sunnyside	1
7307	Harford, Hawley Beach, Latrobe, Moriarty, Northdown, Port Sorell, Sassafras, Shearwater, Thirlstane, Wesley Vale	5
7310	Aberdeen, Devonport, Don, Erriba, Eugenana, Forth, Kindred, Lillico, Melrose, Miandetta, Moina, Paloona, Quoiba, Spreyton, Wilmot	20
7315	Abbotsham, Gawler, Gunns Plains, Leith, Nietta, North Motton, Preston, Spalford, Sprent, Turners Beach, Ulverstone, Upper Castra	7

Postcode	Suburbs	No of Assessments
7320	Brooklyn, Burnie, Cooee, Havenview, Hillcrest, Montello, Romaine, Wivenhoe	6
7330	Alcomie, Arthur River, Brittons Swamp, Christmas Hills, Edith Creek, Forest, Irishtown, Lileah, Marrawah, Mella, Mengha, Montagu, Nabageena, Redpa, Smithton, Three Hummock Island, Togari, Trowutta, Woolnorth	2
7331	Stanley	1
7469	Renison Bell, Zeehan	1
7470	Rosebery	2

Most serious charge

Individuals who were referred to the CMD program faced a variety of charges before the courts. When grouped into five categories the most common most serious offences were against property (n=115, 46.0%), then against a person (n=49, 19.6%), drug offences (n=29, 11.6%), driving offences (n=19, 7.6%) and breaches of court orders (n=6, 2.4%). The most serious charge was not recorded for 32 cases (12.8%).

Table 29: Most Serious Charge

Charge	Total
Non-Aggravated Assault	38
Unlawful Entry with Intent/Burglary, Break and Enter	27
Unlawful Entry with Intent/Burglary, Break and Enter	14
Theft from Retail Premises	13
Driving Under the Influence of Alcohol or Drugs	11
Theft of a Motor Vehicle	10

Charge	Total
Theft from a person (Excluding by Force)	8
Fraud, Forgery or False Financial Instruments	8
Possess Illicit Drug	8
Aggravated Robbery	7
Possess and/or Use Illicit Drugs	7
Theft (Except Motor Vehicles), nec	6
Non-Aggravated Robbery	4
Theft of Motor Vehicle Parts or Contents	4
Unlawfully Obtain or Possess Regulated Weapons/Explosives	4
Breach of Bail	4
Cheque or Credit Card Fraud	3
Deal or Traffic in Illicit Drugs	3
Manufacture or Cultivate Illicit Drugs	3
Use Illicit Drug	3
Property Damage, nec	3
Aggravated Assault	2
Unlawful Entry with Intent/Burglary, Break and Enter	2
Fraud, nec	2
Deal or Traffic in Illicit Drugs - Commercial Quantity	2
Manufacture or Cultivate Illicit Drugs	2
Property Damage by Fire or Explosion	2
Driving While Licence Cancelled or Suspended	2
Driving Without a Licence	2
Threatening Behaviour	2

Charge	Total
Non-Aggravated Sexual Assault	1
Dangerous or Negligent Operation of a Vehicle	1
Dangerous or Negligent Driving	1
Other Dangerous or Negligent Acts Endangering Persons	1
Receiving or Handling Proceeds of Crime	1
Non Fraudulent Trade Practices	1
Other Illicit Drug Offences	1
Sell, Possess and/or Use Prohibited Weapons/Explosives	1
Driving Licence Offences	1
Exceeding the Prescribed Content of Alcohol Limit	1
Breach of Parole	1
Breach of Justice Order, nec	1
Not recorded	32
Total	250

Most (n=216, 90.0%) individuals assessed for the program and who responded to the question had other charges in addition to the most serious offence, 24 individuals (10.0%) stated that they had no other charges. The information was not recorded for 10 individuals. Only 4 individual (1.7%) stated that they had no previous conviction, while 233 stated that they did have a previous conviction (98.3%). The information was not recorded for 13 individuals.

Appendix B – Offender Case Studies

David

'David' is 32 years old and has been on the bail diversion program as part of CMD for 10 weeks. Prior to commencing on CMD, David was in remand at Risdon Prison after returning from Victoria to face charges in relation to stealing and fail to appear.

David says he has a long-standing drug habit involving the use of speed, ecstasy, heroin, cannabis and alcohol. He also takes prescribed morphine on a daily basis to deal with back pain originating from a motorbike accident when he was 21. Most of his drug use dates from this accident and is at least partially to do with pain management according to David.

David was in Victoria working as a labourer when his mother contacted him and asked him to come back to Tasmania. David's mother has the full time care of his 7 years old son and she wants David to take more responsibility for the child. David says it is his commitment to his son that has seen him return to Tasmania to face the charges and to want to deal with his drug addiction once and for all.

David says he was 'blown away' when offered the opportunity to participate in CMD. He says that if he had stayed in prison as he expected to, he probably would have kept using and not done anything to address his issues. As it is when offered the opportunity he gave serious thought about whether or not he really wanted to give up and decided he did. He spoke to others in prison at the time while he was making his decision.

When he first started on CMD it was a bit of a disaster for a while. He thought about just giving up at this point but was concerned that as the time served on CMD wouldn't count as prison time (as remand would have) he might as well keep going. The main problem was that the urine testing did not get up and running for at least the first month and David was worried that he would be blamed for not complying with this condition of his order and end up in prison

anyway – perhaps with an even longer sentence. Access to urine testing was only sorted out once his counsellor from Anglicare and his case manager from Community Corrections went with him to The Bridge to organise it.

David says he has participated in drug treatment programs before but has never had real counselling – “I’m really dealing with the issues now and being really truthfully honest for the first time ever”.

David says he has not used drugs for the period of CMD. He says it is the first time in a long time that he has managed not to smoke cannabis on a daily basis. He says the most amazing thing is that he is managing to make and keep appointments. Before this he would have forgotten about appointments or just not bothered to go. He finds he has much more time in his day to do things. He is now motivated to want to give up his prescribed daily doses of morphine. He really feels he is able to change now.

David is living with mates who are all still using cannabis and other drugs regularly. The fact that he is on CMD and has regular urine tests has been very important in giving him an excuse and a reason for not using. However, he admits that one of the biggest pressures is from old mates and people he knows. He even had the experience of being hassled to sell drugs to an old acquaintance while he was on his way to the interview with the evaluator.

For David, the most important parts of CMD so far has been the counselling and the urine testing. He has also appreciated the support from his case manager as he feels there are lots of people around who have his welfare and best interests at heart.

Richard

‘Richard’ is 34 years old and has been on CMD bail diversion for 8 weeks. Richard has been in prison at least three times before on short sentences of two to three months and has a history of using speed, cannabis and valium. He is also on the methadone maintenance program receiving a dose of 75mls per day.

Since commencing on CMD, Richard has given up using speed for the first time in a long time. The need to provide urine tests every fortnight has been very

important in keeping him focussed. He has also been receiving counselling from Anglicare and says this has been the most important and helpful part of CMD. He has had drug treatment before but has never really wanted to give up using until now.

Richard disclosed that he was a victim of child sexual assault over a prolonged period between the ages of 7 and 12 and that his drug use has been an 'escape from reality'. He is now working through issues to do with this with the counsellor – he feels that no-one has ever wanted to speak to him about it in the past.

The worst part of CMD for Richard was when he arrived for a counselling appointment to find the counsellor was on sick leave that day. He was very upset and worried and took some valium because he was so stressed out. He thinks it is important that there are back-up counsellors for situations such as this.

Richard lives with his girlfriend who is also on the methadone program and they have one child whom Richard takes care of when his girlfriend is at work. Richard and his girlfriend are keeping a low profile while Richard is on CMD and staying away from other drug using mates and acquaintances.

Richard says "I know I do need help. I don't want to use no more and I don't want to blow a urine test".

Chris

'Chris' is 29 years old and has been on a drug treatment order for one month at the time of interview. He is due for his first review at the Magistrates Court tomorrow.

Chris is taking speed on a daily basis and while he says he has cut down since commencing the DTO, he believes that he requires the speed to manage his (self diagnosed) Attention Deficit Disorder.

Chris was brought up in children's homes and still lives with the foster family he first went to when he was 16. He says he has had difficulty with ADD all his life. He also had a golden staph infection in his ankle in 2000 which has left him with chronic pain management issues.

Chris says that his offending has all been property related to fund his drug use. He has been in prison many times – probably more than ten times in Tasmania and once in Victoria. He participated in the CREDIT bail scheme in Victoria but did not participate in the treatment program, choosing instead to skip bail. He was later imprisoned for a substantial period. At this time he was also using heroin.

Chris believes he has been 'set up to fail' on his DTO. He understood that he would be referred for a psychiatric assessment for his ADD and would be able to participate in an ambulatory detox program once a proper diagnosis and treatment was put in place. He says "I've met my side of the bargain but they can't meet their side of it – they've let me down! I'm being set up to fail – my case manager told me as much yesterday".

Chris claims that his case manager has said that the psychiatrist won't see him for an assessment for ADD until he is drug free. Chris believes that he will suffer uncontrollable symptoms if he does attempt to go drug free and does not think he could do so anyway without detox support.

Chris feels that the Magistrate forced him to take on the DTO under false pretences. He says he agreed because he thought it would be good to finally get some help for his ADD. "They shouldn't have set up the program if they weren't ready – there's no ambulatory detox yet and that's not fair because I can't stop using speed without it". He also said "I have tried to do what they want but they aren't doing what they were meant to".

He says he knows he is going to fail on the DTO and feels aggrieved that the period of time he spent on remand will not count and that he'll end up doing a longer sentence – "I'll do 18 months – I know I will – and the six months I've already done wont count!".

Chris is intending to raise his concerns about the fairness of the DTO at this review with the Magistrate tomorrow.

Damian

Damian is a 24 year old male from the Huon Valley who moved to Devonport 10 years ago. He has been with his current partner and her two children from a

previous relationship for the last 2 years. He gets on well with the children and assists in general child caring arrangements. He has been on the Category 1 program, while on bail for the past 3 months. Prior to that Damian's drug use was 100 mgs of morphine per day and cannabis.

Damian's drug treatment program consists of a methadone program in tablet form which he takes in the presence of the pharmacist on Mondays, Wednesdays and Fridays, and on Fridays he is also given a take home tablet for Sunday. He receives weekly counselling sessions from Anglicare and is urine tested on a regular basis. He sees his probation officer case manager on a regular basis to report progress and to receive the results of his urine tests.

Damian had to attend Court twice to have the program set up. On the first occasion he was referred for assessment while on the second occasion, two months later, a CDO) provided the assessment to the Court. He understands that he is required to attend the Court again in one month's time. He is unsure how long the program will last or how he will be assessed as completing the program.

Damian admitted to still using a small amount of drugs on the weekends which he then quickly corrected to only using on the weekend that his take home methadone was stolen. He also still continues to use cannabis as a relaxant prior to sleeping as his doctor does not prescribe him any sleeping tablets. He said he thought he had decreased his methadone too rapidly down to 8 mgs and now intends to discuss with his doctor increasing the dose back up to 12 mgs.

He finds the counselling sessions with Anglicare to be "OK" with more counselling freely available if he requires it. He says he knows that "someone will see me if I need it".

Damian believes that his involvement in CMD has been successful in keeping him away from illicit drugs: "It's helping heaps". He is hopeful that his partner will also be able to go onto CMD which he thinks will be of further benefit to the whole family; although Damian says that his partner only smokes pot.

Damian does have some concerns about the level of urine testing and its intrusion into his daily activities. He says the urine testing is a "pain in the arse" and feels it's unfair that his two friends who are also on CMD know when their

urine tests will happen when he doesn't. By way of example, Damian said that he had a urine test performed today which he was only notified about this morning. He was told to report to the Devonport office in two hours (from his home in Ulverston). His probation officer case manager had to come to get him for the urine test as he was unable to be contacted by mobile phone. Damian said that he believes other participants on CMD are told what day of the week their urine test will be performed. He thinks that CMD would be improved by giving more notice when the urine tests will be performed, noting in particular that "my two mates on the program know when they are going to be tested and I should know as well".

Ruth

Ruth was interviewed while participating in The Bridge Program. She is 26 years old and has a daughter aged 6. She was upset during the interview as the previous evening her ex partner had told her he was not going to let her see her daughter while she is participating on The Bridge Program as it was too disruptive for the child. Ruth felt that this was unfair.

Ruth has been using cannabis since she was 13 and amphetamines since she was 16. She has never really had a real job (although she has occasionally done some casual cleaning work and worked in a shop for a while) and describes herself as being "the main dealer" in her home town prior to her involvement with CMD. However, despite some offending in the past, this is her first real involvement with the criminal justice system. She has never been in prison and never had a probation order; nor any drug treatment except for two previous detox experiences. This time she is facing charges for handling stolen property, drive whilst disqualified, possess and use an illicit substance etc. She expected to go to prison for the charges and knows that if she had gone to prison "it would have been a lot worse. I know that I would not have coped in jail".

Ruth commenced her involvement with CMD in October 2007 (some six months prior to her interview with the evaluator). She thinks she might be on the bail program but she is not sure. She has a review with her magistrate in two weeks time. Ruth describes herself as having been 'remanded in custody' to The Bridge program in October but that soon after she arrived she was kicked out – in fact, she says she was kicked out twice. On the first occasion, she was kicked out

after testing positive for drug use. She says that she was under the impression she was going to be sent to the detox unit down the road from The Bridge (she has been to this detox unit a couple of times before) and wasn't aware that she needed to be drug free. On the second occasion, she says she put two Serapax tablets that she had mistakenly brought in with her in the tampon disposal bin in the upstairs toilet at The Bridge (to get rid of them) which were then retrieved and used by another woman, who, when detected, told the staff that Ruth had supplied the drugs. After being thrown out on this occasion, she ended up being suicidal and being admitted to the Royal Hobart Hospital overnight. She then went to Serenity House on the north coast for a five to six week period (operated by City Mission) and detoxed there. She went back home for a couple of weeks at Christmas and admits that this led to relapse. She says she felt horrible; really disappointed with herself for using again – that she had undone all the good work she had done at Serenity House. She was allowed to re-enter the Bridge program after the other woman (who had taken the Serapax) left.

Ruth is enjoying The Bridge program and has just graduated from Stage 2. She says that this is the first time she has been completely drug free since she was pregnant seven years ago. She has been on the program for a little over 8 weeks and is working towards leaving the program in another month's time. She is feeling apprehensive about leaving – that it feels like home here now and "it's safe here". She had a weekend leave to go home recently and felt very anxious about being there. She knows people there will hassle her to sell drugs. She says she felt a huge sense of relief when she got back to The Bridge - That she was safe again and in control.

Ruth says the REBT (Rational Emotive Behaviour Therapy) they are doing now and the group program has really helped her – that she has been challenged in her thinking and learnt lots of things she didn't know about herself and drugs. She says there is one other woman on the program who has been really supportive. She is currently really looking forward to participating in a camp involving other residents and staff in the wilderness.

Given her negative experience in going home for a weekend, Ruth is now planning to transfer her public housing to another town so she can start afresh.

Her case manager is helping her to organise this. She has been meeting with her case manager once a week and feels she is getting good support from her.

Ruth knows that if she moves to Hobart she won't be able to easily share custody arrangements for her daughter with her ex partner (as she has until now). She thinks that as her daughter has just started school it would be too disruptive to move her. She also thinks it would be good to spend 12 months or so settling in to her new life. She accepts the fact that, at least for a while, she will only see her on some weekends and school holidays.

Ruth says that she is feeling much more positive about the future: "I want to make some real changes. I want to settle down and get a real job that isn't selling drugs".

Trevor

'Trevor' is a 38 year old male who has resided in the Hobart area his entire life, a proportion of which has been as a homeless youth. He has been in a relationship with his current partner for the last three years and together they care for one daughter. He has three additional children from previous relationships all of whom are now adults. His partner also has three children from previous relationships who are cared for by her extended family.

Trevor has had a significant amphetamine use for over 15 years. He attributed his most recent criminal charges of 1 x Assault Police, 2 x Breach Parole, 2 x Drive while disqualified, 6 x Drive while unlicensed, 1 x Aggravated burglary, 1 x Stealing, 1 x Drive unregistered motor vehicle and 1 x Drive without insurance, to his drug use. He stated that many of these offences occurred over a year ago, and that he was only charged when he was apprehended for the aggravated burglary offence and the outstanding warrants for the other offences were served on him. Trevor stated that he was sentenced to six months imprisonment three months ago and that he has three months left to complete the program. It was his understanding that if he remains drug and offence free until the completion of the program he will then receive a suspended sentence or probation.

Trevor stated that he has commenced the CMD program three times. On the first occasion in October 2007 he was on remand and heard about the program

from a fellow prisoner. He suggested to his lawyer that he should request the Magistrate that he be placed on the program. After his release from prison and placement on the program however, he was without accommodation and no beds were available through The Bridge program. He was also unable to contact his Anglicare counsellor who was unwell and away from work. His urine testing was positive for drugs and he was returned to prison.

Trevor's second CMD placement involved him being released from prison just prior to Christmas. He was unable to make appointments to see any of his support services. He committed further offences on 28 December 2007 and lost his place on the program.

His third start at the CMD program commenced on 3rd January 2008. He has been very happy with his support and progress to date. He sees his probation officer case manager on a weekly basis after which he has an appointment with the Anglicare Councillor. He is urine tested weekly on a Monday and has an additional random urine test every week. For the first month of the program the "random" test was conducted every Friday but he stated that this has now changed and is genuinely random. He stated that he is on the highest level of drug testing due to his history of drug use and offences.

He is required to attend Court on a fortnightly basis at which time his Anglicare Councillor, his Bridge program manager and his Probation and Parole case manager provide reports to the Court on his progress. He stated that he has been drug free since 3rd January and has not had a positive drug test in that time. He was very supportive of the program and believed it has given him the strategies to enable him to make significant changes to his life by giving up all drugs including alcohol and nicotine. He stated that for him, "the program has been a 100% success and I enjoy being straight instead of flying high". He also stated that he is now, "living in real man's land instead of being high as a kite. I am enjoying starting from scratch, setting up the house and looking after my daughter".

Trevor was complimentary of the staff providing support to him and said that he feels they are genuinely interested in him and have made him confident in himself. He believes the program provides all the support that he needs and as

unable to provide any suggestions for improvement. He finished the interview by commenting that he definitely gave the program the "thumbs up".