

Magistrates Early Referral Into Treatment

MERIT
Program
Evaluation
and
Monitoring
Framework

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1 MERIT Program Evaluation

1.1 Policy Framework

The measure of performance is a key element in the NSW Government's commitment to managing results in the public sector. A program's performance can be effectively measured and assessed by evaluation. The NSW Government recognises that many important social issues are more effectively addressed using a cross agency approach. A cross-agency program is one that involves more than one NSW government agency. Stakeholder agencies in the MERIT program - Attorney General's Department, NSW Health Department and NSW Police will therefore establish the agreed program goals and the steps required to achieve them.

A MERIT Program Evaluation and Monitoring Group has been formed to oversee the establishment of an evaluation and monitoring framework. The group consists of representatives of NSW Health, Police and Attorney General's Department.

Composition

The Evaluation Group is drawn from the MERIT Statewide Steering Committee and MERIT teams with the potential for expansion to include individuals or groups with specific expertise as required. The Evaluation Group will put its recommendations to the MERIT Forum and the MERIT Statewide Steering Group for endorsement.

Membership

The Evaluation Group contains representatives from the following organisations:

- Drug Programs Bureau, NSW Health – to undertake Chair and Secretariat roles
- NSW Health - MERIT Team representatives
- NSW Police
- Attorney General's Department (MERIT)

Meetings

The Group will meet as required (initially monthly) until the Monitoring and Evaluation Strategy is developed, and then quarterly or an ad hoc basis to monitor its progress.



1.2 Purpose of Program Evaluation and Monitoring

In the following table the aims of a comprehensive evaluation are listed along with the how these would be examined in a general sense for the MERIT program.

Evaluation Aims	General Indicators and Methods of Measurement
Assess the effectiveness of the program particularly within the terms of its original aims and objectives	Criminal justice and health outcomes.
Further specification of aims and objectives	Monitoring process to lead to establishment of performance benchmarks. Qualitative research to inform on other indicators not reliably quantified.
Refinement of program design and documentation	Monitoring process to lead to establishment of performance benchmarks. Qualitative research to inform on other indicators not readily quantified. Ongoing refinement of MERIT database.
Promotion of good practices in program implementation	Ongoing data collection. Qualitative research in different areas where the program shows significant differences.
Reduce variability in program delivery	Monitoring process to contrast differences between areas. Audit process involving annual onsite visits.
Examine resourcing planning and utilisation issues	Data collected on MERIT database. eg Caseworker/client ratios, treatment costs, demand modelling, quantitative monitoring.
Assess the impact of the program as it has worked in practice	Data analysis from MERIT database and other sources. Further qualitative research (eg case studies, participant interviews).
Monitor the development and progress of the program	Ongoing comprehensive data collection as recorded on MERIT database.
Identify problems and find possible solutions during the life of the program	All monitoring and added qualitative and quantitative research should provide data to identify and investigate problems
Provide evidence of the full range of program impacts, both intended and unintended	Criminal justice and health outcomes and process measures. Further research (eg economic indicators) to inform on unintended impacts.
Provide evidence for ongoing program management and decision making	MERIT database to provide quantitative data that has timely and direct data on program

These indicators and methods are examined in more detail in the body of the document.



1.3 Development of Evaluation and Monitoring Framework

Paramount for program evaluation is the process of identifying relevant and useful indicators to measure key result areas of process and outcomes. The MERIT Program Evaluation and Monitoring Group has identified health and criminal justice process and outcome indicators for measurement and aid in the development of benchmarks for program standards through continued monitoring of identified outputs.

While performance or measurement indicators may often be readily identified, the tools or data to measure them may vary greatly in validity and availability.

1.3.1 MERIT Database

A database has been especially developed for the MERIT program and this has, and continues to provide valuable data for measurement of the majority of process and outcome indicators as well as program inputs and outputs. A data dictionary was produced as part of the database development to provide a description of each item recorded. The database has provided a wealth of data on the program and allowed production of monitoring reports as well as fulfilling reporting requirements to the Commonwealth. A dump of program data for the period of program inception to early 2003 to allow whole of program analysis of data has enhanced the ability to analyse whole of program data. This has provided basis for an annual report and for early recidivism studies. Further developments to the database to be implemented in the second half of 2003 will make this process easier and facilitate whole of program analysis.

1.3.2 Data Quality

The quality of data will be affected by a number of factors. Important among these, due to the high number of collection sites, is the consistent recording of data. Training sessions have been held to promote consistency and to inform those entering the data to read and understand criminal record information.

How effectively the quantitative data measures relevant aspects of the program will be informed by ongoing analysis and monitoring of the collection method as well as contrasting this with other research data from various studies and external sources. Access to secondary data sources, for example, sentence outcomes and other criminal justice data, is also vital part of developing an evaluation framework. The development of other sources to capture criminal justice data at the initiative of the Attorney General's Department will relieve health workers of the need to record this data and improve the quality.



1.3.3 Data Availability

It should be recognised that all stakeholders in the MERIT program have a responsibility to ensure that there is provision for a program evaluation that includes measurement of the program's intended outcomes, such as health and criminal justice issues. In recognition it should be agreed that data collected, which is largely undertaken by health workers, be made available to other stakeholders with adequate individual privacy safeguards.

1.3.4 Lismore Evaluation

The evaluation of the trial MERIT program at Lismore has provided insights into potential areas for further research and has provided more information on the reliability and validity of some existing methods of data capture. However, this will not address all program evaluation requirements due largely to the greater scale and complexity of MERIT as a *statewide* program.

The Lismore evaluation had a number of components that included an implementation review with interviews with key stakeholders including participants. There was a three-point collection of certain data at program entry, exit and three to nine months after exit. This involved administration of some standardised health questionnaires that included some self-report crime questions.

The evaluation had included a recidivism study examining a defined period with a comparison group. This had some difficulty, as there have been problems with the process of BOCSAR tracing the offending patterns of program participants. The comparison group was eventually abandoned due to problems with suitability. An economic study was also undertaken that took the form of a cost-benefit analysis. This demonstrated significant cost benefits resulting from a number of factors including social and health costs.

The Lismore evaluation has highlighted some potential problems and this has already lead to the changes to the GLC (Local Courts database), detailed below, to overcome some of these.

Overall the Lismore evaluation has the potential to inform the overall evaluation and has been resourced to allow a greater depth of research into particular features of the program, for example a follow up study that would be unrealistically expensive to undertake at a State level.

1.4 Rollout of MERIT

MERIT commenced operation as a pilot project in the Northern Rivers Health Area in 2000. This was extended to Illawarra Health Area in February 2001. The program is now available in 100% and 95%



respectively of all finalised cases at local courts within these areas. As at 31 October 2003 the program was operating in 16 of the State's 17 Health Service areas, available in 50 local courts, which account for 59% of all finalised cases.¹ As the Statewide rollout continues however there will be consolidation and limited expansion during the remainder of the 2002/2003 financial year contingent on the final funding decision.

1.5 Document Structure

The current document provides a framework for the monitoring and evaluation of the MERIT program. The document is structured on the basis of the three main parts of the evaluation and monitoring process: monitoring, process (including inputs and outputs) and outcomes.

¹ Based on people appearing at NSW Local Courts for 2002 (BOCSAR)



2 Program Monitoring

2.1 Purpose of Monitoring Reports

Monitoring reports seek to convey timely and relevant data regarding certain indicators of the program's outputs. These will serve to highlight areas of difference in the program between different health areas as well as monitor critical indicators of the program's progress and structure. The ongoing monitoring of program as it becomes established will allow the establishment of benchmarks for the main indicators and will provide data to form Key Performance Indicators for program operation. The comparative process will need to take into account the differences between areas in terms of demand and drug related offending.

2.2 Indicators for Program Monitoring

The indicators listed at 2.3.1 are regularly reported and reflect program outputs. They provide quantitative measures of program performance. Differences between areas can be contrasted. Where area programs differ from the state as a whole may indicate areas where the program requires additional support. There can be a number of local factors that explain why particular areas show higher or lower rates of referrals, completion rates or failures to complete the program. This is similarly the case for varying representation and program completion of demographic groups. Monitoring these indicators and benchmarking them against other areas or the state as a whole can provide valuable information on relative program performance. For example are there barriers or practices at an area level that are tending to exclude certain groups from entering the program or completing it?

2.2.1 Referral Numbers and Rate

The number and rate of referrals are key indicators of demand for the program. Areas where there are particularly low numbers of referrals may indicate problems with the process. This could reflect on the level training or non-acceptance of the scheme by referral agencies within an area. Alternatively it may be a true reflection of low demand due to differing patterns of drug use and offending in different areas.

Where significant differences appear in the monitoring reports, further investigation may require a more qualitative approach involving in-depth interviews with the parties concerned, such as magistrates or police. This may shed light on attitudes, practices or resourcing issues that are producing a pattern of lower referral rates.



2.2.2 Source of Referrals

The source of referrals is a potentially important process indicator. The source of referral to the program can provide an indicator of the way the program is working within an area. Low rates of referral from a particular source, such as police, may indicate that further information or training is required to address this. Again, there may be local factors that account for this situation.

2.2.3 Acceptances into MERIT

As well as the acceptance rate, it is also important to monitor reasons for non-acceptance onto the program. This will highlight areas where resources or training are required to make the program more efficient. The proportion of acceptances and non-acceptances is monitored by health area and recorded in monthly and quarterly reports. At present there is no breakdown of these figures but reasons for non-acceptance are recorded in the MERIT database. The reasons could be aggregated by quarter in these reports. This could be an indicator of numbers of inappropriate referrals, if these numbers are not explained by other local considerations.

Further analysis of demographic characteristics, drug use and criminal history would provide a profile of people in the program. This could identify particular groups who are not gaining acceptance into the program as well as those that the program appears to be reaching. Topline demographic and behavioural indicators could be included in quarterly reports (as some are at present), however more in-depth analysis would more usefully be included in an annual report on the program.

2.2.4 Program Completion

The court sets criteria for program completion. Completion involves meeting the court criteria. This is in itself not an indicator that the longer-term problems of the program participant have been met. Program completion will provide a major process indicator. Other indicators, such as re-offending, ongoing treatment and other social functioning criteria, will inform the level of longer-term success of the program in terms of its aims.

2.2.5 Breaches

Criteria for breaches are to be established by the magistrates at each court operating the scheme (Practice Note No5). This would imply that there would be some variation between courts and possibly between health areas. Breaches are monitored as part of the standard reporting system. MERIT database items that relate to this are a "breach initiated by the



MERIT team” and “removed by court”. Significant variability in the relative proportion of breaches in each area could indicate operational program differences requiring further investigation. Higher rates of breaches may be the result of the nature of participants referred to the program in a particular area, for example differing criminal histories and/or levels of drug offending. They may also indicate significantly different practice in relation to breaches. The reasons for breaches are to be recorded in the final report of the MERIT team. Minor offences that are not actioned for breaching purposes are to also be recorded in the final report. These reports could be a data source for comparison of the breaching policies followed by each court and by each area. Further qualitative research could be undertaken if these reports provided inadequate data for informing why particular areas had significantly higher number of breaches.

2.2.6 Program Standards

As well as indicating area differences in the program, the monitoring process outlined can provide information on program quality and standards.

An audit process could check the practice followed by teams in each area. This quality assurance process could be carried out on a regular basis eg annually to ensure that similar standards in relation to good practice are being followed. Existing quality control frameworks for drug and alcohol services in health could be used to form a basis for a similar procedure in MERIT.

The process of referrals from the magistrate and the relationship between the MERIT team and the magistrate of the relevant Local Court is an area that could be examined by further by qualitative research methods. This is covered under criminal justice processes in Section 3.2 below.

2.2.7 Program Availability

The Attorney General’s Department is monitoring program availability. While it is important the program is operational in all areas, its reach within those areas is also significant. The table at Appendix 4 shows the extent of program availability at courts within the state, within each area and the percentage of people appearing in court within an area who appear in a court covered by the MERIT program. This monitoring can also provide a guide to potential demand for the program.

2.2.8 Data Issues

Data quality is an issue that requires frequent communication between sites and the MERIT database management officer to ensure consistent



practices in data recording. The MERIT database will remain the main source of data for reports and the basis of quantitative analysis of much of the program. More of these data issues are examined in greater detail below under separate subject headings.

2.3 Existing Monitoring Reports

At present monthly and quarterly reports are produced by the Drug Programs Bureau after individual sites have sent their data at the end of each month.

A system for the acquisition of unit record data for overall data analysis needs to be put in place. At present this has been done once. It is planned that will become a regular feature and for certain data. The MERIT Program Evaluation and Monitoring Group will need to establish systems for central data collection for all MERIT sites that would include a data dump from each area to allow greater depth of analysis.

2.3.1 Monthly Reports

Comparative statistics are currently collected and reported by each operational health area on a monthly basis. The aim of these reports is to show numbers entering and exiting the program in the period. The indicators are:

- ◆ Number referred for assessment
- ◆ Number partially assessed
- ◆ Number accepted
- ◆ Number ineligible, declined or did not appear
- ◆ Number breached, removed or withdrew voluntarily (these are now recorded individually)
- ◆ Number remaining on program
- ◆ Number completed program/court requirements

The monthly table provides an understanding of the cumulative numbers who have been involved in the program at the State and individual AHS level. From this it is possible to compare rates of referral acceptance and program completion rates. These comparisons must be treated with some caution. Programs in each area currently vary widely in terms of development stage and coverage. These comparisons also need to be viewed in relation to the nature of potential and actual referrals – these could differ widely in terms of their demographics, nature of offending, treatment history and extent of drug use.

2.3.2 Quarterly Reports

Quarterly monitoring reports show more detail and include some of those indicators mentioned above. For example source of referral, gender, Aboriginality, drug of choice, category of offence, number with



previous jail sentences, numbers receiving particular types of health services and court findings. Each health area reports on its MERIT program implementation. Each of the three central agencies Health, Police and Attorney General's contribute qualitative reports on a quarterly basis.

While these indicators are important in monitoring the program, the current format of the quarterly reports could be usefully changed to allow greater comparison and readability to better inform all those involved with the running of the program.

2.3.3 Annual Reports

An annual report has been produced for MERIT based on those exiting the program in 2002. This report has focussed on demographic and other characteristics of participants. In future reports, with the program established and running for a longer period it will be possible to examine differences between area programs. This has provided an opportunity to examine the relative program outcomes for women and ATSI participants for example.



3 Process Evaluation

3.1 Program Implementation

Implementation process measures in a program are those that are done, offered or created by the provider of services.

Some of the data, which will provide information on the implementation of the program, has already been identified above in the section on monitoring.

The rollout of the MERIT program is outlined above and is still in progress. There have been issues on a local basis that have affected the process. Some of these issues are reported in the quarterly and monthly reports where each area submit's a brief summary of program progress.

Successful implementation of the program requires the appropriate training and personnel. The uncertainty over continued funding has made recruitment of suitable staff more difficult. However the completion of the current negotiation of a new agreement between New South Wales and the Commonwealth under the Illicit Drug Diversion initiative for 2003-2007 should resolve that uncertainty.

Rollout within health areas has sometimes progressed slowly; this may be related to budgetary or staffing issues. Geography will play a part in rural areas where extending the program to smaller and more isolated courts may prove difficult especially where there are only small numbers appearing. As an example, in an area like Illawarra where MERIT has been operating since February 2001, the program has 95% coverage in terms of finalised cases in Local Courts. Extending it to Milton Local Court the only one where it is not operational is difficult and costly for reasons mentioned above. Other arrangements may have to be made for people in these areas to have access to the program. In Muswellbrook in the Hunter region, the local MERIT program is run by a well established NGO – the Upper Hunter Drug and Alcohol Service (UHDAS). This may become a means of delivering the program in areas where dedicated MERIT teams will be difficult and costly to establish and run. These issues are likely to be less important in urban areas.

The cross agency nature of MERIT involves Health Areas, Courts and Police Local Area Commands that have different geographical boundaries and this has potential to create confusion. How this may impact on the operation of the program may become more apparent when the program rolls out to further areas of Sydney.

Other specific local conditions affect the numbers eligible and the indicators used in the monitoring process. In South West Sydney the program opened in July 2001 and for the first nine months was restricted to residents of Cabramatta. Data from early indicators in this



area are not comparable with other health areas. These indicators may be affected by the concurrent operation of other diversion programs. In Northern Rivers and Illawarra MERIT operated alongside DOCTP which was a coercive diversion to treatment program that was eventually terminated. In South West Sydney MERIT operated alongside a Police Bail Scheme that diverted people directly into treatment.

Demand for the program varies according to local conditions. Where demand is high, local resourcing for the program will require different responses. For example Hunter Area Health Service region has a high number of referrals and has at times operated a waiting list. This will affect the reported indicators.

3.2 Process Indicators

Objective	Indicator	Possible Data Sources	Process Category / Section
Rehabilitation bed use	Bed occupancy rate for MERIT beds	Relevant NGOs Report	Program Implementation
Client health profile (drug use)	See Appendix 6 for list of indicators	MERIT Team	Health
Client demographic profile	Age, gender, ethnicity, income, education, living arrangements (Appendix 5)	MERIT Team	Demographic
Equity of access	Demographics of non-accepted	MERIT Team	Demographic
Unit client costs	Cost of treatments, caseworker hours, admin & running costs	MERIT Team (from budget info)	Inputs
Court coverage	% eligible for MERIT, % courts referring to MERIT	Attorney General's Department	Criminal Justice
Client criminal profile (criminal history)	Past convictions, served time, current charges	MERIT team/BOCSAR	Criminal Justice
Program Entry	No. Accepted Not Accepted Declined etc	MERIT Team	Program Implementation
Program Exit	No. breached completed removed etc	MERIT Team	Program Implementation
Active clients	no. current at start/accepted/transfers in	MERIT Team	Program Implementation
Source of referral	No. referred from each source	MERIT Team	Program Implementation
Appropriateness of referrals	Reason non-accepted	MERIT Team	Program Implementation



Length of stay on program	Average time in program	MERIT Team	Program Implementation
Sex	No. of each sex	MERIT Team	Demographic
Aboriginality	No. of Indigenous Non Indigenous	MERIT Team	Demographic
Drug of choice	Breakdown by principal drug of concern	MERIT Team	Health
Treatment attendance	Number of occasions of service	MERIT Team	Health
External Services Drug & Alcohol	No. of each service provided while on MERIT	MERIT Team	Health
External Services Non-Drug & Alcohol	No. of each service provided while on MERIT	MERIT Team	Health
Continued engagement in treatment	Continued after exit	MERIT Team	Health
Main Internal treatment by MERIT team	Main Internal treatment by MERIT team	MERIT Team	Health
Other Internal treatments by MERIT team	Other Internal treatments by MERIT team	MERIT Team	Health
No referrals from each court	No. cases at each court	MERIT Team/BOCSAR/GLC	Criminal Justice
Offence types	all offence types bailed to MERIT	MERIT Team/BOCSAR	Criminal Justice
Previous gaol sentences	No. gaoled not gaoled etc	MERIT Team/BOCSAR	Criminal Justice
Court activity	No. of adjournments	MERIT Team/GLC	Criminal Justice
Court Findings	No. guilty, not guilty etc	GLC/BOCSAR	Criminal Justice

3.3 Criminal Justice Process

3.3.1 Court Resources, Supervision and Referring Charges

Entry into the MERIT program is at the order of the magistrate following assessment by the MERIT team.

Data that can be captured under the existing structure of the MERIT database that relates directly to the criminal justice process by recording the number of appearances and number of adjournments for each case.

These variables – depending on the quality of data captured – could give an indication of the comparative resources of court time expended on MERIT participants, both completers and non-completers. This data, when analysed in conjunction with the outcomes of people participating



in the program and other qualitative measures may shed light on whether extra court resources have any effect on a successful outcome. For example, the level of court monitoring and supervision may be a significant predictor of outcome. In conjunction with this, the level of supervision and “gentle persuasion” of the caseworkers could also be significant. The number of appearances in court and/or the number of contacts with the also caseworker provide indicators. If these indicators show promise as possible predictors of positive outcomes, additional research would be required. Simply measuring number of appearances or mentions in court will not accurately measure the time spent or the qualitative nature of these interventions.

Analysis of main charges that resulted in referral to MERIT will provide further insights on program differences by area. The type of charges resulting in referral will add to the capacity to estimate demand for the program.

3.3.2 Magistrates

Procedures for magistrates to follow with regard to MERIT referrals are outlined in Local Court Practice Note No5. A summary of the process deliverables based on this note is listed at Appendix 7. The Practice Note emphasises the importance of the relationship between the magistrate and the MERIT Team Leader in ensuring the success of the process. This note places the onus on the MERIT Team to provide thorough assessments, appropriate treatment plans and detailed reports that allow the magistrate to make sound decisions in relation to case management. Thus, the process the magistrate is required to follow has specific deliverables, which are mostly documented as part of the MERIT caseworker’s management of each case. The assumption is if these deliverable requirements are followed the MERIT process will be successful. The deliverables are verifiable through a program audit process to ascertain that these steps are being carried out at each court and that reports and case management standards are to an accepted minimum. The practice note also stresses that the success of the working relationship between the magistrate and the MERIT is central to the success of the process. Further understanding of this relationship and its importance would require further qualitative research.

The Judicial Commission of NSW will complete a survey of magistrates to gain insights into their attitudes to drug diversion schemes in general but with particular reference to MERIT and to highlight issues that relate to the running and implementation of the program.

The process for construction of the survey involved consultation with of all stakeholders represented in the MERIT Statewide Reference Committee. The Attorney General’s Department has co-ordinated this process. The survey was discussed at the MERIT Forum in April 2003. Feedback since has informed the content of the survey. It is expected the findings will be published before the end of the calendar year 2003.



3.3.3 Police

The Police are a major stakeholder in MERIT both at an agency and operational level. Police conduct regular, ongoing internal monitoring activities that inform capacity building, education and training activities in regard to MERIT.

Should funds for evaluation become available, it would be desirable for a comprehensive evaluation to be undertaken that addresses police attitudes, perceptions and implementation of MERIT. Such an evaluation would allow more in-depth evaluation of potential factors affecting the process and outcomes of the program from a police perspective.

Evaluation of police involvement in MERIT would be undertaken with input from stakeholder agencies, under the auspices of the MERIT Statewide Reference Committee. The scope of the evaluation would be dependent on resources available. The evaluation would be directed at police in areas where MERIT is operational.

3.4 Health Process

3.4.1 Assessment process

The percentage of acceptances relative to referrals may vary for a number of reasons. Where there are significant differences the assessment process may need to be investigated. This would use quantitative data to look for measurable differences between areas eg is the source of referrals noticeably different? Is the volume of referrals and resourcing of caseworkers different between areas? Where necessary, additional qualitative research may be required to investigate these differences. The form of this would be dictated by the precise nature of the problems. An audit process that verified program standards on a regular basis could cover this.

3.4.2 Proportion continuing treatment post program

The MERIT program is a structured 12-week intervention. The program is designed and resourced to direct and engage clients in intensive short-term treatment. Direction into mainstream drug treatment services should be a part of the ongoing process of addressing the program participant's problem. While this is not a stated aim of the MERIT program it can be seen as an important process indicator of lasting effect of the diversion process. In this sense it is an indicator of the success of the program. Data on this is captured in the MERIT database.



3.4.3 Drug Use

Existing data capture on the MERIT database enables a useful picture to be built about participants' existing drug use. This includes drugs of concern including the principal drug of concern. The frequency of use of all substances that a client has mentioned are recorded on an ordinal scale down to less than once per month. Data is collected on injecting drug use on a less detailed ordinal scale indicating recency of this behaviour. Data is also collected on the method of use of all substances mentioned by the client or potential client and the pattern of use, for example binge use.

This data is self reported and this can cast doubt on its validity. Background research may confirm that self reported drug use tends to be accurate. There could be some validation of self reports by examining previous treatment information from health files, where possible, or by sampling some who are referred to or are participating in the program where their past and present drug use may be well documented and comparing this with self reports to caseworkers.

Overall the data collected and reported in the MERIT database is potentially rich in informing the pattern of people's drug use who are being referred to the program. Examining the pattern of drug use of referrals to MERIT can form part of an overall picture of the program especially when analysed with other data such as criminal history and demographic descriptors. This data can build part of an analysis that attempts to predict success in completing the program.

Ongoing monitoring will reveal the differing nature of drug use that is occurring within each health area in terms of the principal drugs of concern among referrals and participants.

A summary of data collected in the MERIT database on drug use is shown in Appendix 6 below.

3.4.4 Other Health and Psychological Characteristics

Information on the physical and mental health status of the MERIT client, and the severity of their drug dependence is collected as part of the pre and post program assessment of the client. (See 4.3 – Health Outcomes).

3.5 Demographic Descriptors

An important factor in evaluating the program is an understanding of the people the program is reaching and the people the program is not covering. What do the people being referred to MERIT look like in terms of age, gender, ethnicity, income, education and living circumstances? This should be measured both in terms of referrals and acceptances. Are there people with common characteristics who are being referred



to, but less likely to be accepted into the program? It is also important that MERIT participants are representative of people within the criminal justice system, particularly Aboriginal people and women for example. The comparative under-representation of particular groups can alert program managers to potential problems. These will vary by area as the demographics of particular areas vary throughout NSW.

The demographic descriptors of participants on the program can inform both process and outcomes for particular subgroups. If certain groups are under-represented this could be the result of the referral process within particular geographical areas. Given that MERIT was originally rolled out in a rural area, contrasting the process and outcomes with urban areas would also be a focus of future study. Of particular interest also is the representation of Aboriginal and Torres Strait Islanders in the program and their comparative outcomes.

Research may shed some light on predictors of successful outcomes for people with differing degrees of drug problems and criminal behaviour. For example: What previous treatment episodes have these people experienced? What has been the extent and pattern of these people's criminal behaviour? Are particular groups of participants showing greater success rates in completing the program?

This is addressed in more detail in other sections. Similarly health history such as the treatment modality that program participants have received in the past could be significant in terms of program completion. Some of this analysis is being undertaken as part of the 2002 Annual Report that has been produced by the Attorney General's Department.

3.5.1 Criminal History

Length and severity of criminal history has importance as a possible predictor of successful program completion. It also is significant in understanding the types of crimes that are bringing people into contact with the program. Differences in patterns of offences and the histories of referrals are a further factor to be considered when examining differences between areas. For example are there significant differences in offending histories between referrals in rural and urban areas? Does this explain differing rates of referrals, acceptances and rates of program completion between areas?

3.5.2 Data availability

The MERIT database contains an array of demographic variables that describe the characteristics of the person referred to the program in terms of age, gender, Aboriginality, education level. A summary of these descriptors is shown at Appendix 5 below. If data is collected



consistently and as thoroughly as possible, this will provide valuable information for overall program evaluation.

The criminal history of people referred or accepted into MERIT can be recorded on the MERIT database. These data items are shown at Appendix 3. This data may be indicative of recent history. Also recorded is if the referral or participant has served time in jail. This data source may provide part of the criminal history profile and also details about the charges that have brought the referral to MERIT. Other data sources, such as court records, police records and BOCSAR would be able to provide more detailed criminal histories or verification of MERIT data items.

3.6 Inputs

Inputs include anything that is required to carry out the program. This includes personnel, money, equipment, buildings time or any other resources required. Measurement of inputs would form the basis of an economic evaluation of the program. Inputs also inform the evaluation process insofar as identifying differences within and between areas. These inputs would be from all agencies that are involved in MERIT, such as police, judiciary and health.

Time spent on the program by participants as well as administrative and infrastructure costs are indicators of resources expended. Data collected on the MERIT database that indicates the number of appearances made by the person referred in courts (see Appendix 5) – can be an indicator of court resources expended. This item will be gathered from other sources as the amount of data collected on judicial items by MERIT teams decreases. However this in itself may not be an adequate measure of court resources as the time expended on each case will vary and it would not be entirely clear whether a matter was for mention only or dealt with at length.

In terms of the program there would be start up costs and ongoing costs. Included in the start up costs is the cost of recruiting new staff and any training required in order for staff to perform the duties required. Any purchase of equipment required and initial costs associated with buildings.

Inputs would include diverted resources. For example the use of workers normally employed fully on other projects or tasks. Even buildings or equipment provided free of charge would be regarded as having opportunity costs as these might have been employed elsewhere.

Infrastructural costs may include access to central information systems or access to other resources including implementation policy workers. These are essentially “sunk costs” however they still impact on the overall set up costs.



The evaluation and monitoring process of the program are also a cost. The establishment of data collection systems such as the MERIT database and the changes to the GLC for data capture of sentencing outcomes as well as any further research required to evaluate areas of the program not adequately addressed by standard data systems.

Large variations in the cost of inputs will result from the type of treatment given to different program participants. Costs of treatment are recorded on the MERIT database.

Standard measures for costing and the systems to record these would form the basis of an economic evaluation.

3.7 Outputs

Output measures are quantitative measures to describe how many people have used the program and have passed through it. The longer-term outcomes of a program are to a large extent the product of the outputs.

Measurement of outputs and how these can inform the process with consequent effect on outcomes are largely dealt with above in terms of ongoing monitoring reports of outputs as the program rolls out and develops.



4 Outcome Evaluation

4.1 Criminal Justice Outcomes

The intended criminal justice outcomes of the MERIT program have been expressed as:

- 1) Decreased drug-related crime by participating offenders for the duration of their program
- 2) Decreased drug-related crime by participating offenders following program completion
- 3) Reduced sentences due to better rehabilitation prospects.

4.1.1 Recidivism

A major outcome measurement for program evaluation is recidivism. This can be measured at various stages by examining offending before entering the program, while on the program and after completion. It can be measured by the time to first offence after exiting the program and also the frequency of offending. The incidence of offending while on the program may come to the attention of the MERIT caseworkers and would be recorded in the MERIT database. However, the primary role of MERIT caseworkers is to provide treatment.

While there is some research on the rate of offending on bail, this is influenced by a range of factors. Heale and Lang (2001) in the process evaluation of the CREDIT scheme in Victoria showed no difference between scheme participants and a comparable group who did not participate. Brown's (1998) study of re-offending rates shows that setting stricter bail conditions inevitably increases propensity to re-offend. Length of bail, age, criminal history and type of offence are also significant factors in likelihood to re-offend. Each of these studies used different comparison group methodologies. Finding a valid comparison group for MERIT participants is problematic and any decision about the benchmark for effective comparison of re-offending rates will need to be made after further discussion and background research.

The Lismore Pilot Evaluation abandoned a comparison group study, however the study's comparison in post program offending rates between program completers and non-completers may offer some evidence of the program's effect. An evaluation of the South East Queensland Drug Court (Makkai & Veraar 2003) used those who refused the program, a prisoner comparison group and completers and non-completers in comparative recidivism studies. All of these methods have validity problems however they still provide some comparative basis for measurement of the possible effects of the



program. It is likely that MERIT recidivism studies in the future will compare those who completed or did not complete the program.

A high incidence of offending on the program might highlight the issue of public safety. However one of the conditions of entry to the MERIT program is that those referred would have been released on bail even if they did not agree to undergo treatment for their drug problem. People charged with serious violent or sexual offences are not eligible for the program.

The situation for 2 above is also problematic. The expectation is that it would be possible to examine the criminal activity of former MERIT participants at, for example, six month, one year or two-year periods after completing the program. This could be done by using the Centralised Name Index (CNI) as the main identifier of the participants to examine the pattern of offending over a specific period. This method has been used and presents a relatively cost effective and unobtrusive method (i.e. does not involve contacting the former participant). This could also address the issue of back capture of re-offending data by previous participants as a separate project or to validate existing data capture.

This raises the problems of the reliability of using existing data sources to examine offending. Low clear up rates for offences such as break and enter mean that official measures could greatly underestimate re-offending. Another potential source of under-reporting is the recording of offences committed outside of NSW.

The privacy issue of NSW Health holding the criminal record data of those being assessed for the program may also be an issue. Even if the person referred to the scheme agrees to this data being released there is the question of "duress". That is they felt they should consent to release of this information rather than doing so freely. Area Health Services have been advised that the recommendation of the MERIT Statewide Steering Group and the Drug Programs Bureau is that criminal history information should be destroyed once a MERIT episode of treatment has been completed.

The data sources that could be used to capture this information are summarised below. A major concern here has been that criminal justice and law enforcement agency databases do not flag people referred to, or participating in, a MERIT based program. Changes made to the GLC system for flagging people referred to, and accepted into the program have been made and this is now flagged on police databases.

The BOCSAR Re-offenders Database has been built from all of Local and Higher Court records from 1995 to 2001 and includes data from the Department of Juvenile Justice covering records back to 1991. The database uses multiple methods of matching to overcome problems such as aliases multiple CNI's or birth dates. The database



can link court and criminal histories and has the potential to build a more complete criminal justice history.

As it is unlikely that names would be made available for a project such as this, a CNI will remain the basis of any check. The Lismore evaluation study will further inform this research as it used the BOCSAR ROD to examine re-offending rates with a comparison group. The flag on the GLC will provide another means of identification of MERIT participants and the ability to track them through the court system.

As mentioned above, a major limitation is that crimes that come to the attention of the police may represent a small percentage of the offending committed by program participants and program completers. On this basis a stand-alone project which sought to interview previous MERIT participants and obtain self-reported instances of their criminal offending at various stages after completion of the program would be an alternative method. A project such as this would involve re-contacting past participants at particular time periods after program completion and conducting interviews where they were asked to self-report on their offending. This would be problematic insofar as contacting previous participants willing to be interviewed and would require further refinement and costing. The validity of data would need to be informed by further research.

4.1.2 Sentence outcomes

The positive effect of program completion on sentence outcomes is a key result area of the program. Given the voluntary nature of the program, magistrates are directed to regard program completion as a favourable factor in sentencing with the implication that this will lead to reduced sentences for these people. Those who have failed to complete the program should not have this adversely affect their sentence outcome. Thus it would be informative to know if those who have completed do in fact tend to attract lesser sentences compared with people who have 1) entered the program and failed to complete it and 2) those sentenced on similar offences who have not taken part in the program. It would also be of interest to examine whether those entering and failing the program attract sentence outcomes worse than that of those who never entered the program. This presents difficulties with measurement as sentencing involves a range of factors often relating solely to the person being sentenced.

The problems lie in the areas of finding an adequate comparison group (essentially some form of sentencing benchmark) and problems with collection of data to inform these questions.



4.1.3 Data Issues

The court findings recorded on MERIT quarterly monitoring reports show a very high “Not known” count for those who did not complete the program. This adds further to the argument that better communication of court outcomes was required or external sources needed to provide better information. Previously, efforts were made to ensure that relevant outcomes were copied by court staff for distribution to MERIT caseworkers to record court outcomes.

Enhancements to the GLC have been completed to flag people referred to MERIT for assessment and acceptance on the program, which would allow sentence data for MERIT participants to eventually be sent directly to BOCSAR along with other court data for analysis. There are also potential problems with GLC database design to ensure that this is recorded properly. Not all courts in NSW are covered by the GLC, approximately 56 of over 150 local courts although this accounts for well over 80% of cases. It is anticipated that GLC coverage will capture the vast majority of MERIT referrals. The flag has been operational since December 2002 and now appears to be identifying a large number of MERIT participants. MERIT teams will no longer need to capture court findings.

The sentence outcomes would require some basis for comparison, for example a sample of non-MERIT participants who would be eligible and/or suitable for the program. This (as in the Lismore evaluation) could be from an area where the program was not available. Use of comparison groups of this type is even more difficult as the program has expanded. The alternative maybe to benchmark against the average sentences for similar types of crimes or sentencing guidelines or other populations such as total MERIT referrals, total court population, prison population, Drug Court participants and/or other treatment populations.

A method used in the Lismore evaluation was to use a magistrate to review MERIT case notes and to pass a sentence on this basis. This offers a solution of sorts but has problems of potential bias.

4.2 Health Outcomes

A major stated health outcome for the program is the improved health and social functioning for the duration of the program and in the post program period. NSW Health will determine those areas of significance for program evaluation from a health outcomes perspective. So far those areas indicated for evaluation of the MERIT program are:

- ◆ Drug use - reduction
- ◆ Physical health - improvement
- ◆ Psychological health – improvement in psychological adjustment
- ◆ Social functioning – eg employment, social stability



- ◆ Risk behaviour – reduction in these behaviours (eg needle sharing)

4.2.1 Measurement of Health Outcomes

Measurement of health outcomes will rely on the application of selected existing measurement techniques already employed by NSW Health. A pre and post program interview using these techniques will give information on the immediate effects of the program on those measurements.

A number of standard assessment tools have been compiled into a pre and post program questionnaire, which has been trialled at two Area Health Service MERIT sites for six months. These have now been implemented at all sites. They may be subject to some modification after a six month implementation at all sites.

The adoption of these measures and their implementation have been geared to encouraging the use of a standard set of assessment instruments for MERIT. They are designed to produce useable measures and results that will be of value to the caseworker as well as providing a base for a health outcome evaluation.

The pre and post program questionnaires can be found at Appendix 9. Some notes on how these are to be administered are found at Appendix 10.

Criteria used for selecting assessment tools that can also be used for evaluation were:

- Must be relevant to the client (useful for case planning)
- Time effective – short time to administer
- Outcome focussed
- Consideration must be given to cost of instrument and availability
- Must be able to be administered by MERIT staff and interpreted (Who can administer? Training availability?)
- Valid for purpose intended
- Consideration must be given to the definition, collection, reporting and analysis of data
- Tools must have been tested for validity and reliability
- Must be able to be administered within MERIT time frames (eg 12 weeks but also consider early exiters)
- Consistent with other relevant/similar programs statewide/national

Based on these criteria, tools used for measurement are:



Objectives	Indicator	Possible Data Sources
♦ Drug use - reduction	-Self reported drug use	- SDS - MDS items measuring drug use
Reduction in drug-related risk behaviours	- Needle Sharing	- Brief Treatment Outcome Measure, questions 13-17
Improvement in social functioning/social stability/employment	- Source of income - Accommodation – Social functioning	- SF 36 - MDS items measuring social functioning
Improvement in physical health	- Self reported health status	- SF 36
Improvement in psychological adjustment	- Mental Health score	- Kessler 10

4.2.2 MERIT Program Health Outcome Evaluation Strategy

The MERIT Outcome Evaluation strategy was initiated at the first MERIT Forum in response to a need identified by senior members of the Drug Programs Bureau.

Managers at the MERIT Forum and the MERIT Evaluation Group endorsed the design of the outcome evaluation. The first stage of the evaluation is a pilot at two sites, Northern Rivers AHS and Illawarra AHS, commencing March and May 2003 respectively.

The design of the outcome evaluation incorporates many elements of the Brief Treatment Outcome Measure (BTOM) which is the main drug and alcohol outcome measure adopted by the NSW Department of Health. Outcome measures also include the Kessler-10 and the SF-36. The questionnaire is given to all clients at program entry, as part of the assessment protocol, and again at program exit. Changes in scores on these measures will give an indication of the success or otherwise of the MERIT program in meeting its aims and objectives. A brief client satisfaction questionnaire is also administered at program exit. These questionnaires are not intended to be used in a follow up study.

It is acknowledged that there may be difficulties interviewing clients who are breached or who otherwise do not complete the program. The purpose of the pilot is to find out what difficulties there are in implementing the procedures and propose solutions.

The design of an outcome strategy for health related indicators has involved selection of the most appropriate instruments and



endorsement by MERIT Managers and DPB; modifications to the MERIT database; the design of the pre and post interviews; the incorporation of test results into the assessment and casework process; briefing of caseworkers in administration of the interviews. The DPB has purchased the rights to use the SF-36 for the evaluation. An example of the output available to individual caseworkers, detailing the test scores, is shown at Annex 2.

Conclusions from a pilot implementation of the BTOM conducted by National Drug and Alcohol Research Council were:

- The introduction of a monitoring system must be preceded by consultation, training and piloting
- Duplication of data collection is a major cause of staff discontent
- The objective of the data collection must be clearly spelt out.
- Both the process of data collection and the data, itself must be clinically useful
- Every attempt must be made to integrate data collection into routine clinical practice
- Feedback must be provided to clinicians in a timely fashion
- How a clinician views the process will colour the client's view
- The findings must be put to practical use

All of these considerations have been addressed in the design of the MERIT outcome measure.

4.2.3 Treatment modalities

The comparative success of different treatment modalities in terms of health outcomes is another area for potential research. Are we seeing greater success in terms of improved health (and criminal outcomes- if this can be shown) for particular types of treatments? Are there noticeably more successful treatment methods for those presenting with particular drug problems?

This may be outside the scope of the program evaluation and may be the subject of research by other agencies. It would be useful to analyse existing data in order to investigate whether any useful conclusions can be made about further research in this regard.



5 Economic Evaluation

5.1 Scope of Economic Evaluation

An economic evaluation of the program involves some of the problems inherent in the measurement of outcomes. Inputs, which deal largely with the process, are discussed above. They would form the cost of program delivery. Essentially economic evaluation would seek to answer whether the outcome of a program, which diverts drug-related offenders into treatment programs, offers economic benefits to the community in terms of reduced crime and the improved health and social functioning. This compared with the costs of the status quo where there was no diversion option for eligible offenders. Much of the true cost of the program would be informed by the outcomes. For example if the program did have an effect of reducing offending both on and after participants had completed it, the overall economic impact requires the reduced cost of lower offending be taken into account. Similarly, if the outcome of addressing the participants' drug taking were improved social stability and social functioning leading to employment and consequently reduced welfare costs, this would also be a significant economic impact of the program.

The complex nature of the questions and the problems of comparison are discussed in other parts of the document. For example there are problems measuring the extent of offending on or after the program and this will complicate measurement of the economic impact of the program in terms of savings through crime reduction.

A cost benefit analysis was undertaken as part of the Lismore evaluation and provided an assessment of the cost savings of diversion into treatment. A cost effectiveness analysis would concentrate more on the process of service delivery. As area programs become more established it may be necessary to examine the comparative cost of delivering services.

5.2 Economic Evaluation of MERIT

A full economic evaluation of the MERIT program is probably not possible within existing resources. The Lismore study includes an economic evaluation and the results from this may indicate possible areas for future research. Evaluation in this area will be driven by the needs expressed by stakeholders.

Information collected on the MERIT database has the potential to derive cost-per-client measures and this can give indications of overall program costs. The costs of program delivery will be a part of the monitoring process and may become part of the Key Performance Indicators informed by this process. This process also has the potential to inform comparative costs between regions – rural and urban.



6 Additional Research

As mentioned frequently above, there will be a need for qualitative projects to be undertaken as part of the evaluation to gain insights on the program. These could be in the form of ad hoc surveys of police, magistrates or MERIT caseworkers to gain insights into practices and attitudes that inform differences between areas and form part of the overall picture of the process of the program. Some of these possibilities are highlighted above. There is also the option of individual case studies to highlight the experiences of MERIT clients and the particular problems they may have experienced with the program. This has the potential to provide additional insights into the MERIT process.

Resources for research and evaluation are always limited. The use of outside agencies and parties to undertake research that cannot be undertaken as part of the program evaluation process would be a useful way to gain greater insights on the process and performance of MERIT. The process for this research would have to follow privacy and ethics guidelines. Each area health service has an ethics committee to approve research projects and this would need to address the use of appropriate ownership and use of program data.

6.1 Participant satisfaction

The issue of participants' attitudes to the program would be a necessary part of any evaluation. The question here is to what depth this would need to be measured.

For monitoring purposes this could take the form of a customer satisfaction questionnaire. This would allow for simple indicators to be measured and could also involve a large sample of these participants. Such a method has the disadvantage of being a fairly crude measure of people's attitudes and the way in which it is administered could lead to inadequate measurement. The addition of open ended or the use of partial open-ended questions allows a relatively useful method of gathering qualitative feedback. A survey such as this can serve to highlight areas where participants feel the program was particularly strong or weak. Research of this kind would tend to focus on the process of the MERIT program, as the form of treatment they have undertaken will be different according to their particular need. Participant feedback would be necessary on the treatment phase of the program. It is expected that those programs already have some form of participant satisfaction measurement. Additionally, the post program questionnaire (Appendix 9b) contains a client satisfaction survey, which will allow statewide client satisfaction with the MERIT program to be monitored.

Alternatives may be a follow up study involving in-depth interviews or focus groups. This could inform about both outcomes and process.



These methods have the advantage of drawing out further thoughts through a longer process of discussion and interaction with peers or an interviewer. The problems could be the difficulty of re-contacting former participants and the privacy considerations in doing so. There could be issues of validity as those that are ready to participate in post program surveys may not be representative of program participants as a whole. Such considerations do not disqualify this method as a means of research.

At present, some areas do conduct forms of participant satisfaction questionnaires. There is a need to standardise at least part of this among all areas to gain some comparable measure. The client (health) outcomes study at present being piloted in Northern Rivers and Illawarra includes a short client satisfaction questionnaire (see Appendix 9b) and this provides a core set of questions to obtain program wide data. There is the option for various health area teams to add further to these core set.

6.2 Case Studies

Case studies are a potentially valuable source of qualitative information about the program. These are produced at present and included in area monthly reports on an ad hoc basis. There will be a benchmark established for production of these and what minimum information they should contain.

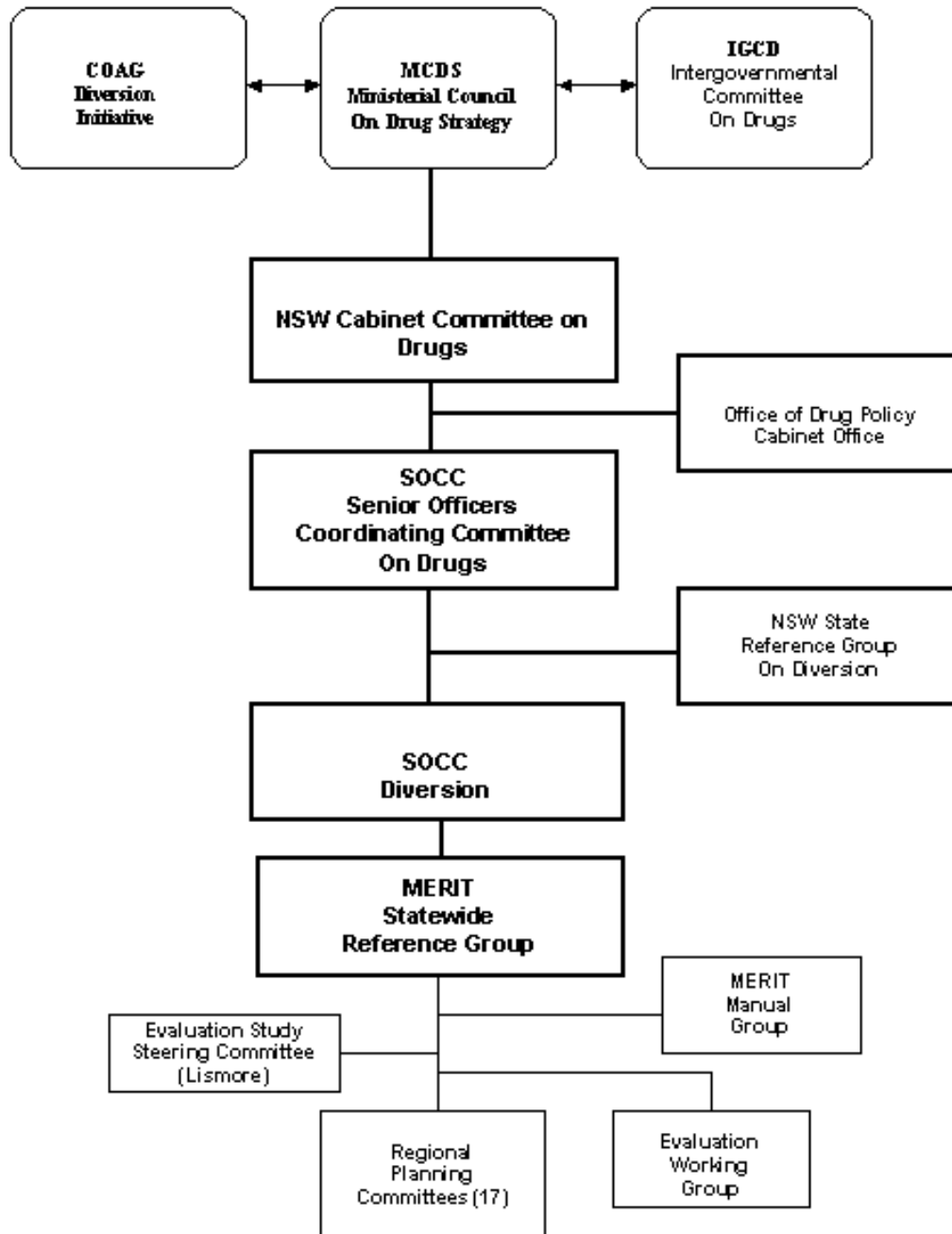
At present there appears to be a bias in collection of these towards program successes and more balance is required. Ongoing collection will build up a larger number and a summary report can be produced.



Appendices



Appendix 1 – Committee Structure Overseeing Drug Diversion Programs in NSW





Appendix 2 – Comparative Indicators for Operational Sites

Area Health Service	Number Referred for Assessment	Number Partially Assessed	Number Ineligible, Declined or Did Not Appear	Number Accepted into MERIT	Number Breached, Removed or Withdrew Voluntarily	Number Remaining on Program	Number Completed Program/ Court Requirements	Date Commenced Operation	% of Referrals Accepted	% Who Completed Program/ Court Requirements Successfully	No of Referrals per Month
Central Coast AHS	167	9	49	109	35	29	45	20/05/02	65.3%	56.3%	15
Central Sydney	64	10	21	33	1	31	1	20/01/03	51.6%	50.0%	19
Greater Murray AHS	78	2	32	44	16	15	13	06/05/02	56.4%	44.8%	7
Hunter AHS	306	24	120	162	79	29	54	01/02/02	52.9%	40.6%	20
Illawarra AHS	529	9	163	357	159	40	158	09/01/01	67.5%	49.8%	19
Macquarie AHS*	44	3	19	22	12	3	7	30/05/02	50.0%	36.8%	4
Mid North Coast AHS	107	9	29	69	21	18	30	15/07/02	64.5%	58.8%	11
Mid West AHS	120	12	61	47	10	12	25	01/01/02	39.2%	71.4%	7
New England	20	4	6	10	0	10	0	09/12/02	50.0%	0.0%	4
Northern Rivers AHS	581	1	150	430	190	46	194	01/07/00	74.0%	50.5%	17
North Sydney AHS	70	3	20	47	8	17	22	01/08/02	67.1%	73.3%	8
South East Sydney AHS	64	13	19	32	8	21	3	25/11/02	50.0%	27.3%	12
South West Sydney AHS	307	4	146	157	61	12	84	01/07/01	51.1%	57.9%	14
Southern AHS	38	0	11	27	7	5	15	02/09/02	71.1%	68.2%	5
Wentworth AHS	29	4	12	13	0	12	1	06/01/03	44.8%	100.0%	8
Western Sydney AHS	60	4	29	27	7	16	4	27/11/02	45.0%	36.4%	12
Total	2584	111	887	1586	614	316	656		61.4%	51.7%	

* Excludes Wellington Options

Completion rate = Number completed/(Number accepted - Number remaining on program)

Prepared by Brett Furby, Crime Prevention Division, Attorney General's Department



Appendix 3 – MERIT Database Criminal Justice Variables

Descriptor	MERIT Database Variables	Description
Court and sentence outcomes	Court Location Current Court Orders Date of Court Appearances Finding Of Court Date of Finding of Court Date of Initial Court Appearance Date of Program Entry By Court Notes (Court Appearances) Report Type (Court Appearances) Notes (Sentence Outcomes)	Three digit identifier of court where MERIT charges heard Numeric coding of existing court orders Guilty, Not Guilty
Criminal History	Date of Last Conviction Date of Most Serious Charge Date of Most Serious Offence Past Convictions – Number Periodic Detention (Y/N) Served Time in Gaol	Date of last conviction before MERIT charges
Current charges	Charge Type Drug Quantity for Drug-Related Charge Drug Type Relating to Drug-Related Charge Postcode of Most Serious Offence Suburb of Most Serious Charge Client Final Plea	Two digit code as used by BOCSAR Ordinal scale from small qty to supply large commercial Drug type
Referral to MERIT	Source of Referral Date of Referral to MERIT	
Identifiers	CNI (Police) Svc ID-MIN (Probation/Parole)	Police identifier collected on all program referrals Probation and parole identifier



Appendix 4 – MERIT Coverage By Health Area

Court Coverage by NSW Health Area

Area Health Service	No of courts in Area	No of courts covered by MERIT	% of finalised cases in courts covered by MERIT
Northern Rivers	10	10	100%
Illawarra	6	5	95%
South West Sydney	8	3	58%
Mid West	14	6	66%
Hunter	11	6	73%
Greater Murray	21	2	26%
Macquarie	10	1	49%
Central Coast	3	2	91%
Mid North Coast	9	3	36%
North Sydney	4	3	86%
South East Sydney	4	2	39%
Wentworth	3	2	85%
Southern	12	1	23%
New England	15	1	28%
Central Sydney*	5	2	58%
Western Sydney	2	1	52%
Far West	9	-	-
New South Wales	146	50	59%

Figures are based on numbers of finalised cases in court calendar year 2002.

Percentages represent the percentage of all cases that were concluded in local courts covered by the MERIT program.

Coverage is based on that existing at 31 October 2003

*Excludes St James Court



Appendix 5 – MERIT Database Demographic Descriptors

Descriptor	MERIT Database
Age	<i>Date of birth</i> (a field exists where DOB is estimated if not known)
Gender	Sex
Marital status	Single/Married/De facto/Separated/Divorced/Not Stated
Number of children	Number of children living with client (includes partner's children)
Number of dependents	Children and other dependents that may or may not live with client
Others living with	Number of others living with client
Aboriginal or Torres Strait Islander	Aboriginal but not TI origin/TI but not Aboriginal origin/Aboriginal and TI origin/Neither Aboriginal or TI origin/not stated
NESB	<i>Country of birth</i> <i>Preferred language</i>
Nationality/ ethnicity	<i>Country of birth</i> <i>Preferred language</i>
Education level	<i>Highest level of education</i> – Year 10 or less/Year 11 or less/TAFE or trade/tertiary/inadequately described
Employment status	<i>Principal source of income</i> – Full time/part time/temporary benefit (eg unemployment)/pension/student allowance/dependent on others/retirement fund/no income/other/not stated
Place of residence	Suburb, postcode of residence
Living circumstances	<i>Usual accommodation</i> – Rent/own/boarding house/hostel or supported acc. Services/psychiatric hospital/alcohol or other drug treatment residence/shelter or refuge/prison or detention centre/caravan on serviced site/no usual residence or homeless/other/not known <i>Living arrangement</i> – alone/spouse or partner/alone with child(ren)/spouse or partner and child(ren)/parent(s)/other relative(s)/friend(s)/friend(s)&parent(s)&relative(s)&child(ren)/other/ not known
Identifiers	CNI, Medicare number/Probation and Parole number/MERIT establishment ID



Appendix 6 – MERIT Database Drug Use Descriptors

Descriptor	MERIT Database
<i>Drug of Concern</i>	Whether the substance is of concern to a MERIT client
<i>Frequency of Use</i>	Of all mentioned substances - < 1 time per month/monthly/ < 4 times a month/weekly/daily/not known or inadequately described
<i>Injecting Drug Use</i>	Last injected in the previous 3 months/ Last injected more than 3 months ago but within last 12 months/ Last injected 12 or more months ago/never injected/not stated
<i>Length of Use</i>	Of all mentioned substances – no. of years used
<i>Method of Use for Principal Drug of Concern</i>	Ingest/smoke/inject/sniff (powder)/inhale (vapour)/other/not stated
<i>Pattern of Use</i>	Of all mentioned substances – Binge use/recreational/uncontrollable/not stated
<i>Principal Drug of Concern</i>	



Appendix 7 – Summary of Process Deliverables for Magistrates

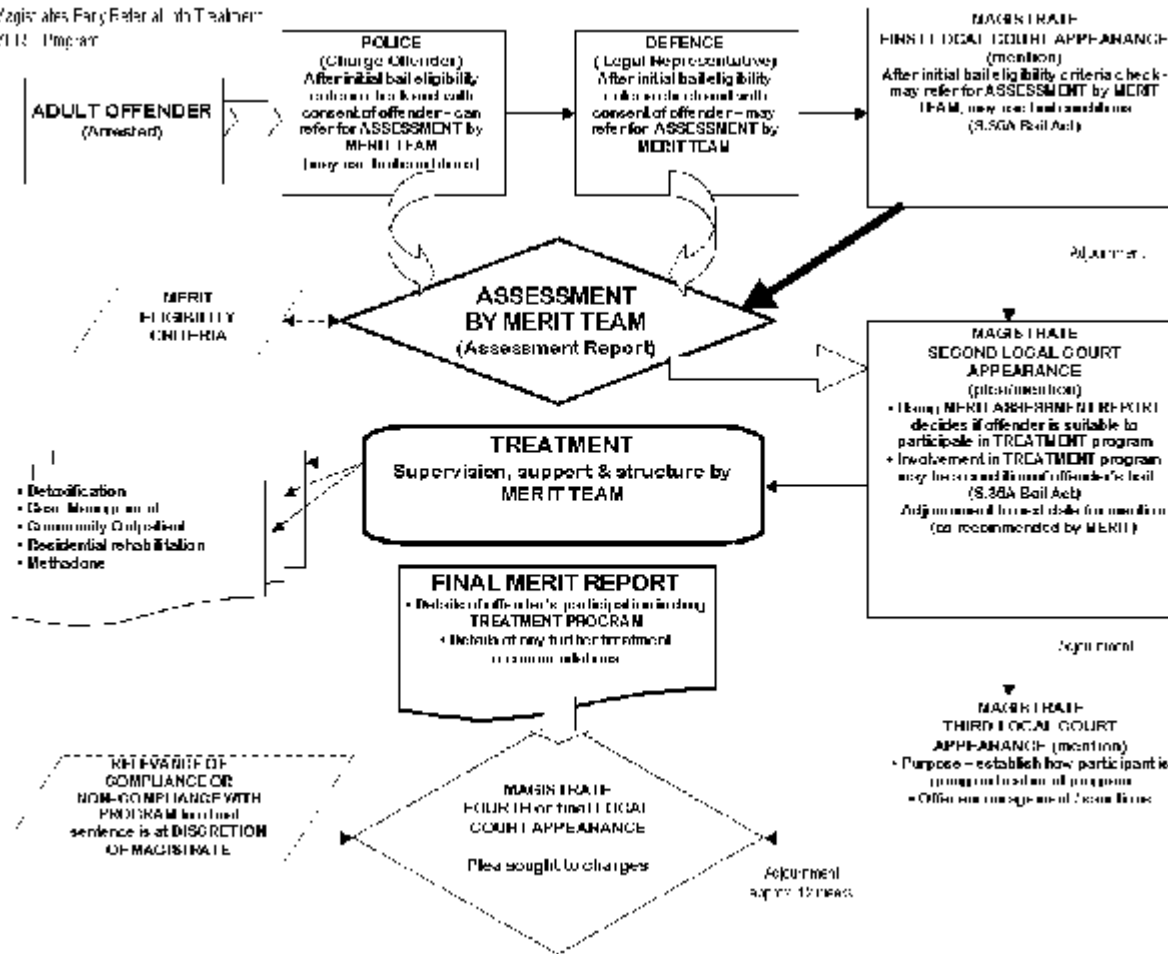
- Client must meet the eligibility criteria
- A thorough assessment is to be conducted including
 - Nature of drug use
 - Other associated problems
 - Identification of needs, risks, long and short-term goals
- An appropriate initial treatment plan is to be prepared
- A detailed initial report is supplied to the court
- An intensive program is provided, based on the initial treatment plan
- The program is to be generally of 12 weeks duration
- Extension of the program for longer than 12 weeks is to be with the agreement of Magistrate, caseworker and client
- The caseworker is to oversee provision of appropriate treatment services, e.g.
 - Detoxification
 - Methadone
 - Residential rehab
 - Individual/group counselling
 - Psychiatric treatment
- An updated report to be provided at each adjournment hearing
- Client is required to attend adjournment hearings unless excused by the Court with concurrence of the MERIT team
- A final report is to be provided at program conclusion which sets out achievements or otherwise
- Breach action is to be initiated if continued non-compliance
- Major breaches (e.g. major further offences; failure to comply) are to be notified to the Court as soon as possible and the client suspended from the program
- Minor breaches are to be referenced in the interim or final Court report
- Breaches involving a significant threat to the community or the offender to be reported as a matter of urgency
- Final sentence is to be recorded by the MERIT team



MERIT Evaluation Framework

Appendix 8 - MERIT Process

Magistrates Party Federal Youth Treatment
VIR Program





Appendix 9a – Health Outcome Measures – Program Entry

**MERIT PROGRAM
HEALTH-RELATED OUTCOME INDICATORS**

PROGRAM ENTRY VERSION

1. Drug use
2. The Severity of Dependence Scale
3. Extent of Recent Drug Use
4. Risk behaviour
5. Psychological adjustment: Kessler-10
6. Physical/Social/Emotional Functioning: SF-36 (version 1)



1. Drug use

In this section you will be asked about your use of drugs and alcohol in the **last 3 months**. This does not include methadone maintenance treatment, but may include “street methadone” or “diverted doses”.

1. What drug is causing you the greatest concern?

Please specify (only one drug or alcohol) _____

2. How do/did you usually take this drug?

- | | | |
|------------------------------|--------------------------|---|
| Ingest (eat, drink, swallow) | <input type="checkbox"/> | 1 |
| Smoke | <input type="checkbox"/> | 2 |
| Inject | <input type="checkbox"/> | 3 |
| Sniff (powder) | <input type="checkbox"/> | 4 |
| Inhale (vapour) | <input type="checkbox"/> | 5 |
| Other | <input type="checkbox"/> | 6 |

3. What other drugs or alcohol have caused you concern over the last 3 months?

Please specify (one or more drugs, up to a maximum of 3)

1. _____
2. _____
3. _____

2. The Severity of Dependence Scale (SDS)

These five questions ask about how you have been thinking and feeling about your main problem drug in the **last 3 months**, even if you have not been using:

- (a) Over the last 3 months did you ever think your use of this drug was out of control?

- | | |
|-----------------------|---|
| Never or almost never | 0 |
| Sometimes | 1 |
| Often | 2 |



Always or nearly always 3

(b) Did the prospect of missing this drug make you very anxious or worried?

Never or almost never	0
Sometimes	1
Often	2
Always or nearly always	3

(c) Did you worry about your use of this drug?

Not at all	0
A little	1
Quite a lot	2
A great deal	3

(d) Do you wish you could stop?

Never or almost never	0
Sometimes	1
Often	2
Always or nearly always	3

(e) How difficult would you find it to stop or go without?

Not difficult	0
Quite difficult	1
Very difficult	2
Impossible	3

Scoring: each of the five items is scored on a four point scale from 0-3. Addition of the five items produces a total score with higher scores indicating a higher level of dependence.

SDS SCORE = /15

Extent of Recent Drug Use

The next seven questions are about the drugs and alcohol you have taken in the **last month (that is, the last 30 days)**. Please refer to “Chart 1”.

1. (a) How many days in the last month did you drink **alcohol**? (beer, wine, spirits)

Please specify _____ days



- (b) On average, how many standard drinks did you have on those days when you were drinking? (please refer to standard drinks chart)

Please specify _____ drinks

2. (a) How many days in the last month did you use **heroin** or another opioid-based drug?

That is, morphine, pethidine, codeine or street methadone (not including legally obtained methadone).

Please specify _____ days

- (c) On average, how many (hits/pills/smokes/oral street (diverted) **methadone** – *circle whichever appropriate*) did you have on those days when you used opioid-based drug?

Please specify _____ hits/pills/smokes/oral
Street Methadone

3. (a) How many days in the last month did you use **cannabis** (marijuana, dope, grass, hash, pot)?

Please specify _____ days

- (d) On average, how many (cones/joints – *circle whichever is appropriate*) did you have on those days when you used cannabis?

Please specify _____ cones/joints

4. (a) How many days in the last month did you use **cocaine** (coke)?

Please specify _____ days

- (e) On average how many (hits/snorts/pipes – *circle whichever is appropriate*) did you have on those days when you used cocaine?

Please specify _____ hits/snorts/pipes

5. (a) How many days in the last month did you use **amphetamines** (speed, wiz, go-ee, ice)?

Please specify _____ days

- (f) On average, how many (pills/snorts/hits/pipes – *circle whichever is appropriate*) did you have on those days when you did use amphetamines?

Please specify _____ pills/snorts/hits/pipes



6. (a) How many days in the last month did you use **traquilisers** (benzos, valium, rohypnol)?

Please specify _____ days

- (g) How many (pills/hits – *circle whichever is appropriate*) did you have on those days when you did use tranquilisers?

Please specify _____ pills/hits

7. (a) How many days in the last month did you use **tobacco** (cigarettes, cigars, pipe tobacco)?

Please specify _____ days

- (h) How many (cigarettes/cigars/pipes – *circle whichever is appropriate*) did you have on those days when you did use tobacco?

Please specify _____ cigarettes/cigars/pipes

6.2.1.1 Total types of drugs: Total out of 7: _____

Occasions of Use: Sum of (a) x (b) , questions 1 - 7:

4. Risk Behaviour

The Blood Borne Virus Risk Scale gives an indication of the extent the client puts themselves at risk of contracting or transmitting blood borne viruses.

1. Did you last inject/hit up any drug

- | | | | |
|-------------------------|--------------------------|---|--------------------------|
| In the last 3 months | <input type="checkbox"/> | 1 | |
| 3 to 12 months ago | <input type="checkbox"/> | 2 | Go to Section 5 . |
| More than 12 months ago | <input type="checkbox"/> | 3 | Go to Section 5 |
| Never injected | <input type="checkbox"/> | 4 | Go to Section 5 |

2. How many times in the last 3 months did you use a needle and syringe after someone else had already used it (including your sex partner and even if it was cleaned)?



- More than 10 times 1
- 6 to 10 times 2
- 3 to 5 times 3
- Twice 4
- Once 5
- Never 6

3. How many times in the last 3 months did you pass on a needle and syringe to someone else after you had used it?

- More than 10 times 1
- 6 to 10 times 2
- 3 to 5 times 3
- Twice 4
- Once 5
- Never 6

4. Tick any injecting equipment that you have shared with anyone else in the last 3 months. (you may tick more than one box)

- Spoon
- Water
- Filter
- Tourniquet
- Drug solution/mix
- Swabs

5. How many times have you overdosed in the last 3 months?

Please specify _____ times

Score 1 for any positive response to Q2 (boxes 1 – 5)

Score 1 for each positive responses to Q4

Add these together to get total score _____ /7

5. Psychological adjustment: Kessler-10

Question 1

In the past 4 weeks, about how often did you feel tired out for no good reason?

All of the time 1



- Most of the time 2
- Some of the time ... 3
- A little of the time... 4
- None of the time ... 5

Question 2

In the past 4 weeks, about how often did you feel nervous?

- All of the time 1
- Most of the time ... 2
- Some of the time ... 3
- A little of the time... 4
- None of the time ... 5

Question 3

In the past 4 weeks, about how often did you feel so nervous that nothing could calm you down?

- All of the time 1
- Most of the time ... 2
- Some of the time ... 3
- A little of the time... 4
- None of the time ... 5

Question 4

In the past 4 weeks, about how often did you feel hopeless?

- All of the time 1
- Most of the time ... 2
- Some of the time ... 3
- A little of the time... 4
- None of the time ... 5

Question 5

In the past 4 weeks, about how often did you feel restless or fidgety?

- All of the time 1
- Most of the time ... 2
- Some of the time ... 3
- A little of the time... 4
- None of the time ... 5

Question 6

In the past 4 weeks, about how often did you feel so restless you could not sit still?

- All of the time 1
- Most of the time ... 2



- Some of the time ... 3
- A little of the time... 4
- None of the time ... 5

Question 7

In the past 4 weeks, about how often did you feel depressed?

- All of the time 1
- Most of the time 2
- Some of the time ... 3
- A little of the time... 4
- None of the time ... 5

Question 8

In the past 4 weeks, about how often did you feel that everything was an effort?

- All of the time 1
- Most of the time 2
- Some of the time ... 3
- A little of the time... 4
- None of the time ... 5

Question 9

In the past 4 weeks, about how often did you feel so sad that nothing could cheer you up?

- All of the time 1
- Most of the time 2
- Some of the time ... 3
- A little of the time... 4
- None of the time ... 5

Question 10

In the past 4 weeks, about how often did you feel worthless?

- All of the time 1
- Most of the time 2
- Some of the time ... 3
- A little of the time... 4
- None of the time ... 5

6. Physical/Social/Emotional Functioning: SF-36

These questions are about your health, how you feel and how well you are able to do your usual activities. If you are unsure give the best answer you can.



5. In general, would you say your health is:

Excellent	1
Very good	2
Good	3
Fair	4
Poor	5

6. **Compared to one year ago**, how would you rate your health in general **now**?

Much better now than one year ago	1
Somewhat better now than one year ago	2
About the same as one year ago	3
Somewhat worse now than one year ago	4
Much worse now than one year ago	5

7. The following questions are about activities you might do during a typical day. As I read each item, please tell me if your health **now** limits you a lot, limits you a little, or does not limit you at all in these activities?

Does your health limit the following Activities For you?	Yes, limited a LOT	Yes, limited a LITTLE	NO, not limited at all
a. Vigorous activities such as running, lifting heavy objects, participating in strenuous sports	1	2	3
b. Moderate activities such as moving a table, pushing a vacuum cleaner, bowling or playing golf	1	2	3
c. Lifting or carrying groceries	1	2	3
d. Climbing several flights of stairs	1	2	3
e. Climbing one flight of stairs	1	2	3
f. Bending, kneeling or stooping	1	2	3
g. Walking more than one kilometre	1	2	3
h. Walking half a kilometre	1	2	3
i. Walking 100 metres	1	2	3
j. Bathing or dressing yourself	1	2	3

1. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

	YES	NO
a. Cut down on the amount of time you spent on work or other activities	1	2
b. Accomplished less than you would like	1	2



c. Were limited in the kind of work or other regular daily activities	1	2
d. Had difficulty performing the work or other regular daily activities (eg it took extra effort)	1	2

1. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** such as feeling depressed or anxious?

	YES	NO
Cut down on the amount of time you spent on work or other activities	1	2
Accomplished less than you would like	1	2
Did not do work or other activities as carefully as usual	1	2

1. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities like family, friends, neighbours, or groups?

Not at all	1
Slightly	2
Moderately	3
Quite a bit	4
Extremely	5

2. How much **bodily pain** have you had during the **past 4 weeks**?

No bodily pain	1
Very mild	2
Mild	3
Moderate	4
Severe	5
Very severe	6

3. During the **past 4 weeks**, how much did pain interfere with your normal work, including both work outside the home and housework?

Not at all	1
Slightly	2
Moderately	3
Quite a bit	4
Extremely	5



4. These questions are about how you feel and how things have been with you during the **past 4 weeks**. For each question, please give the one answer that comes closest to way you have been feeling. How much of the time during the **past 4 weeks**....

	All the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Did you feel full of life?	1	2	3	4	5	6
Have you been a very nervous person?	1	2	3	4	5	6
Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
Have you felt calm and peaceful?	1	2	3	4	5	6
Did you have a lot of energy?	1	2	3	4	5	6
Have you felt down?	1	2	3	4	5	6
Did you feel worn out?	1	2	3	4	5	6
Have you been a happy person?	1	2	3	4	5	6
Did you feel tired	1	2	3	4	5	6

1. During the **past 4 weeks**, how much of your time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives etc)?

All of the time	1
Most of the time	2
Some of the time	3
A little of the time	4
None of the time	5

2. How true or false is each of the following statements for you?

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
I seem to get sick a little easier than other people	1	2	3	4	5
I am as healthy as anybody I know	1	2	3	4	5
I expect my health to get worse	1	2	3	4	5
My health is excellent	1	2	3	4	5



Appendix 9b Health Outcome Measures – Program Exit

**MERIT PROGRAM
HEALTH-RELATED OUTCOME INDICATORS**

PROGRAM EXIT VERSION

1. Drug use
2. The Severity of Dependence Scale
3. Extent of Recent Drug Use
4. Risk behaviour
5. Psychological adjustment: Kessler-10
6. Physical/Social/Emotional Functioning: SF-36 (version 1)
7. Social Functioning: Income Sources & Accommodation
8. Client Satisfaction



1. Drug use

In this section you will be asked about your use of drugs and alcohol in the **last 3 months**. This does not include methadone maintenance treatment, but may include “street methadone” or “diverted doses”.

9. What drug is causing you the greatest concern?

Please specify (only one drug or alcohol) _____

10. How do/did you usually take this drug?

- | | | |
|------------------------------|--------------------------|---|
| Ingest (eat, drink, swallow) | <input type="checkbox"/> | 1 |
| Smoke | <input type="checkbox"/> | 2 |
| Inject | <input type="checkbox"/> | 3 |
| Sniff (powder) | <input type="checkbox"/> | 4 |
| Inhale (vapour) | <input type="checkbox"/> | 5 |
| Other | <input type="checkbox"/> | 6 |

1. What other drugs or alcohol have caused you concern over the last 3 months?

Please specify (one or more drugs, up to a maximum of 3)

1. _____
2. _____
3. _____

2. The Severity of Dependence Scale (SDS)

These five questions ask about how you have been thinking and feeling about your main problem drug in the **last 3 months**, even if you have not been using:

(a) Over the last 3 months did you ever think your use of this drug was out of control?

- | | |
|-------------------------|---|
| Never or almost never | 0 |
| Sometimes | 1 |
| Often | 2 |
| Always or nearly always | 3 |

(b) Did the prospect of missing this drug make you very anxious or



worried?

Never or almost never	0
Sometimes	1
Often	2
Always or nearly always	3

(c) Did you worry about your use of this drug?

Not at all	0
A little	1
Quite a lot	2
A great deal	3

(d) Do you wish you could stop?

Never or almost never	0
Sometimes	1
Often	2
Always or nearly always	3

(e) How difficult would you find it to stop or go without?

Not difficult	0
Quite difficult	1
Very difficult	2
Impossible	3

Scoring: each of the five items is scored on a four point scale from 0-3. Addition of the five items produces a total score with higher scores indicating a higher level of dependence.

6.2.1.2 SDS SCORE = /15

Extent of Recent Drug Use

The next seven questions are about the drugs and alcohol you have taken in the **last month** (that is, the last 30 days). Please refer to “Chart 1”.

1. (a) How many days in the last month did you drink **alcohol**? (beer, wine, spirits)

Please specify _____ days

(b) On average, how many standard drinks did you have on those days when you were drinking? (please refer to standard drinks chart)

Please specify _____ drinks



2. (a) How many days in the last month did you use **heroin** or another opioid-based drug?

That is, morphine, pethidine, codeine or street methadone (not including legally obtained methadone).

Please specify _____ days

- (c) On average, how many (hits/pills/smokes/oral street (diverted) **methadone** – *circle whichever appropriate*) did you have on those days when you used opioid-based drug?

Please specify _____ hits/pills/smokes/oral
Street Methadone

3. (a) How many days in the last month did you use **cannabis** (marijuana, dope, grass, hash, pot)?

Please specify _____ days

- (d) On average, how many (cones/joints – *circle whichever is appropriate*) did you have on those days when you used cannabis?

Please specify _____ cones/joints

4. (a) How many days in the last month did you use **cocaine** (coke)?

Please specify _____ days

- (e) On average how many (hits/snorts/pipes – *circle whichever is appropriate*) did you have on those days when you used cocaine?

Please specify _____ hits/snorts/pipes

5. (a) How many days in the last month did you use **amphetamines** (speed, wiz, go-ee, ice)?

Please specify _____ days

- (f) On average, how many (pills/snorts/hits/pipes – *circle whichever is appropriate*) did you have on those days when you did use amphetamines?

Please specify _____ pills/snorts/hits/pipes

6. (a) How many days in the last month did you use **traquilisers** (benzos, valium, rohypnol)?

Please specify _____ days



- (g) How many (pills/hits – *circle whichever is appropriate*) did you have on those days when you did use tranquilisers?

Please specify _____ pills/hits

- 7. (a) How many days in the last month did you use **tobacco** (cigarettes, cigars, pipe tobacco)?

Please specify _____ days

- (h) How many (cigarettes/cigars/pipes – *circle whichever is appropriate*) did you have on those days when you did use tobacco?

Please specify _____ cigarettes/cigars/pipes

Total types of drugs: Total out of 7: _____

Occasions of Use: Sum of (a) x (b) , questions 1 - 7: _____

Risk Behaviour

The Blood Borne Virus Risk Scale gives an indication of the extent the client puts themselves at risk of contracting or transmitting blood borne viruses.

- 1. Did you last inject/hit up any drug

In the last 3 months	<input type="checkbox"/>	1	
3 to 12 months ago	<input type="checkbox"/>	2	Go to Section 5 .
More than 12 months ago	<input type="checkbox"/>	3	Go to Section 5
Never injected	<input type="checkbox"/>	4	Go to Section 5

- 2. How many times in the last 3 months did you use a needle and syringe after someone else had already used it (including your sex partner and even if it was cleaned)?

More than 10 times	<input type="checkbox"/>	1
6 to 10 times	<input type="checkbox"/>	2
3 to 5 times	<input type="checkbox"/>	3
Twice	<input type="checkbox"/>	4
Once	<input type="checkbox"/>	5
Never	<input type="checkbox"/>	6

- 3. How many times in the last 3 months did you pass on a needle and syringe to



someone else after you had used it?

- | | | |
|--------------------|--------------------------|---|
| More than 10 times | <input type="checkbox"/> | 1 |
| 6 to 10 times | <input type="checkbox"/> | 2 |
| 3 to 5 times | <input type="checkbox"/> | 3 |
| Twice | <input type="checkbox"/> | 4 |
| Once | <input type="checkbox"/> | 5 |
| Never | <input type="checkbox"/> | 6 |

4. Tick any injecting equipment that you have shared with anyone else in the last 3 months. (you may tick more than one box)

- | | |
|-------------------|--------------------------|
| Spoon | <input type="checkbox"/> |
| Water | <input type="checkbox"/> |
| Filter | <input type="checkbox"/> |
| Tourniquet | <input type="checkbox"/> |
| Drug solution/mix | <input type="checkbox"/> |
| Swabs | <input type="checkbox"/> |

5. How many times have you overdosed in the last 3 months?

Please specify _____ times

Score1 for any positive response to Q2 (boxes 1 – 5)

Score 1 for each positive responses to Q4

Add these together to get total score _____ /7

5. Psychological adjustment: Kessler-10

Question 1

In the past 4 weeks, about how often did you feel tired out for no good reason?

- | | |
|-------------------------|---|
| All of the time | 1 |
| Most of the time | 2 |
| Some of the time ... | 3 |
| A little of the time... | 4 |
| None of the time ... | 5 |

Question 2

In the past 4 weeks, about how often did you feel nervous?



- All of the time 1
- Most of the time 2
- Some of the time ... 3
- A little of the time... 4
- None of the time ... 5

Question 3

In the past 4 weeks, about how often did you feel so nervous that nothing could calm you down?

- All of the time 1
- Most of the time 2
- Some of the time ... 3
- A little of the time... 4
- None of the time ... 5

Question 4

In the past 4 weeks, about how often did you feel hopeless?

- All of the time 1
- Most of the time 2
- Some of the time ... 3
- A little of the time... 4
- None of the time 5

Question 5

In the past 4 weeks, about how often did you feel restless or fidgety?

- All of the time 1
- Most of the time 2
- Some of the time ... 3
- A little of the time... 4
- None of the time ... 5

Question 6

In the past 4 weeks, about how often did you feel so restless you could not sit still?

- All of the time 1
- Most of the time 2
- Some of the time ... 3
- A little of the time... 4
- None of the time ... 5

Question 7

In the past 4 weeks, about how often did you feel depressed?

- All of the time 1



- Most of the time 2
- Some of the time ... 3
- A little of the time... 4
- None of the time ... 5

Question 8

In the past 4 weeks, about how often did you feel that everything was an effort?

- All of the time 1
- Most of the time 2
- Some of the time ... 3
- A little of the time... 4
- None of the time ... 5

Question 9

In the past 4 weeks, about how often did you feel so sad that nothing could cheer you up?

- All of the time 1
- Most of the time 2
- Some of the time ... 3
- A little of the time... 4
- None of the time ... 5

Question 10

In the past 4 weeks, about how often did you feel worthless?

- All of the time 1
- Most of the time 2
- Some of the time ... 3
- A little of the time... 4
- None of the time ... 5

6. Physical/Social/Emotional Functioning: SF-36

These questions are about your health, how you feel and how well you are able to do your usual activities. If you are unsure give the best answer you can.

1. In general, would you say your health is:

- Excellent 1
- Very good 2
- Good 3



Fair 4
 Poor 5

2. Compared to one year ago, how would you rate your health in general **now**?

Much better now than one year ago 1
 Somewhat better now than one year ago 2
 About the same as one year ago 3
 Somewhat worse now than one year ago 4
 Much worse now than one year ago 5

3. The following questions are about activities you might do during a typical day. As I read each item, please tell me if your health **now** limits you a lot, limits you a little, or does not limit you at all in these activities?

Does your health limit the following Activities For you?	Yes, limited a LOT	Yes, limited a LITTLE	NO, not limited at all
a. Vigorous activities such as running, lifting heavy objects, participating in strenuous sports	1	2	3
b. Moderate activities such as moving a table, pushing a vacuum cleaner, bowling or playing golf	1	2	3
c. Lifting or carrying groceries	1	2	3
d. Climbing several flights of stairs	1	2	3
e. Climbing one flight of stairs	1	2	3
f. Bending, kneeling or stooping	1	2	3
g. Walking more than one kilometre	1	2	3
h. Walking half a kilometre	1	2	3
i. Walking 100 metres	1	2	3
j. Bathing or dressing yourself	1	2	3

1. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

	YES	NO
a. Cut down on the amount of time you spent on work or other activities	1	2
b. Accomplished less than you would like	1	2
c. Were limited in the kind of work or other regular daily activities	1	2
d. Had difficulty performing the work or other regular daily activities (eg it took extra effort)	1	2



1. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** such as feeling depressed or anxious?

	YES	NO
Cut down on the amount of time you spent on work or other activities	1	2
Accomplished less than you would like	1	2
Did not do work or other activities as carefully as usual	1	2

1. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities like family, friends, neighbours, or groups?

Not at all	1
Slightly	2
Moderately	3
Quite a bit	4
Extremely	5

2. How much **bodily pain** have you had during the **past 4 weeks**?

No bodily pain	1
Very mild	2
Mild	3
Moderate	4
Severe	5
Very severe	6

3. During the **past 4 weeks**, how much did pain interfere with your normal work, including both work outside the home and housework?

Not at all	1
Slightly	2
Moderately	3
Quite a bit	4
Extremely	5

4. These questions are about how you feel and how things have been with you during the **past 4 weeks**. For each question, please give the one answer that comes closest to way you have been feeling. How much of the time during the **past 4 weeks**....



	All the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Did you feel full of life?	1	2	3	4	5	6
Have you been a very nervous person?	1	2	3	4	5	6
Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
Have you felt calm and peaceful?	1	2	3	4	5	6
Did you have a lot of energy?	1	2	3	4	5	6
Have you felt down?	1	2	3	4	5	6
Did you feel worn out?	1	2	3	4	5	6
Have you been a happy person?	1	2	3	4	5	6
Did you feel tired	1	2	3	4	5	6

1. During the **past 4 weeks**, how much of your time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives etc)?

All of the time	1
Most of the time	2
Some of the time	3
A little of the time	4
None of the time	5

2. How true or false is each of the following statements for you?

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
I seem to get sick a little easier than other people	1	2	3	4	5
I am as healthy as anybody I know	1	2	3	4	5
I expect my health to get worse	1	2	3	4	5
My health is excellent	1	2	3	4	5

7. Income sources & Accommodation

(These two items are already on the assessment form as they form part of the minimum data set. However they also need to be asked at followup).

1. What is your main source of income?



Full-time employment	1
Part-time employment	2
Temporary benefit (e.g. sickness, unemployment,)	3
Pension (e.g. aged, disability)	4
Student allowance	5
Dependant on others	6
Retirement fund	7
No income	8
Other	98
If other, please specify _____	

2. Do you live in a

rented house or flat (public or private)	1
privately owned house or flat	2
boarding house	3
hostel	4
psychiatric home/hospital	5
alcohol/other drug treatment residence	6
shelter/refuge	7
prison/detention centre	8
caravan on serviced site	9
no usual residence/homeless	10
other	98
If other, please specify _____	

8. Client Satisfaction Questionnaire

Circle your answer

1. To what extent has the MERIT program met your needs?

4	3	2	1
Almost all of my needs have been Met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

2. Have the services you received helped you to deal more effectively with your problems?

4	3	2	1
Yes, they helped a great deal	Yes, they helped somewhat	No, they didn't really help	No, they seemed to make things worse



3. To what extent were you satisfied with the treatment service you received?

- | | | |
|----------------------|--------------------------|---|
| Extremely satisfied | <input type="checkbox"/> | 0 |
| Very satisfied | <input type="checkbox"/> | 1 |
| Satisfied | <input type="checkbox"/> | 2 |
| Not very satisfied | <input type="checkbox"/> | 3 |
| Not at all satisfied | <input type="checkbox"/> | 4 |

4. To what extent were you satisfied with the relationship established between yourself and the counselor?

- | | | |
|----------------------|--------------------------|---|
| Extremely satisfied | <input type="checkbox"/> | 0 |
| Very satisfied | <input type="checkbox"/> | 1 |
| Satisfied | <input type="checkbox"/> | 2 |
| Not very satisfied | <input type="checkbox"/> | 3 |
| Not at all satisfied | <input type="checkbox"/> | 4 |

5. If a friend were in need of similar help, would you recommend our program to him or her?

- | | | | |
|--------------------|----------------|----------------|-----------------|
| 4 | 3 | 2 | 1 |
| No, definitely not | No, not really | Yes, generally | Yes, definitely |



Appendix 10 Notes for Administration of MERIT Outcome Measures (Summary)

The MERIT Outcome Monitoring design is a 'before and after' study, with provision to assist in client assessment and case management. A standard set of questions is administered to MERIT clients at program entry and again at program exit. This means that the same questions must be administered in the same format and follow the same procedure on both occasions. For methodological and practical reasons it is not envisaged that clients be followed up post program exit though this may be undertaken later as a separate study.

Following are some practical and administrative issues which should be followed in administering the questionnaires.

- It is highly desirable for caseworkers to administer the questionnaires rather than allowing clients to complete them. The Kessler 10 and SF-36 can be either self-completion or interviewer administered. However be aware that a client may be unable or unwilling to self-complete; it is better to complete them with the client if there is any question of difficulty. All items should be based on the client's response, not clinician's guesses or assumptions.
- Ranges or approximations (eg between 'some' and 'most') are not acceptable. If the client self completes some of the questions, go over them to ensure all are answered and there are no approximations.
- To ensure consistency, the same procedure for administering the questionnaire should be followed at entry and exit. That is, if the questionnaire is interviewer administered at entry it should be interviewer administered at exit, and *vice versa*.
- The entry interview questions should preferably be administered at assessment or within two days of the MERIT team's assessment being completed; otherwise in the first week but no later than this. However if this is not possible, the interview should still be completed. In all cases the date of the interview should be recorded on the front page.
- Make every attempt to administer the 'program entry' questionnaire to all clients entering the program. However if this is not possible for an individual client there is little point, in terms of measuring health outcomes, in asking that client to complete the 'program exit' version. In these cases an explanatory note should be entered on the front page of the database (in 'notes'). A benchmark has been set of 80% completion of all new clients.
- All sections of the questionnaire should be completed on the same occasion. If this is not possible the date recorded should be the date on which the questionnaire is completed.
- The data from the program entry interview should be entered in the database as soon as possible and the initial Health Outcomes

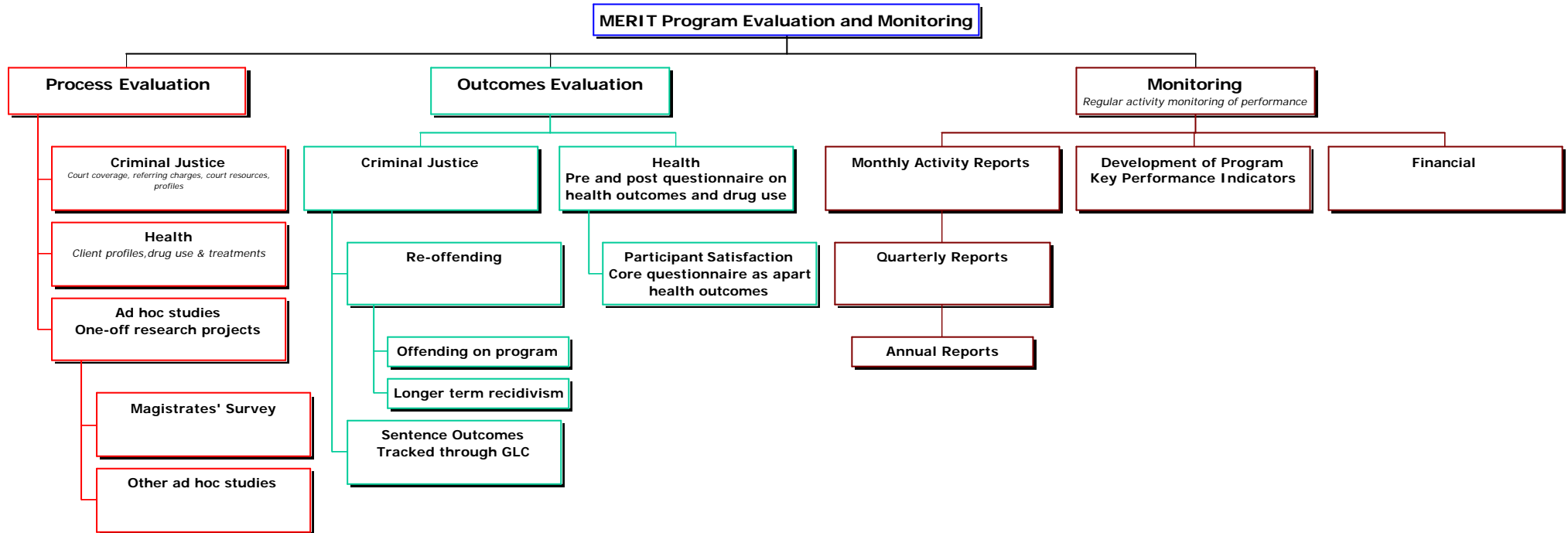


report given to the caseworker immediately. This will facilitate use of the scores for assessment and case management.

- For clients completing the MERIT program the exit interview should be done at or as soon as possible before the program exit date (not at the cessation of treatment date, if this is later).
- For clients completing the MERIT program, the exit interview will normally be administered about 3 months after the entry interview. However, many clients who did not complete the program may nevertheless have gained substantial health-related benefits as a result of their participation and it is highly desirable to measure this. Consequently attempts should be made to administer the exit interview to as many of these clients as possible.
- Be watchful for clients who may be lying, stoned or otherwise giving invalid responses. In such cases terminate the interview and if appropriate, make an appointment to do another interview. Be alert for inconsistencies in responses. If there is any doubt about the veracity of the information, note this on the front page of the questionnaire. (The person entering the responses into the database should type this into the 'comments' box on the first screen).
- Be alert for, and attempt to resolve, any inconsistencies between the outcome information and information collected in the course of the assessment.
- The program exit version of the outcome measures includes a brief client satisfaction questionnaire. It is suggested that this be administered by someone other than the client's caseworker to avoid bias. Alternatively it can be given to the client at program exit with an addressed and stamped envelope to post back to the program; or completed by the client and put into a box at reception.
- Transferred clients: the entry questionnaire is to be administered by the MERIT team who complete the assessment (usually but not always the 'transferred to' team).

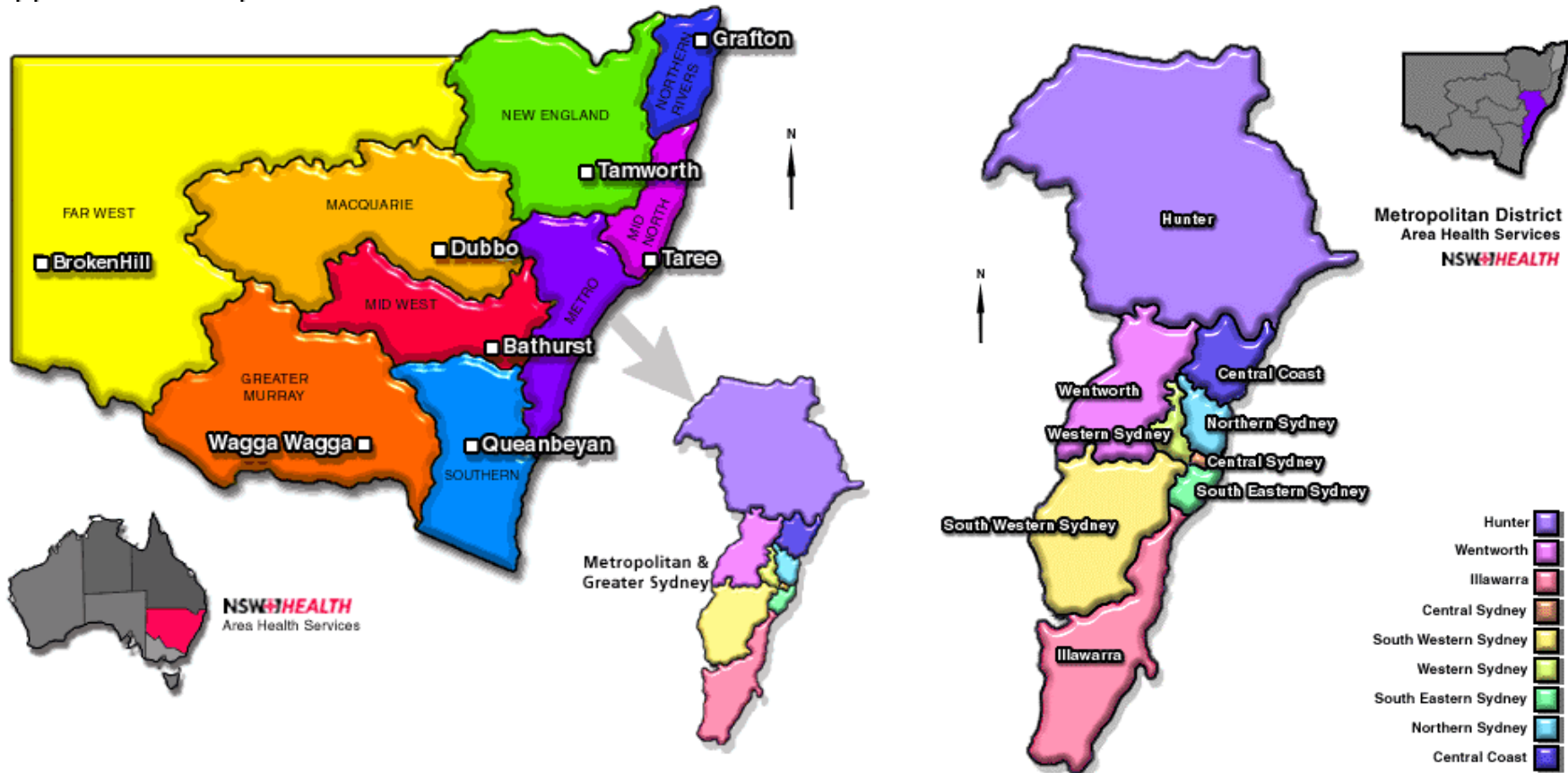


Appendix 11 Map of Evaluation





Appendix 12 Map of NSW Health Areas





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