



*cutting through complexity*

# Evaluation of the Drug Court of Victoria

FINAL REPORT  
Magistrates' Court of Victoria  
18 December 2014

GOVERNMENT ADVISORY SERVICES

## Disclaimer

### **Inherent Limitations**

*This report has been prepared as outlined in the Project Scope Section. The services provided in connection with this engagement comprise an advisory engagement which is not subject to Australian Auditing Standards or Australian Standards on Review or Assurance Engagements, and consequently no opinions or conclusions intended to convey assurance have been expressed.*

*The findings in this report are based on a qualitative study and the reported results reflect a perception of the Drug Court of Victoria, but only to the extent of the sample surveyed, being the Department of Justice's approved representative sample of management, personnel and stakeholders. In order to maintain stakeholder confidentiality, the names of these stakeholders have been removed from this version of the report which has been made available for public release. No warranty of completeness, accuracy or reliability is given in relation to the statements and representations made by, and the information and documentation provided by, the Magistrates' Court of Victoria, the Department of Justice, the Drug Court of Victoria, Victoria Police and stakeholders consulted as part of the process.*

*KPMG have indicated within this report the sources of the information provided. We have not sought to independently verify those sources unless otherwise noted within the report.*

*KPMG is under no obligation in any circumstance to update this report, in either oral or written form, for events occurring after the report has been issued in final form.*

### **Third Party Reliance**

*This report is solely for the purpose set out in the Project Scope Section and for the Department of Justice's information and is not to be used for any other purpose.*

*This report has been prepared at the request of the Department of Justice in accordance with the terms of KPMG's contract dated 14 November 2013. Other than our responsibility to the Department of Justice, neither KPMG nor any member or employee of KPMG undertakes responsibility arising in any way from reliance placed by a third party on this report. Any reliance placed is that party's sole responsibility. This report may be made available on the Magistrates' Court of Victoria's website. Third parties who access the report are not a party to KPMG's contract with the Department of Justice and accordingly, may not place reliance on this report.*

*Any redistribution of this report requires the prior written approval of KPMG and in any event is to be complete and unaltered version of the report and accompanied only by such other materials as KPMG may agree. Responsibility for the security of any electronic distribution of this report remains the responsibility of the Magistrates' Court of Victoria and KPMG accepts no liability if the report is, or has been, altered in any way by any person.*

## Table of contents

---

Glossary of terms	1
1. Executive summary	2
Introduction	2
KPMG's engagement	2
Evaluation findings	3
Conclusion	7
2. Introduction	8
2.1. Project purpose and background	8
2.2. Project scope	8
2.3. Methodology	8
3. Background to the Drug Court of Victoria	11
3.1. Program establishment and development	11
3.2. Principles of the Drug Court of Victoria	11
3.3. Acceptance on to the Drug Treatment Order	12
3.4. Operation of the Drug Treatment Order	17
3.5. Completion of the Drug Treatment Order	23
3.6. Offending cohort	24
4. Therapeutic jurisprudence and diversion in the criminal justice system	34
4.1. The role of, and rationale for, drug courts	35
4.2. Contemporary approaches to managing offenders with drug and alcohol problems and the design and delivery of drug courts	39
4.3. Policy priorities informing the DCV's operations	42
5. Justification/problem	44
5.1. Is there a continuing and demonstrable need for the DCV?	44
5.2. Other options considered	45
5.3. Changes to economic, environmental and social conditions	46
5.4. Can the market deliver the DCV?	47
5.5. Are similar services provided by the Victorian Government, Commonwealth Government or Non-Government Organisations?	48
5.6. Capacity and capability to continue	48
5.7. Alignment between stated objectives, outputs and broader Departmental and government priorities	48
6. Effectiveness of the DCV in improving the health and wellbeing of participants	51
6.1. Data sources and limitations	51
6.2. Objective one: to improve the health and wellbeing of participants through reducing alcohol and other drug use and criminal behaviour, and improved connection to the community	52

6.3. Case study analysis	69
7. Effectiveness of the DCV in reducing the severity and frequency of reoffending for participants	72
7.1. Objective two: To reduce the severity and frequency of offending for participants	72
7.2. Unintended benefits	82
7.3. External factors impacting on achievement of the Court's objectives	82
8. Funding/delivery and efficiency	84
8.1. Funding received and expenditure	84
8.2. Cost comparison to other problem-solving court initiatives	87
8.3. Cost effectiveness of the Drug Court	91
8.4. Governance arrangements	94
8.5. Risk management practices	95
9. Future	98
9.1. Service delivery improvements	98
9.2. Expansion and reform opportunities	99
Appendix A : Evaluation framework	101
Appendix B : Stakeholders consulted	116
Appendix C : Additional analysis	117
Appendix D : Recidivism study methodology	118
Appendix E : Participant interview responses	120

## Glossary of terms

<b>ARC</b>	Assessment and Referral List
<b>BOCSAR</b>	Bureau of Crime Statistics and Research
<b>CALD</b>	Culturally and Linguistically Diverse
<b>CBSP</b>	Credit/Bail Support Program
<b>CISP</b>	Court Integrated Services Program
<b>COATS</b>	Community Offenders Advice and Treatment Service Court
<b>CROP</b>	Court Integrated Services Program Remand Outreach Program
<b>DCV</b>	Drug Court of Victoria
<b>DoJ</b>	Department of Justice
<b>DTF</b>	Department of Treasury and Finance
<b>DTO</b>	Drug Treatment Order
<b>JHREC</b>	Justice Human Research Ethics Committee
<b>KPIs</b>	Key Performance Indicators
<b>MCV</b>	Magistrates' Court of Victoria
<b>NDS</b>	National Drug Strategy
<b>NGOs</b>	Non-Government Organisations
<b>NOI</b>	National Offence Index

# 1. Executive summary

---

## Introduction

The Drug Court of Victoria (DCV, 'the Court') was established in May 2002 to further improve the safety of the community by focusing on the rehabilitation of offenders with a drug and/or alcohol dependency, and by providing assistance in reintegrating them into the community. It was designed using international best practice principles on the basis of the 10 key principles defined by the National Association of Drug Court Professionals and U.S. Department of Justice in 1997.

Since 2005, the DCV has received ongoing funding, including additional national drug strategy funding, and has had an operating budget of approximately \$1.6 million per annum.

The Court has not been evaluated since 2005, however in 2010, the Victorian Auditor General released a report finding that problem solving approaches to justice in Victoria had reduced recidivism.<sup>1</sup> In response to this, the government at the time confirmed that problem solving courts would remain in operation, and the then Attorney-General stated '*we are looking to identify successful elements...which can be taken up and implemented more widely*'.<sup>2</sup>

To this end, it is understood that the Magistrates' Court of Victoria (MCV) is considering how the DCV may deliver its services to the wider community, including a proposal for expansion to additional locations.

## KPMG's engagement

KPMG has been engaged by the MCV to undertake an evaluation of the DCV over the period 1 July 2010 to 30 June 2013.

The objectives of the evaluation are to:

- assess the performance of the DCV against its specified activities and anticipated outcomes;
- document key lessons learnt from the Court; and
- provide an evidence base to inform government decision-making.

Key evaluation questions have been drawn from the Department of Treasury and Finance (DTF) evaluation policy and standards for evaluating lapsing programs, to facilitate the use of the evaluation in any potential future funding bid. These include consideration of:

- What is the evidence of a continued need for the DCV and the role for government in delivering it?
- Has the DCV been effective, considering progress made towards its stated objectives and outcomes and the alignment between the Court, its outputs, MCV's objectives and government priorities?
- Has the DCV been delivered within its scope, budget, expected timeframes and in line with appropriate governance and risk management practices?
- Has MCV demonstrated efficiency and economy in delivering the DCV?

The evaluation has sought to collect both quantitative and qualitative evidence to support key findings and recommendations, and this has included analysis of DCV participant related data, finance data, a recidivism study undertaken by the Department of Justice (DoJ) for the purposes of this evaluation, a review of publicly available literature and data, and widespread consultation with key stakeholders, including program participants.

---

<sup>1</sup> Victorian Auditor-General's Office, *Problem-Solving Approaches to Justice* (Victorian Government 2011) p. 30.

<sup>2</sup> David Rood, 'Libs to keep "apartheid" courts', *The Age* (online), 8 April 2011 < <http://www.theage.com.au/victoria/lib-to-keep-apartheid-courts-20110407-1d66e.html>>.

## Evaluation findings

### *Evidence of a continued role for the DCV and the role of government in its delivery*

Literature indicates that drug courts remain more effective at addressing the revolving door of drug related offending than the use of traditional criminal justice approaches in isolation. Increases in usage rates of certain drugs, and persistently high alcohol-abuse related statistics, together with strong evidence of the link between crime and substance misuse, shows a continuing need for an intervention such as a drug court.

In Greater Dandenong itself, police data on the number of crime related offences indicates that the location of the DCV remains appropriate, with rates of drug related offences running at between 200 per cent and 150 per cent of state-wide averages, depending on the type of offence.<sup>3</sup>

As a sentencing option involving judicial oversight, the Drug Treatment Order (DTO) can only be delivered by the state. Although other aspects of the program, such as counselling or housing advice, could be delivered by the market, the cost of access, coupled with a lack of motivation to access support services in the first place, would likely prove an insurmountable barrier to access for the DCV Cohort.

The DCV targets a particular cohort of individuals who have entrenched criminal behaviour related to substance misuse that has developed often over a number of years. A high proportion exhibit a number of vulnerabilities and have records which include multiple terms of imprisonment. This is a cohort who impose a high burden on society and front line services. It remains the state's interest to minimise the continuing involvement of this cohort with the justice sector, and indeed other front line services. The program is strongly aligned with the stated objectives of the DoJ and broader government priorities.

### *Has the DCV been effective in delivering the stated objectives?*

The DCV has two stated objectives:

- to improve the health and well-being of participants, and
- to reduce the severity and frequency of reoffending.

The DTO is comprised of three phases: stabilisation (Phase 1), consolidation (Phase 2), and re-integration (Phase 3). Each phase contains different treatment requirements and expectations of the participant. Of the 130 participants who started and completed their DTO during the evaluation period, only 70 (54 per cent) progressed to Phase 2, and an even smaller number, 29 (22 per cent), progressed to Phase 3. The DCV does not record data on key indicators of health and wellbeing within individual phases and, as a result, it is not possible to analyse changes in participant health and wellbeing for the cohort who do not progress beyond Phase 1. Since some participants who do not complete Phase 1 may only be on the treatment order for a very short period of time, it has been assumed that only those participants who have reached phases two and three will have experienced any positive outcomes.

Overall, for this relatively small cohort, there is evidence of reduced risk factors, such as medical risk, psychiatric risk, and drug and alcohol risk, all of which indicates an improvement in health. Participants also reported improvements in their health as a result of being on the program. The data does not show that amphetamine-users have more difficulty in progressing through the phases than other substance misusers, although case managers reported that this was the case for crystal methamphetamine ('ice') users. All participants progressing to phases two and three also experienced improvements in their family relationships and housing stability, as well as improvements in other life skill areas such as time management and accountability.

Whilst these are all outcomes which are difficult to maintain, track and attribute to the DCV over the longer term, the evidence shows that, while participants remain on the DTO, they experience

---

<sup>3</sup> Victoria Police, *Victoria Police 2010-11 Crime Statistics* (Victoria Police 2010); Victoria Police, *Victoria Police 2012-13 Crime Statistics* (Victoria Police 2013).



improvements in their wellbeing and connectedness to the community, which would be expected to improve their chances of staying off drugs and alcohol, and thus reduce the risk of reoffending.

During the evaluation period between 1 July 2010 and 30 June 2013, a total of 130 participants commenced a DTO at DCV. The recidivism study undertaken for this evaluation by DoJ used a small cohort of DCV participants, including only those participants who completed a full DTO intervention of two years' duration, or who graduated (completed each phase of treatment) at an earlier stage, between the period of 1 July 2006 and 30 June 2012. While this cohort is not an exact reflection of those participants who completed a DTO during the evaluation period, this cohort ('DCV Cohort') was considered to be the best comparator for a two year imprisonment intervention. The group, numbering 61 individuals, were tracked through the court records over the 24 month period after they completed their DTO, to establish the frequency and severity of their reoffending. This DTO Cohort was then compared to a control cohort of another 61 individuals ('Control Cohort'<sup>4</sup>) who had been released from a two year sentence of imprisonment on similar principle primary offences. Other attributes, such as offending history in the previous two years, were used, however, it was not possible to identify a cohort who more closely matched the DCV Cohort in terms of their substance use or entrenched criminal behaviour.

The results of this study need to be treated with caution due to the difficulties in matching the Control Cohort, and the very small number (n = 61) of participants included in the study, making the results susceptible to individual results and not suitable for extrapolation over a wider group. Nevertheless, the results show significant improvements in the rate and severity of offending by the DCV Cohort as compared to their counterparts in the mainstream system, as noted below.

Key findings include:

- a 31 per cent lower rate of reoffending for the DCV Cohort compared to the Control Cohort within the first 12 months (51 per cent compared to 74 per cent, 23 percentage points lower);
- a 34 per cent lower rate of re-offending for the DCV Cohort compared to the Control Cohort within 24 months (56 per cent compared to 85 per cent, 29 percentage points lower);
- after 220 days, the DCV Cohort rate of reoffending plateaus out, whereas the Control Cohort rate continues to increase until approximately 440 days;
- a reduction in the average seriousness of offences being committed by both cohorts, compared to the presenting pre-intervention offence. The DCV Cohort showed a 67 per cent reduction in more serious offences (National Offence Index (NOI) 23 – 71) compared to a 47 per cent decrease for the Control Cohort. Specific highlights for the DCV Cohort include a 90 per cent reduction in trafficking offences (down from 30 to three); 54 per cent reduction (from 13 to six) for assaults with a weapon; 60 per cent reduction in possession of a weapon offences (from 20 to eight); 70 per cent reduction (from 72 to 17) for burglary and deception offences; and 30 per cent reduction (from 10 to seven) for theft from a motor vehicle. The rates for the Control Cohort are a 71 per cent increase for trafficking offences (up to 12 from seven) and decreases of 47 per cent, 81 per cent, 64 per cent respectively for assault, weapon possession and burglary; with another slight increase (from 13 to 46) for theft from a motor vehicle;
- both cohorts show significant increases in theft offences (not related to motor vehicles) from low bases (from 12 to 59 for DCV, an increase of 383 per cent, and from 13 to 46 for the Control Cohort, an increase of 254 per cent). The DCV Cohort also shows a 133 per cent increase in dealing in stolen goods (from six to 14). Notably for the Control Cohort, offences related to the use of drugs increase from four to 24, a 500 per cent increase.<sup>5</sup>

<sup>4</sup> The term "Control Cohort" within this report is used to describe a comparison cohort, and not in the strict sense used within scientific research

<sup>5</sup> All recidivism figures sourced from Department of Justice, Dandenong Drug Court Recidivism Study 2014 (Department of Justice 2014).



### *Has the DCV been delivered in scope, on time and within budget?*

The funding provided for the operation of the DCV over the three-year evaluation period, totalling \$4,472,000, has been underspent for two of the three years under review, and is overspent overall by \$25,650 at the end of the period.

It is likely that the minor under and overspends each year are a result of the fluctuating number of participants moving through the program, and the varying levels of service provision which each participant requires depending on need. However, the financial records provided appear to show inconsistent classification of expenditure and budget allocations, and do not record expenditure at a sufficiently granular level to enable the changes in expenditure to be linked to changes in the number of participants.

There are other costs associated with the program which are not recorded in the operational expenditure records, including some MCV related costs, and the costs of imprisonment as a sanction during treatment.

### *Has the DCV demonstrated efficiency and economy in delivering the program?*

A comparison of DCV cost per participant with other similar programs shows that DCV costs are comparable, as demonstrated in Table 1-1. In the absence of more detailed cost records, cost per participant for DCV has been calculated as a straight average of operational costs in 2012-13, divided by the target number of participants at any one time (namely 60).

*Table 1-1: Court-based early intervention and diversion services – unit costs of service delivery*

Program	Participant status	2012-13 unit cost on the basis of program funding (\$)	Comparison to DCV
Victoria			
Drug Court of Victoria	Average number of participants on program (includes partially completed)	26,000	Includes range of services including residential rehabilitation if required. Up to 24 months' duration.
Court Services (CISP)	Integrated Program	Did not complete program	Lower unit costs per participant. No urinalysis or rehab. Four months' duration.
		Completed program	
Western Australia			
Supervised Treatment Intervention	Assessment only	7,069	Range of services, including urinalysis and rehabilitation where required. Up to six months' duration.
	Did not complete program	8,580	
	Completed program	10,601	
New South Wales			
NSW Drug Court	Accepted onto program	24,000 <sup>6*</sup>	Mandatory week of residential secure rehabilitation for each participant. Up to 24 months' duration.

Sources: PricewaterhouseCoopers, *Economic Evaluation of the Court Integrated Services Program (CISP)* (PwC 2009) 6-7 (note that unit costs have been indexed for inflation to June 2013) Victorian Government, *2009-10 State Budget: Budget Paper 3* (Victorian Government 2009) 286; University of Western Australia Crime Research Centre, *WA Diversion Program*

<sup>6</sup> Haas et al. (2008) The Costs of NSW Drug Court. The NSW unit cost figure has been calculated to, as close as possible, reflect the operating costs included in the DCV unit cost shown above. Due to a lack of detail regarding NSW line items, however, an exact comparison cannot be made and this comparison should be considered indicative rather than exact. \* Excludes final sentencing costs.

(POP/STIR/IDP) - Final Report (University of Western Australia 2007) 128, 131 (note that unit costs have been indexed for inflation to June 2013); KPMG analysis.

Further analysis of the make-up of costs for each comparator program is required to identify where efficiencies may lie, but it appears that DCV is in the "ball park" for delivery costs, but probably not the least expensive. The NSW Drug Court is the most comparable diversionary program in terms of services offered although notable differences exist.<sup>7</sup> A 2008 evaluation of the NSW Drug Court estimated the unit cost per participant to be approximately \$24,000 per year, based on an average client case load of approximately 143 clients per year, which is more than twice the size of the DCV case load and likely contributes to the slightly lower comparative unit cost.

DCV also appears to be cost effective when compared to the alternative, which for many of the cohort would be imprisonment. A two year sentence would equate to 730 days at a daily rate of \$270<sup>8</sup>, namely \$197,000. This is clearly much more expensive than the DTO, even if additional costs from the MCV and cost of incarceration sanctions were added to the \$26,000 unit cost.

In addition, the recidivism data shows a marked decrease in the frequency and severity of offending by the DCV Cohort. The number of days' imprisonment for the DCV Cohort reoffenders totalled 6,125 over the two year period of the recidivism study, compared to 10,617 days for the Control Cohort. This represents a reduction over a two year period of 4,492 days, which at \$270 per day equates to approximately \$1.2 million in reduced costs of imprisonment. This compares favourably to the cost of the DCV operations, and does not take into account the other benefits to the community of the reduction in recidivism provided by the DCV.

### *Recommendations going forward*

The evaluation has identified a number of data collection activities which should be regularly undertaken by the DCV in order to improve the understanding of the demand for DCV, participant outcome trends, and enable the identification of indicators which can assist in monitoring changes in compliance.

At the assessment and intake stage of the program, the DCV should begin to collect, monitor and report on the number and source of referrals received, as well as eligibility and suitability trends. All professional stakeholders reported that there is a level of unmet demand for DTOs. In order to test this assumption, data should be collected on the referrals made which do not progress on to the program, and on the number of offenders outside the Dandenong area who would be suitable for a DTO if they met the geographic requirement. Not only would this provide useful indicators of where demand lies, it would also facilitate the identification of a "true" control cohort for on-going recidivism studies.

More broadly, regular monitoring, reporting and analysis of trends in participant outcomes (e.g. graduation rates) is not systematically undertaken by DCV at present. The DCV should collect and analyse data to identify aggregate outcome trends, as well as specific points through the DTO where there are noted trends in a lack of compliance or breaching of DTO conditions. In addition, we recommend the DCV collect, to the extent possible, longitudinal data on client health, wellbeing and reoffending patterns for both completing and non-completing clients. Doing so would create a larger evidence base to compare long-term intervention outcomes for DCV clients against other interventions, in addition to facilitating the development of appropriate, targeted interventions to improve compliance and completion rates.

Identifying and conducting detailed analysis of specific service delivery improvements was beyond the scope of this evaluation, however, stakeholders identified a number of improvements which could be introduced to generate improved outcomes for the program, as well as expansion and reform opportunities. These are detailed in Section 9.1. As KPMG has not fully analysed all of these potential service improvements and their potential impact on outcomes, it is not possible to state with any certainty the need for, or potential effectiveness of, these changes. Any changes should take into account both the specific context of the DCV and the leading practice principles outlined in Section 4.2.

<sup>7</sup> For example, the NSW Drug Court includes a mandatory residential rehabilitation component, the costs of which are included in the unit cost noted in Table 1-1.

<sup>8</sup> Prison cost data provided by Magistrates' Court of Victoria in e-mail dated 18 March 2014.

Stakeholders identified potential additional locations which would benefit from a drug court, such as the Neighbourhood Justice Centre, Footscray, Sunshine, Shepparton, Geelong, Ballarat and Mildura, as well as the Melbourne CBD. The demand for access to the DTO as a sentencing option is likely to increase as the impact of the removal of suspended sentencing continues to be felt within the justice and corrections systems. However, stakeholder feedback strongly suggested that the DTO alone would not be as effective at delivering outcomes without the wrap around support services currently provided as part of the DCV in Dandenong.

Further analysis of the constituent parts of the DTO, and their impact on the generation of outcomes is recommended before any changes are made to the model of delivery.

## Conclusion

The DCV continues to deliver positive outcomes for the community and participants, as evidenced by improvements in health and wellbeing for the participants, and a reduction in recidivism by those who complete the program. Although the recidivism study was limited to a very small sample size, it indicates that a reduction in reoffending has occurred within this limited group, and backs up the stakeholder feedback on the efficacy of the program. Case studies of individual participants also illustrate the significant impact on their lives that the DTO and participating in the drug court has had.

The DCV also offers a cost effective sentencing alternative, being considerably cheaper than an equivalent term of imprisonment, and in line with other therapeutic justice programs. While further detail on the make up of cost, and the demand for DTOs would be preferable, there is sufficient data currently available to determine that the DCV at Dandenong should continue in its current format, and that further serious consideration should be given to rolling out this service delivery model to other locations with high incidences of drug related crime.

## 2. Introduction

---

### 2.1. Project purpose and background

The DCV was established in May 2002 to further improve the safety of the community by focusing on the rehabilitation of offenders with a drug and/or alcohol dependency, and by providing assistance in reintegrating them into the community.

Since 2005, the DCV has received ongoing funding and has an operating budget of approximately \$1.6 million per annum.

The Court has not been evaluated since 2005, however in 2010, the Victorian Auditor General released a report finding that problem solving approaches to justice in Victoria had reduced recidivism.<sup>9</sup> In response to this:

- the then government confirmed that problem solving courts will remain in operation; and
- the then Attorney-General stated '*we are looking to identify successful elements...which can be taken up and implemented more widely*'.<sup>10</sup>

To this end, it is understood that the Magistrates' Court of Victoria (MCV) is considering how the DCV may expand services to the wider community, including a proposal for expansion to additional locations.

KPMG has been engaged by MCV to undertake an evaluation of the DCV over the period 1 July 2010 to 30 June 2013. The objectives of the evaluation are to:

- assess the performance of the DCV against its specified activities and anticipated outcomes;
- document key lessons learnt from the Court; and
- provide an evidence base to inform government decision-making.

### 2.2. Project scope

The key evaluation questions used to guide the evaluation have been drawn from the Department of Treasury and Finance's (DTF) Evaluation policy and standards for lapsing programs (DTF Guidelines), and include consideration of the following:

- What is the evidence of a continued need for the DCV and the role for government in delivering it?
- Has the DCV been effective, considering progress made towards its stated objectives and outcomes and the alignment between the Court, its outputs, MCV's objectives and government priorities?
- Has the DCV been delivered within its scope, budget, within expected timeframes and in line with appropriate governance and risk management practices?
- Has MCV demonstrated efficiency and economy in delivering the DCV?

In addition to these key evaluation questions, given the Government's consideration of expanding the DCV model to additional locations, consideration will be given to improvements and efficiencies which may be introduced in the future.

### 2.3. Methodology

This section outlines the methodology of the evaluation, including the key research questions and the methods used to collect data and analyse results.

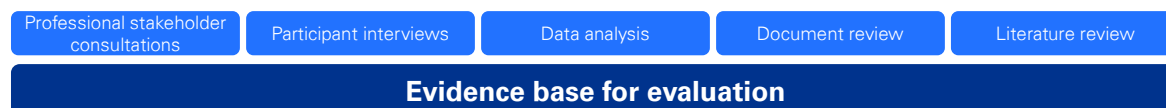
---

<sup>9</sup> Victorian Auditor-General's Office, *Problem-Solving Approaches to Justice* (Victorian Government 2011) p. 30.

<sup>10</sup> David Rood, 'Libs to keep "apartheid" courts', *The Age* (online), 8 April 2011 < <http://www.theage.com.au/victoria/lib-to-keep-apartheid-courts-20110407-1d66e.html>>.

For this review, KPMG collected and analysed a combination of qualitative and quantitative evidence to provide the evidence base for our key findings and recommendations. Evidence gathered to inform the review were sourced from a document review, professional stakeholder consultations, participant interviews, a literature review and analysis of DCV data, as outlined in Figure 2-1.

Figure 2-1: Evidence base for the evaluation of the Drug Court of Victoria



For the evaluation, KPMG constructed a review framework that enabled the gathering of appropriate evidence and facilitated analysis of qualitative and quantitative data sources. KPMG employed an eight stage methodology for this engagement, which is outlined in Table 2-1.

Table 2-1: Methodology

Stage	Details
<b>Project initiation</b>	<ul style="list-style-type: none"> <li>KPMG developed a detailed project plan, which confirmed the objectives and scope of the project, and the deliverables and timeframes. This included identification of relevant stakeholders for consultation.</li> </ul>
<b>Evaluation framework</b>	<ul style="list-style-type: none"> <li>The availability and format of data was assessed to determine any gaps.</li> <li>KPMG developed an evaluation framework in consultation with the MCV including key review questions, sub-questions and data collection methodology (see Appendix A). The framework was drawn from the Department of Treasury and Finance's (DTF) Evaluation policy and standards for lapsing programs (DTF Guidelines)</li> </ul>
<b>Ethics Applications</b>	<ul style="list-style-type: none"> <li>The evaluation framework included consultation with DCV program participants and, as a result, an ethics application and questionnaire was prepared in consultation with MCV and DCV and submitted to JHREC. Approval from JHREC was received in February 2014.</li> <li>The evaluation framework also included consultation with members of Victoria Police and, as such, an application was made to the Victoria Police Research Coordinating Committee. Approval was received in March 2014.</li> </ul>
<b>Literature review</b>	<ul style="list-style-type: none"> <li>A literature review was undertaken to examine: <ul style="list-style-type: none"> <li>the rationale for drug courts and the role of the Victorian Government in providing the DCV;</li> <li>the principles of therapeutic jurisprudence and how they are applied in drug courts; and</li> <li>the latest developments in design and delivery of drug courts, and how the DCV aligns to these developments.</li> </ul> </li> <li>In researching and preparing the literature review, KPMG drew upon a range of national and international sources, including academic, government and non-governmental sources.</li> </ul>
<b>Data collection and analysis</b>	<ul style="list-style-type: none"> <li>Relevant data from MCV was collected and assessed including: <ul style="list-style-type: none"> <li>process data</li> <li>outcome data; and</li> <li>economic data.</li> </ul> </li> </ul>
<b>Stakeholder consultations</b>	<ul style="list-style-type: none"> <li>Consultations were conducted with the following persons during the evaluation: <ul style="list-style-type: none"> <li>Drug Court Magistrate;</li> <li>Other Victorian Magistrates;</li> <li>DCV case managers and clinical advisors;</li> <li>DCV service providers;</li> <li>Legal representatives;</li> <li>Health and medical service representatives;</li> <li>Departmental representatives;</li> <li>Victoria Police officers; and</li> <li>13 active DCV clients on site at the DCV.</li> </ul> </li> <li>A full list of stakeholders consulted is available in Appendix B.</li> </ul>
<b>Analysis and interim findings</b>	<ul style="list-style-type: none"> <li>Information from the stakeholder consultations and data collection was evaluated to assess the DCV's efficiency and effectiveness and answer key evaluation questions.</li> <li>An interim findings presentation was made to the Steering Committee initially in May 2014, and again in November 2014 following receipt and analysis of a revised recidivism study.</li> </ul>

Stage	Details
Reporting	<ul style="list-style-type: none"> <li>A Draft Report (this report) was provided to the Steering Committee in December 2014.</li> </ul>

### *DoJ Recidivism Study*

As part of the evaluation framework, DoJ agreed to undertake a recidivism study of DCV clients and compare rates of recidivism against a Control Cohort. This study was to be provided to KPMG as an input to the assessment of the overall effectiveness and efficiency of the DCV. Initially, the findings from this study were planned to be provided to KPMG in late February 2014. Delays in the provision of this study resulted in revised timelines for the overall engagement, and the study was not received by KPMG until April 2014.

After reviewing the initial DoJ recidivism study, it was determined by the Steering Committee that there were data reliability issues and methodological issues material to the project relating to the parameters used to select the DCV Cohort for tracking and analysis. In the initial study, all participants who were accepted onto a DTO during the evaluation period were selected and tracked for recidivism. However, as a significant portion of these clients did not complete the program and had their DTOs cancelled within a relatively short period, it was agreed that it would be more appropriate to select and track recidivism for the DCV clients who completed the program (either by graduating or completing their two year DTO). These completing clients had benefited from a 'full DCV intervention' and provided a more appropriate cohort to compare to a Control Cohort, who had likewise experienced a comparable 'imprisonment intervention'. This agreement with regards to cohort selection led to the need for DoJ to conduct a revised recidivism study, which resulted in a delay of several months to the evaluation timelines. A revised recidivism study was provided to KPMG in October 2014. Details of the methodology and findings from the DoJ recidivism study are contained in Section 7.



### 3. Background to the Drug Court of Victoria

The DCV was one of the first problem-solving justice initiatives in Victoria. It incorporates both judicial supervision and monitoring with the provision of support services which seek to address the underlying issues contributing to offending behaviour, particularly drug and alcohol misuse.

#### 3.1. Program establishment and development

The DCV was established in 2002 to provide for the sentencing and supervision of treatment for offenders with a drug and/or alcohol dependency who have committed an offence under the influence of drugs or alcohol, or to support a drug or alcohol habit.

The objectives of the DCV are to:

- improve the health and wellbeing of participants through reduced alcohol and other drug use, and reduced criminal behaviour, and increased connection to the community; and
- reduce the severity and frequency of offending for participants.

An eligible offender attending the DCV has been sentenced to a Drug Treatment Order (DTO) for two years under the *Sentencing Act 1991* (Vic) s 18. The DTO consists of two components: treatment and supervision, and a custodial component which is held in abeyance whilst the offender undergoes treatment in the community.

Since 2002, the DCV has operated out of the Dandenong Magistrates' Court, and is restricted to offenders whose usual place of residence is in the Dandenong area (or a nearby postcode specified in the Government Gazette). This is due to the fact that the DTO requires a significant level of attendance at the Dandenong Magistrates' Court (the DCV), and presenting regularly at the DCV would not be feasible for offenders who are not living in the area.

During the evaluation period (1 July 2010 to 30 June 2013), a total of 130 persons were sentenced to a DTO and participated in the DCV. At any one point in time, the DCV may service up to 70 participants, although the DCV maintains a target of 60 active participants.

The purpose of this section is to provide an overview of:

- how the DCV operates in practice, including how offenders are sentenced to a DTO and progress through its various phases and roles and responsibilities of the DCV team;
- key DCV processes, including assessment and screening, Case Management, Review Hearings; and
- characteristics of the DCV Cohort analysed over the evaluation period, being 1 July 2010 to 30 June 2013.

#### 3.2. Principles of the Drug Court of Victoria

The DCV is enabled by the *Sentencing Act 1991* (Vic), which specifies the aims of a DTO to be:

- to facilitate the rehabilitation of the offender by providing a judicially-supervised, therapeutically-oriented, integrated drug or alcohol treatment and supervision regime;
- to take account of an offender's drug or alcohol dependency;
- to reduce the level of criminal activity associated with drug or alcohol dependency; and
- to reduce offender's health risks associated with drug or alcohol dependency.<sup>11</sup>

<sup>11</sup> *Sentencing Act 1991* (Vic) s 18X.



The DCV aims to use principles of therapeutic jurisprudence to achieve therapeutic outcomes for participants, whilst employing traditional legal measures in the form of the DTO as a vehicle to encourage compliance. It is premised on the operation of drug courts in other Australian and international jurisdictions (particularly the United States) and is underpinned by the following assumptions:

- criminal sanctions for drug-related offences are more likely to have positive, long-lasting effects if they involve treatment of offenders' substance use issue;
- it is appropriate and necessary for sentencing powers to be used as a basis for extensive intervention into the life of a DCV participant;
- drug-abusing offenders are most susceptible to successful therapeutic intervention in the moment after arrest;
- active and ongoing judicial supervision and engagement of an offender with a drug problem, including the imposition of rewards and sanctions, can positively influence the offender's behaviour in addressing his or her drug addiction;
- in order for treatment for drug addiction to be effective, it may need to address other elements of a participant's life such as education, accommodation, employment, family and personal relationships to provide stability; and
- drug addiction is a chronic relapsing condition. Frequent relapse forms part of recovery from drug addiction and it is unrealistic to expect participants to achieve immediate or total abstinence from drug use.<sup>12</sup>

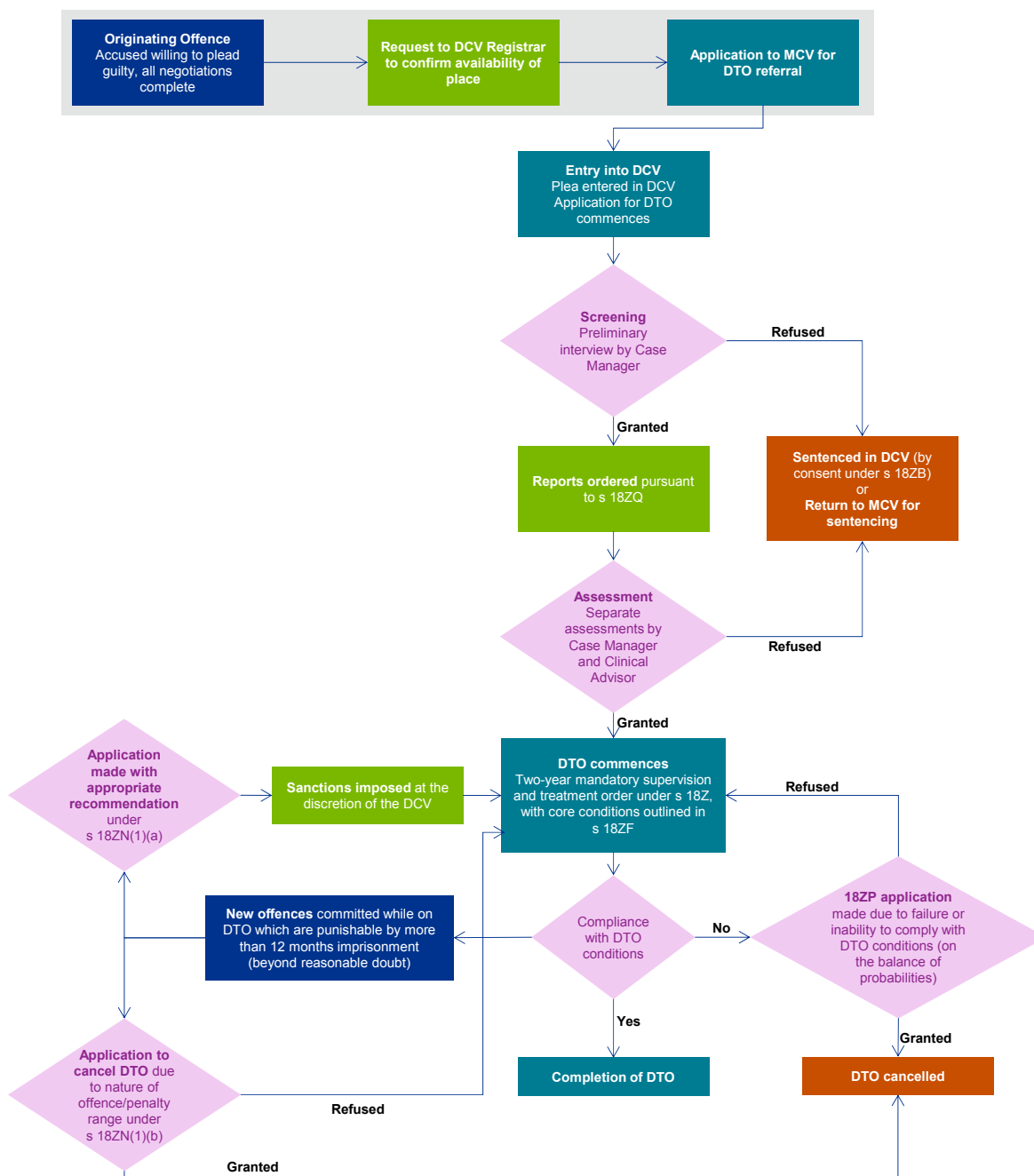
### 3.3. Acceptance on to the Drug Treatment Order

The DTO is a unique sentencing option that enables offenders who are facing an immediate term of imprisonment to serve this custodial period in the community whilst accessing mandatory supervision and treatment. A high-level overview of key stages in the DTO is provided in Figure 3-1.

---

<sup>12</sup> Drug Court of Victoria, *Drug Court Policy No. 1 – Key Components and Principles* (Drug Court of Victoria, undated).

Figure 3-1: Drug Court of Victoria process



Source: Drug Court of Victoria, *Drug Court Process Version 1.0* (Drug Court of Victoria 2011)

### 3.3.1. Eligibility criteria

To be eligible for a DTO, the offender must meet the following conditions outlined in the *Sentencing Act 1991* (Vic) s 18Z:

- the offender must not be subject to a Parole Order, Combined Custody and Treatment Order or a Sentencing Order of the County or Supreme Court of Victoria;
- the offender must plead guilty to an offence within the jurisdiction of the MCV and punishable upon conviction by up to two years imprisonment;
- the offence must not be a sexual offence or an offence involving the infliction of actual bodily harm;

- the offender's usual place of residence must be within a postcode area serviced by the DCV as specified in the Government Gazette;
- on the balance of probabilities, the DCV must be satisfied that:
  - the offender is dependent on drugs and/or alcohol; and
  - the offender's dependency contributed to the commission of the offence;
- the DCV considers that under normal conditions, it would not have ordered that the sentence be served by way of intensive corrections in the community, nor would it have suspended the sentence; and
- the offender must be willing to consent, in writing, to a DTO.

If an offender has been found guilty on previous occasions to an offence where drug and alcohol dependency contributed, a DTO can still be made. Similarly, a DTO may also be imposed regardless of whether the offender has previously served a term of imprisonment.

If the Police Prosecutor has no preliminary objection to an offender being placed on a DTO, the DCV Magistrate stands the matter down for a Screening Hearing to take place. This is a 45-minute interview undertaken by a Case Manager from Corrections Victoria in which the offender's suitability to participate in a DTO is assessed against the following criteria:

- **demographic:** determines whether the offender is living in, or has a significant connection to an area within, the Dandenong or specified catchment area;
- **justice:** considers an offender's eligibility for the program based on prior and current offences; and
- **clinical:** confirms that an offender's drug and/or alcohol misuse is a significant and causal factor in the current and prior offences committed, and also identifies any immediate intervention needs.<sup>13</sup>

During the Screening Hearing, the offender is also provided with detailed information regarding the expectations and requirements of the DTO in order to provide informed consent.

At the conclusion of the Screening Hearing, the DCV Magistrate may:

- determine the offender as being **suitable**, in which case the matter is adjourned for approximately three weeks to allow for two assessments to take place (discussed in Section 3.3); or
- determine the offender as being **unsuitable**, in which case the offender may be sentenced at that point, or the matter is remitted back to the MCV for sentencing.<sup>14</sup>

Upon the DCV Magistrate finding the offender to be an eligible candidate for a DTO, the case is adjourned while two assessment reports are requested and provided to the DCV.

### 3.3.2. Assessment

Upon the DCV Magistrate finding the offender to be an eligible candidate for a DTO, the case is adjourned while two assessment reports are requested and provided to the DCV as follows:

- **Case Management assessment**, which considers the offender's:
  - legal history, including previous conditions and penalties, imprisonment history and comments on current offences before the MCV;
  - family and social history, including cultural background and support networks;

<sup>13</sup> Magistrates' Court of Victoria, *Drug Court Processes*, available at <https://www.magistratescourt.vic.gov.au/jurisdictions/specialist-jurisdictions/drug-court/drug-court-processes>, accessed 6 May 2014.

<sup>14</sup> Ibid.

- education and employment status;
- housing and accommodation needs, including the need for referral to the Drug Court Homelessness Assistance Program (DCHAP); and
- general information regarding the offender's background, current circumstances and presentation.<sup>15</sup>

The Case Management assessment is approximately 1.5 hours in duration, and is undertaken by a Case Manager from Corrections Victoria with reference to the *Drug Court of Victoria Assessment Tool: Case Management*.

- **Clinical Advisor assessment**, which considers the offender's:

- drug and alcohol use history;
- behavioural indicators;
- treatment history;
- health status; and
- motivation to change.<sup>16</sup>

The Clinical Advisor assessment is of approximately 1.5 hours in duration, and is undertaken by a Clinical Advisor employed through MCV with reference to the *Enhanced Addiction Severity Index*.

Each report contains a recommendation as to the suitability or unsuitability of the offender for a DTO, along with case management, treatment plans and any specific conditions that should be attached to the DTO.<sup>17</sup>

### 3.3.3. Sentencing hearing

Following consideration of the Case Manager and Clinical Advisor assessments, the DCV Magistrate hears any submissions on whether the offender should be placed on a DTO.

If the DCV Magistrate determines the offender is not suitable for a DTO, they may impose a sentence at that time or refer the matter back to the MCV for sentencing.

If the DCV Magistrate determines an offender as suitable for a DTO and they consent to being placed on a DTO, the Magistrate will hear the offender's plea and sentence the offender to a two-year DTO, which consists of two components as outlined in Table 3-1.

---

<sup>15</sup> Magistrates' Court of Victoria, *Drug Court Processes*, available at <https://www.magistratescourt.vic.gov.au/jurisdictions/specialist-jurisdictions/drug-court/drug-court-processes>, accessed 6 May 2014.

<sup>16</sup> Ibid.

<sup>17</sup> Ibid.

Table 3-1: Drug Treatment Order components

Component	Description
<b>Treatment and supervision component</b>	<ul style="list-style-type: none"> <li>Operates for two years or until cancelled under the <i>Sentencing Act 1991</i> (Vic) ss 18ZK, 18ZN or 18ZP</li> <li>The DCV Magistrate maintains responsibility for the supervision of offenders on a DTO. They will include specific conditions in the participant's DTO which are intended to assess the offender's drug and alcohol dependency, such as regular drug testing, attendance at appointments with Case Managers and Clinical Advisors, drug and alcohol counselling and regular attendances before the DCV Magistrate.</li> </ul>
<b>Custodial component</b>	<ul style="list-style-type: none"> <li>A sentence conferring a period of custody on the offender (not exceeding two years) which is held in abeyance to allow for the treatment of the offender</li> <li>May be activated by the DCV at any time throughout the DTO, noting that if the participant breaches any of the conditions imposed by the DTO, the DTO may be cancelled and the offender sentenced to serve the unexpired portion of their sentence in prison</li> </ul>

Source: Magistrates' Court of Victoria, *Sentencing at the Drug Court*, available at <https://www.magistratescourt.vic.gov.au/jurisdictions/specialist-jurisdictions/drug-court/sentencing-drug-court>, accessed 6 May 2014.

The treatment and supervision component of the DTO consists of both core and program conditions. Core conditions apply to all DTOs, and program participants must continue to comply with them throughout their DTO. Program conditions are attached to the DTO as the DCV Magistrate considers necessary to achieve the purpose for which the DTO is made.<sup>18</sup> An offender must comply with all program conditions attached to the DTO for the entire time the Order is in force. An overview of core conditions and program conditions is provided in Table 3-2.

<sup>18</sup> Magistrates' Court of Victoria, *Treatment and Supervision*, available at <https://www.magistratescourt.vic.gov.au/jurisdictions/specialist-jurisdictions/drug-court/treatment-and-supervision>, accessed 6 May 2014.

Table 3-2: Drug Treatment Order core and program conditions

Core conditions	Program conditions
<p>The offender must:</p> <ul style="list-style-type: none"> <li>• Not commit, either within or outside Victoria, another offence punishable upon conviction by imprisonment during the time that the DTO is in force</li> <li>• Attend the DCV when required to do so</li> <li>• Report to a specified Community Corrections Centre or other specified place within two clear working days after the order is made</li> <li>• Report to, and accept visits from, a member of the DCV team or by a specified Community Corrections Officer</li> <li>• Undergo treatment for drug and/or alcohol dependency specified in the DCV, by the DCV or by a specified Community Corrections Officer</li> <li>• Give notice of any change of address at least two clear working days before the change, to a member of the DCV team</li> <li>• Not leave Victoria without the permission of the DCV or a specified Community Corrections Officer</li> <li>• Obey all lawful instructions from the DCV and the specified Community Corrections Officer</li> </ul>	<p>The offender must:</p> <ul style="list-style-type: none"> <li>• Submit to drug and/or alcohol testing as specified in the DTO</li> <li>• Submit to detoxification or other treatment as specified in the DTO</li> <li>• Attend vocational, educational, employment or other programs as specified in the DTO</li> <li>• Submit to medical, psychiatric or psychological assessment as specified in the DTO</li> <li>• Not associate with specified persons</li> <li>• Reside at a specified place for a specified period</li> <li>• Comply with anything else that the DCV considers necessary or appropriate concerning the offender's drug and/or alcohol dependency, or the personal factors that the DCV considers contributed to the offender's criminal behaviour</li> </ul>

Source: Magistrates' Court of Victoria, *Treatment and Supervision*, available at <https://www.magistratescourt.vic.gov.au/jurisdictions/specialist-jurisdictions/drug-court/treatment-and-supervision>, accessed 6 May 2014.

### 3.4. Operation of the Drug Treatment Order

As a specialist problem-solving court, the DCV has a number of features which facilitate the application of therapeutic jurisprudence principles to assist in sentencing and rehabilitating eligible offenders. These features, discussed in turn below, are:

- application of the DTO in three discrete phases;
- a multidisciplinary DCV team, comprising the DCV Magistrate, Case Managers, Clinical Advisors, Victoria Police members, legal representatives and housing support worker;
- a range of case management and judicial monitoring practices; and
- application of rewards and sanctions to support behavioural change.

#### 3.4.1. Drug Treatment Order phases

The DTO is comprised of three phases, as illustrated in Table 3-3. Each phase contains different treatment requirements and expectations of the participant. In order to progress from a lower phase to a higher phase, participants must have achieved all the goals of their current phase, and meet certain phase progression criteria. The DCV Magistrate determines whether the offender is ready to progress to a higher phase on the basis of:

- feedback from the DCV team regarding the offender's progress in treatment;
- levels of compliance with the DTO; and

- submission of a Phase Progression Petition (a short paragraph prepared by the participant with the assistance of their Case Manager) outlining what they have learnt in the previous phase, and what will be expected of them in the next phase.<sup>19</sup>

Table 3-3: Drug Treatment Order phases, requirements and progression criteria

Phase	Objectives	Participant requirements
<b>Phase 1 Stabilisation (3-6 months)</b>	<p>The aim is to assist participants to:</p> <ul style="list-style-type: none"> <li>• Reduce drug use</li> <li>• Be honest about their drug use and treatment</li> <li>• Punctually attend all treatment and reporting requirements</li> <li>• Cease criminal activity</li> <li>• Stabilise their physical and mental health</li> <li>• Stabilise their housing/accommodation</li> <li>• Begin to address 'life skills' (including financial management, parenting and self-esteem development)</li> </ul>	<p>Participants are required to:</p> <ul style="list-style-type: none"> <li>• Attend weekly Court Review Hearings</li> <li>• Attend weekly Case Management appointments</li> <li>• Attend weekly Drug and Alcohol Counselling</li> <li>• Attend all other appointments as directed by the DCV</li> <li>• Submit for urinalysis testing three times per week (Mondays, Wednesdays and Fridays)</li> <li>• If on an alcohol ban, submit for breath-testing twice weekly (Tuesdays and Thursdays)</li> </ul>
<b>Progression criteria</b>	<p>In order to progress from Phase 1 to Phase 2, offenders must:</p> <ul style="list-style-type: none"> <li>• Demonstrate a reduction in drug use</li> <li>• Demonstrate a material and substantial reduction of offending</li> <li>• Demonstrate engagement in achieving stable accommodation</li> <li>• Reduce contact with criminal peers</li> <li>• Submit a phase petition</li> <li>• Demonstrate reliability and punctuality in attendance at appointments</li> <li>• Demonstrate a positive attitude towards rehabilitation</li> <li>• Establish a treatment and medication regime</li> <li>• Address immediate medical and mental health needs</li> <li>• Demonstrate honesty regarding their drug use</li> </ul>	
<b>Phase 2 Consolidation (3-6 months)</b>	<p>The aim is to assist participants to:</p> <ul style="list-style-type: none"> <li>• Maintain honesty about their drug use and treatment</li> <li>• Achieve periods of abstinence from drug use</li> <li>• Continue to punctually attend all treatment and reporting requirements</li> <li>• Continue to refrain from criminal activity</li> <li>• Maintain stable accommodation according to their needs</li> <li>• Consolidate their social and domestic environment</li> <li>• Improve their health and general wellbeing</li> <li>• Identify job skill needs and undertake education or training</li> </ul>	<p>Participants are required to:</p> <ul style="list-style-type: none"> <li>• Attend fortnightly Court Review Hearings</li> <li>• Attend fortnightly Case Management appointments</li> <li>• Attend fortnightly Drug and Alcohol Counselling</li> <li>• Attend all other appointments as directed by the DCV</li> <li>• Submit for urinalysis testing twice weekly (Mondays and Fridays)</li> <li>• If on an alcohol ban, submit for breath-testing weekly (Thursdays)</li> </ul>
<b>Progression criteria</b>	<p>In order to progress from Phase 2 to Phase 3, offenders must:</p> <ul style="list-style-type: none"> <li>• Demonstrate control over their drug use</li> <li>• Demonstrate a lack of offending</li> </ul>	

<sup>19</sup> Drug Court of Victoria, *Drug Court Participant Manual* (Drug Court of Victoria, undated) p. 13.



Phase	Objectives	Participant requirements
	<ul style="list-style-type: none"> <li>• Demonstrate engagement in achieving financial stability</li> <li>• Demonstrate engagement in achieving stable accommodation</li> <li>• Demonstrate independence from criminal and drug-using peers</li> <li>• Submit a phase petition</li> <li>• Demonstrate a positive attitude towards rehabilitation</li> <li>• Commence addressing underlying medical and mental health issues</li> <li>• Comply with their treatment regime, including counselling or other treatment</li> <li>• Comply with their medication regime, including pharmacotherapy</li> <li>• Have the ability to successfully implement relapse prevention measures</li> </ul>	
<b>Phase 3 Re-integration (minimum six months)</b>	<p>The aim is to assist participants to:</p> <ul style="list-style-type: none"> <li>• Maintain honesty regarding their drug use and treatment</li> <li>• Maintain abstinence from drug use</li> <li>• Maintain a crime-free lifestyle</li> <li>• Maintain their general health and wellbeing</li> <li>• Maintain stable accommodation according to their needs</li> <li>• Continue to punctually attend all their treatment and reporting requirements</li> <li>• Undertake education or training, or gain employment</li> <li>• Be fiscally responsible</li> <li>• Engage in family reconnection</li> </ul>	<p>Participants are required to:</p> <ul style="list-style-type: none"> <li>• Attend monthly Court Review Hearings</li> <li>• Attend monthly Case Management appointments</li> <li>• Attend monthly Drug and Alcohol Counselling</li> <li>• Attend all other appointments as directed by the DCV</li> <li>• Submit for weekly urinalysis testing (Mondays)</li> <li>• If on an alcohol ban, submit for weekly breath-testing (either Tuesdays or Thursdays)</li> </ul>

Source: Drug Court of Victoria, *Drug Court Participant Manual* (Drug Court of Victoria, undated) 9-15.

Should participants on Phase 2 or 3 begin to show reduced performance of phase goals, or fail to meet requirements of their phase, the DCV Magistrate may:

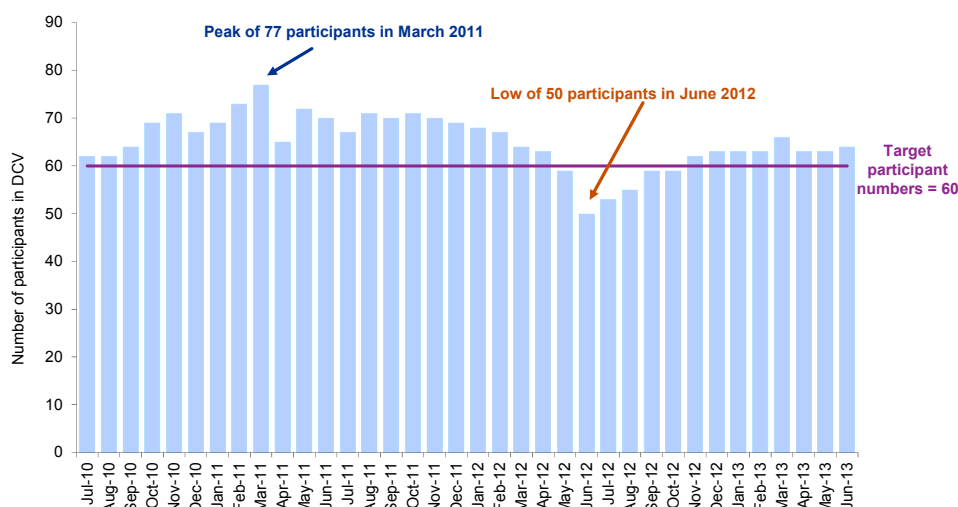
- place the participant on a four-week 'trial run' of a lower phase, in which drug testing, court attendance and case management appointments will be increased. If the participant demonstrates significant improvement over this time, they may be allowed to stay on their original phase;<sup>20</sup> or
- if significant improvement is not demonstrated following the four-week 'trial run', demote the participant to a lower phase.<sup>21</sup>

The DCV program has a target of 60 participants enrolled on the program at any given time as displayed in Figure 3-2. This figure is driven in turn by case-load targets.

<sup>20</sup> Drug Court of Victoria, *Drug Court Participant Manual* (Drug Court of Victoria, undated) p. 16.

<sup>21</sup> Ibid, p. 17.

Figure 3-2: DCV numbers of participants on the program by month (2010-11 through 2012-13)



Source: Drug Court of Victoria, *DRUIS Database Extracts* (1 July 2010 – 30 June 2013).

During the evaluation period, enrolment fluctuated from as high as 77 in March 2011 to as low as 50 in June 2012. Stakeholders reported that the low point in June 2012 coincided with a period when the DCV did not have a permanent Magistrate, which resulted in a number of Magistrates rotating through the Court. As the DCV Magistrate is an active stakeholder in participants DTO, the lack of a permanent Magistrate potentially resulted in declining engagement and participation. Since this low point in June 2012, however, the number of participants in the program is back to over 60 participants. Sometimes, a higher number of participants than 60 is manageable because of the differing levels of case management required on different phases, and the diverse range of needs of participants. However, 77 was considered by stakeholders to be a maximum with the existing resources, and during periods of above average numbers enrolled on the program, that the DCV can (and has) introduce a waiting list.

### 3.4.2. Role of the Drug Court team

The Drug Court Magistrate has responsibility for the supervision of offenders on the Drug Court program, assisted by a multi-disciplinary team as outlined in Table 3-4.

Table 3-4: Drug Court of Victoria team composition

Team member	Role
<b>Case Manager</b>	Community Corrections Services employee who advises the DCV on matters relating to offender management, criminal behaviour, compliance with orders, substance use and assists the participant in day-to-day management of their DTO.
<b>Legal Aid Lawyer</b>	Victoria Legal Aid solicitor who provides legal assistance to participants on any legal matters relevant to their DTO, including current or outstanding criminal matters.
<b>Clinical Advisor</b>	MCV employee with a background in drug and alcohol treatment who develops treatment plans to address substance use and associated issues, and provide expert advice to the MCV in relation to the participant's psychosocial history and substance use.
<b>DCHAP Case Worker</b>	Representative from local housing agency WAYSS who provides assistance to participants through the DCHAP program where there is an identified high risk of homelessness or unsafe/inadequate current accommodation.
<b>Victoria Police Liaison Officer</b>	Unsworn Victoria Police member who provides relevant information and updates to the DCV team on contemporary police matters.

Source: Magistrates' Court of Victoria, *Drug Court Information Sheet*, available at <https://www.magistratescourt.vic.gov.au/publication/drug-court-information-sheet>, accessed 8 May 2014.

### 3.4.3. Case management

Ongoing supervision of treatment and compliance with a DTO is effected through:

- **Case Conferences**, which are held prior to each participant's Review Hearing and attended by the DCV Registrar, Police Prosecutor, Legal Aid Lawyer, Clinical Advisor and Case Manager, all of whom provide the DCV Magistrate with updates regarding:
  - the ongoing performance of the participant in relation to drug use, treatment and compliance on the DTO;
  - possible variations of the DTO;
  - appropriate rewards and/or sanctions; and
  - further offending or dealings with the police.<sup>22</sup>

Regardless of what has been discussed and put forward at the Case Conference by the DCV team, no decision will be made officially until the participant is given the opportunity to be heard at the Review Hearing.<sup>23</sup>

- **Review Hearings (within the DCV)**, where the DCV Magistrate discusses progress and issues raised during the Case Conference directly with the participant, who is subsequently provided with an opportunity to respond and give their opinion or version of events in relation to the issues raised. After hearing from the participant, the DCV Magistrate then decides whether the participant's DTO needs to be varied, or whether a reward or sanction should be imposed. Review Hearings may be weekly, fortnightly or monthly depending on the DTO phase.<sup>24</sup>

In addition to these mechanisms, once a DTO is imposed, it may be varied, and participants sentenced to a DTO may be required to attend Breach Hearings in the event of non-compliance.

- **Applications to Vary** may be initiated by the offender, informant or Police Prosecutor or a prescribed person (including a Community Corrections Officer). The application may vary the treatment and supervision component of the DTO through:
  - addition or removal of one or more program conditions; or
  - varying one or more of the core conditions, including the frequency of treatment, degree of supervision, frequency of drug and alcohol testing and type or frequency of vocational, educational, employment or other programs that the offender must attend.<sup>25</sup>

The DCV Magistrate will approve the Application to Vary if it is considered appropriate to do so, based on his/her assessment of the offender's progress on their DTO.

- **Breach Hearings** are held when it is believed that the participant should be terminated from the program based on any non-compliance issues raised at the Review Hearings, such as inappropriate behaviour whilst attending a program, continuing drug use or further offending. Reports are prepared outlining the issues relating to the participant's non-compliance, and the Police Prosecutor and Legal Representative assume traditional roles during the hearing; if the hearing is contested, the participant may be called and cross-examined. The DCV Magistrate presides over all breach hearings and may decide to:
  - *continue the participant on the DTO*, meaning that they will resume their treatment, drug testing and court appearances; or
  - *terminate the participant from the program*, meaning that the DTO is cancelled and the offender must be re-sentenced.<sup>26</sup>

<sup>22</sup> Magistrates' Court of Victoria, *Drug Court Processes*, available at <https://www.magistratescourt.vic.gov.au/jurisdictions/specialist-jurisdictions/drug-court/drug-court-processes>, accessed 8 May 2014.

<sup>23</sup> Ibid.

<sup>24</sup> Ibid.

<sup>25</sup> Ibid.

<sup>26</sup> Ibid.

### 3.4.4. Rewards and sanctions

Rewards and sanctions are tools used by the DCV to encourage positive behaviour and support participants to engage in treatment.<sup>27</sup>

- **Sanctions** are imposed by the Drug Court Magistrate each time the participant does not comply with phase requirements or a DTO condition is breached.
- **Rewards** are awarded each time a participant follows their phase requirements and DTO conditions, or shows progress towards the goals of a higher phase.

The range of sanctions and rewards which may be imposed/received by the DCV Magistrate are outlined in

Table 3-5, and illustrate the escalating severity (in the case of sanctions) and benefit (in the case of rewards).

Table 3-5: Drug Court of Victoria sanctions and rewards

	Guideline sanctions	Guideline rewards
Low	Verbal warning Keep a drug diary	Verbal praise
Moderately low	Admonishment from DCV Magistrate Write a journal entry Write an essay	Verbal praise and clapping
Moderate	Court Review Sit-In Sanction <sup>28</sup> Community work days imposed Increase in frequency of court appearance Increase in frequency of case management Increase in frequency of drug testing Imprisonment days imposed	Court Review Quick List <sup>29</sup> Reduction of community work days Reduction of imprisonment days Reduction in frequency of court appearance Reduction in frequency of case management Reduction in frequency of drug testing  Fishbowl reward <sup>30</sup>
Moderately high	Phase demotion Activation of imprisonment days, <sup>31</sup> following by full phase demotion if not recently actioned	Phase progression
High	Warrant of arrest issued Order suspension Order cancellation and resentencing	Order completion Order graduation

Source: Drug Court of Victoria, *Drug Court Participant Manual* (Drug Court of Victoria, undated) 18.

<sup>27</sup> Magistrates' Court of Victoria, *Drug Court Processes*, available at <https://www.magistratescourt.vic.gov.au/jurisdictions/specialist-jurisdictions/drug-court/drug-court-processes>, accessed 8 May 2014.

<sup>28</sup> The Court Review Sit-in Sanction is a sanction for attending a Court Review late. Participants who receive this sanction are required to attend the next Review Hearing on time and sit at the back of the courtroom to listen to all other participants' Review Hearings on that day; the participant is not allowed to leave the courtroom until the Court day is complete.

<sup>29</sup> The Court Review Quick List is a reward for attending a Court Review Hearing punctually. If a participant's name is put on this list, they are one of the first participants to have their case heard, and are automatically put on the Quick List for the following review.

<sup>30</sup> A fishbowl reward is a chance to take a 'lucky dip' from a large fishbowl that contains a variety of prizes, including vouchers to various events and social activities, and large and small gifts.

<sup>31</sup> A minimum of seven imprisonment days can be activated, however, in practice, usually 15 days' imprisonment are activated.

The sanctions and rewards imposed may vary according to the phase of the DTO, and the length of time a participant has been on the DTO. Greater expectations regarding drug use, behaviour, etc., are imposed on participants who have been on the DTO for a longer period of time.<sup>32</sup>

Sanctions and rewards are imposed/granted very frequently by the Magistrate, with DCV participants receiving an average of 28 sanctions and 13 total rewards over the course of their DTO.<sup>33</sup> For all 130 DCV clients, the total number of imprisonment days received while on the Order was 2,965 days, or an average of 23 imprisonment days per client.<sup>34</sup>

### 3.5. Completion of the Drug Treatment Order

The DTO expires two years from the date it was imposed and may be finished in one of four ways: graduation, completion, cancellation as a reward, or cancellation. Each method is described in Table 3-6.

Table 3-6: Drug Treatment Order exit pathways

DTO Exit Pathway	Description
<b>Cancellation as a reward</b>	Refers to circumstances in which the DCV considers that the participant has (to date) fully or substantially complied with the conditions attached to the DTO and the continuation of the Order is no longer necessary to meet the purposes for which it was made. If the DTO is cancelled as a reward, any orders which activate the custodial component of the order cease to have effect.
<b>Graduation</b>	Refers to circumstances in which a participant achieves all the goals of Phase 3 and meets the graduation criteria by the time the DTO expires. Both the treatment and supervision <i>and</i> the custodial components of the DTO are cancelled. In order to graduate, a participant must meet the following criteria: <ul style="list-style-type: none"> <li>• sustained periods of abstinence from drug use;</li> <li>• maintenance of independence from criminal and drug-using peer group;</li> <li>• no further offending in the previous six months;</li> <li>• demonstrated fiscal responsibility;</li> <li>• maintenance of physical and mental health and wellbeing;</li> <li>• demonstrated reliability and punctuality in attendance;</li> <li>• maintenance of stable accommodation;</li> <li>• development of a comprehensive Exit Plan in consultation with the DCV team;</li> <li>• achievement of all treatment goals of Phase 3 indicated in the participant's Treatment Plan; and</li> <li>• in the event of a lapse, has shown the ability to successfully implement relapse prevention measures.</li> </ul>
<b>Completion</b>	Refers to circumstances in which a participant satisfactorily complies with the requirements of either Phase 2 or Phase 3 but has not graduated by the time the DTO expires. Both the treatment and supervision <i>and</i> the custodial components of the DTO are cancelled. In order to complete a DTO, a participant must meet the following criteria: <ul style="list-style-type: none"> <li>• satisfactory compliance with the requirements of Phase 2 or above;</li> <li>• reduced contact with criminal peer group/co-offenders;</li> <li>• no further offending in the previous three months;</li> <li>• demonstrated reliability and punctuality in attendance;</li> <li>• maintenance of stable accommodation according to needs;</li> <li>• development of a comprehensive Exit Plan in consultation with the DCV team;</li> <li>• addressing of immediate physical and mental health concerns;</li> </ul>

<sup>32</sup> Drug Court of Victoria, *Drug Court Participant Manual* (Drug Court of Victoria, undated) p. 20.

<sup>33</sup> Averages based on 128 participants, 1,659 total rewards and 3,633 total sanctions during the review period. Drug Court of Victoria, DRUIS Database Extracts (1 July 2010 – 30 June 2013). Note that discrepancies arise in relation to the number of participants for which data is available due to a high proportion of optional fields for completion in the DRUIS database.

<sup>34</sup> Drug Court of Victoria, *DRUIS Database Extracts* (1 July 2010 – 30 June 2013).

DTO Exit Pathway	Description
	<ul style="list-style-type: none"> <li>demonstrated control over drug use; and</li> <li>making of some progress towards achieving all the treatment goals of the current phase.</li> </ul>
<b>Cancellation</b>	<p>An <i>Application to Cancel</i> a DTO may be filed by the participant, informant or Police Prosecutor, prescribed person (including a Community Corrections Officer) or the DCV Magistrate. Following consideration of this application, the DCV Magistrate may cancel the treatment and supervision component of a DTO if he/she is satisfied on the balance of probabilities that:</p> <ul style="list-style-type: none"> <li>before the DTO was made, the participant's circumstances were not accurately presented to either the DCV or the authority of the assessment reports;</li> <li>the participant will not be able to comply with a certain condition attached to their DTO because their circumstances have materially changed since the Order was made;</li> <li>the offender is no longer willing to comply with one or more conditions attached to the DTO; or</li> <li>continuation of the treatment and supervision component of the DTO is not likely to achieve one or more of the purposes for which it was made.</li> </ul> <p>If the DCV Magistrate cancels the treatment and supervision component of the DTO, then the following ensues:</p> <ul style="list-style-type: none"> <li>making of an order activating some or all of the custodial component of the DTO; or</li> <li>cancellation of the custodial component of the DTO and re-sentencing of the offender.</li> </ul>

Sources: Drug Court of Victoria, *Drug Court Participant Manual* (Drug Court of Victoria, undated) 22-25; Magistrates' Court of Victoria, *Drug Court Processes*, available at <https://www.magistratescourt.vic.gov.au/jurisdictions/specialist-jurisdictions/drug-court/drug-court-processes>, accessed 8 May 2014.

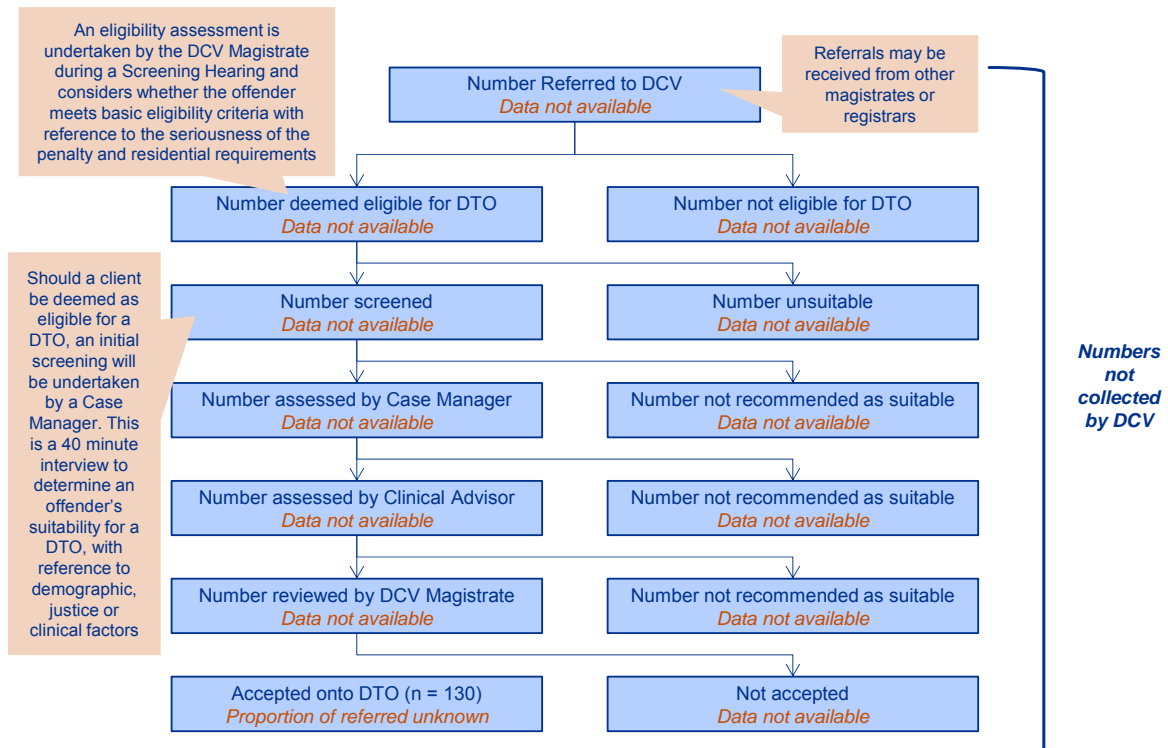
### 3.6. Offending cohort

This section provides a summary of the key characteristics of the DCV client cohort. Currently, the DCV only collects data on clients admitted onto a DTO and does not collect data on the total number of people referred or the number considered ineligible. Collecting this data would allow for a more in-depth analysis of the demand for the DCV and characteristics of those referred, accepted and not accepted onto a DTO to be properly assessed.

The process for being accepted onto a DTO from referral to acceptance is displayed in Figure 3-3.



Figure 3-3: DCV program entry process



Sources: Drug Court of Victoria, Drug Court Participant Manual; Drug Court of Victoria, DRUIS Database Extracts (1 July 2010 – 30 June 2013); Data provided by MCV in e-mail dated 17 May 2014.

Since July 2010, 130 clients have been accepted onto a Drug Treatment Order (DTO), with 18 per cent of these clients still active (n = 24).

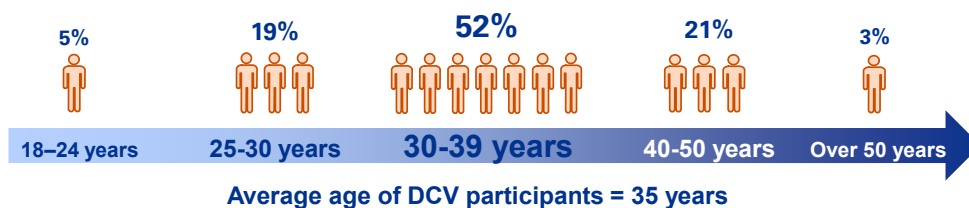
The DCV's DRUIS database has been analysed to identify key DCV client characteristics over the evaluation period (1 July 2010 to 30 June 2013). The key findings of this analysis, as recorded during the client intake and assessment process, and contrasted against demographic data of the broader Dandenong area (as recorded in the 2011 Census), are outlined in the following sub-sections.

### 3.6.1. Age and gender

#### Age

Defendants accepted onto a DTO during the review period ranged in age from 22 to 52. The majority of clients, 68 of 130 (52 per cent), were aged 30-39 years. A roughly equal proportion of clients fell in the 25-30 and 40-50 year age group (19 per cent and 21 per cent respectively). A breakdown of age distribution amongst the DCV clients during the review period is provided in Figure 3-4.

Figure 3-4: Age of Drug Court of Victoria evaluation cohort



Source: Drug Court of Victoria, DRUIS Database Extracts (1 July 2010 – 30 June 2013). Note that discrepancies arise in relation to the number of participants for which data is available due to a high proportion of optional fields for completion in the DRUIS database. For the above analysis n = 130.

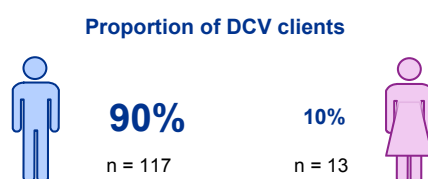


There is a degree of similarity in age distribution patterns amongst the DCV and the Greater Dandenong population. Of the Greater Dandenong population aged between 20 and 64, 28 per cent of persons were aged between 25 and 34, and 22 per cent between 35 and 44.<sup>35</sup>

### Gender

Nine in 10 DCV clients (90 per cent) accepted onto a DTO during the review period were male. Whilst this high proportion of males is not indicative of the Greater Dandenong area, which demonstrates a more equal distribution of males and females (50 per cent in each gender category), this high proportion of male participants in DCV is indicative of the broader over-representation of males in the state criminal justice system. At 30 June 2013, males represented 93 per cent of the total Victoria prison population.<sup>36</sup> The distribution of DCV clients by sex is shown in Figure 3-5.

Figure 3-5: Distribution of DCV clients by gender (2010-11 through 2012-13)



Source: Drug Court of Victoria, *DRUIS Database Extracts* (1 July 2010 – 30 June 2013). Note that discrepancies arise in relation to the number of participants for which data is available due to a high proportion of optional fields for completion in the DRUIS database. For the above analysis n = 130.

### 3.6.2. Cultural background

As part of the intake process, most DCV participants have their country of birth recorded in the DRUIS database. Of those accepted, eight in 10 clients (91 of 114, 80 per cent) were born in Australia, with the next most common countries of birth being:

- Vietnam: seven clients (six per cent);
- Fiji: three clients (three per cent);
- Cambodia: two clients (two per cent); and
- England: two clients (two per cent).<sup>37</sup>

A similarly homogenous picture is present with regards to language, with 109 of 121 clients (90 per cent), stating English as a first language.<sup>38</sup> During the evaluation period, six clients (five per cent) stated Vietnamese as a first language.

This relatively homogenous client cohort is not reflective of the noted cultural diversity of the Greater Dandenong area, in which only 38 per cent of persons are born in Australia – with significant Vietnamese (nine per cent), Indian (seven per cent), Cambodian and Sri Lankan populations (both four per cent).<sup>39</sup> Fourteen per cent of the population of Greater Dandenong do not speak English well, or do not speak English at all.

DCV case workers also record a client's Indigenous status should they choose to state it. During the evaluation period, three clients (three per cent of those who stated) were recorded as Indigenous.<sup>40</sup> This proportion of Indigenous clients is greater than for the wider Dandenong community, which had

<sup>35</sup> Australian Bureau of Statistics, *2011 Census of Population and Housing – Basic Community Profile (Greater Dandenong)* (Cat No. 2001.0) (Australian Government 2011).

<sup>36</sup> Australian Bureau of Statistics, *Prisoners in Australia* (Cat. No. 4517) (Australian Government 2013).

<sup>37</sup> Drug Court of Victoria, *DRUIS Database Extracts* (1 July 2010 – 30 June 2013). Note that 16 clients did not have their country of birth recorded in the database; these clients have been excluded from the above analysis.

<sup>38</sup> Drug Court of Victoria, *DRUIS Database Extracts* (1 July 2010 – 30 June 2013). Note that nine clients did not state their first language; these clients have been excluded from the above analysis.

<sup>39</sup> Australian Bureau of Statistics, *2011 Census of Population and Housing – Basic Community Profile (Greater Dandenong)* (Cat No. 2001.0) (Australian Government 2011).

<sup>40</sup> Drug Court of Victoria, *DRUIS Database Extracts* (1 July 2010 – 30 June 2013). Note that 26 clients did not have their status recorded in the database; these clients have been excluded from the above analysis.

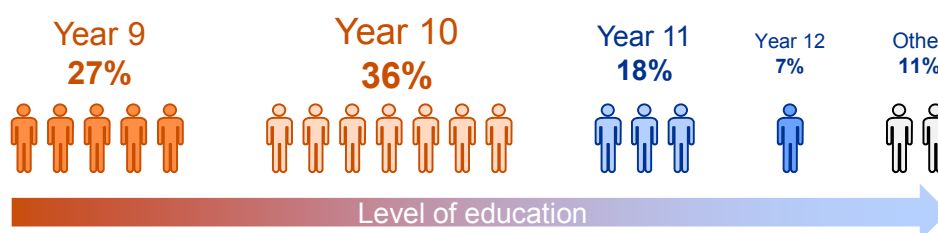
just 0.35 per cent of the population identifying as Indigenous in 2011. Once again, this over-representation of Indigenous clients in the DCV program is reflective of the broader over-representation of Indigenous persons in the Victorian criminal justice system. At 30 June 2013, Indigenous people represented seven per cent of the total Victorian prison population.<sup>41</sup>

### 3.6.3. Education, employment and housing

#### Education

DCV participants have their level of education recorded in the DRUIS database. Of those clients with their education level recorded, 72 of 88 clients screened (82 per cent) had an education level below Year 12. A breakdown of the relative levels of educational attainment is provided in Figure 3-6.

Figure 3-6: Education level of the Drug Court of Victoria evaluation cohort



Source: Drug Court of Victoria, *DRUIS Database Extracts* (1 July 2010 – 30 June 2013). Note that discrepancies arise in relation to the number of participants for which data is available due to a high proportion of optional fields for completion in the DRUIS database. 88 clients had their level of education recorded in the database. Note 2: The above diagram is not to exact scale.

These findings suggest the DCV Cohort has significantly lower levels of educational attainment than the Greater Dandenong population, 50 per cent of whom had attained Year 12 or equivalent at the time of the last Census.<sup>42</sup>

#### Employment

A very high proportion of DCV clients were unemployed at intake, with 74 of 94 clients screened (79 per cent) reporting being unemployed.<sup>43</sup> A further:

- two clients (two per cent) reported being employed full-time;
- two clients (two per cent) were employed part-time;
- two clients (two per cent) were self-employed; and
- four clients (four per cent) were listed as pensioners.<sup>44</sup>

Whilst the Greater Dandenong unemployment rate was 8.9 per cent in 2011, a significantly higher proportion of persons aged 15 and over were not in the labour force (40 per cent).<sup>45</sup> This is considerably higher than the Victorian average of 5.4 per cent unemployment, and 33 per cent of persons not in the labour force.<sup>46</sup>

<sup>41</sup> ABS 2014, Cat. No. 4517, Prisoners in Australia, 2013. And ABS 2013, Cat. No. 3238.0.55.001, Estimates of Aboriginal and Torres Strait Islander Australians, June 2011.

<sup>42</sup> Australian Bureau of Statistics, *2011 Census of Population and Housing – Basic Community Profile (Greater Dandenong)* (Cat No. 2001.0) (Australian Government 2011).

<sup>43</sup> Drug Court of Victoria, *DRUIS Database Extracts* (1 July 2010 – 30 June 2013). Note that one client did not have their employment status recorded in the database; this client has been excluded from the above analysis.

<sup>44</sup> Ibid.

<sup>45</sup> Australian Bureau of Statistics, *2011 Census of Population and Housing – Time Series Profile (Greater Dandenong)* (Cat No. 2003.0) (Australian Government 2011).

<sup>46</sup> Australian Bureau of Statistics, *2011 Census of Population and Housing – Time Series Profile (Victoria)* (Cat No. 2003.0) (Australian Government 2011).

## Housing

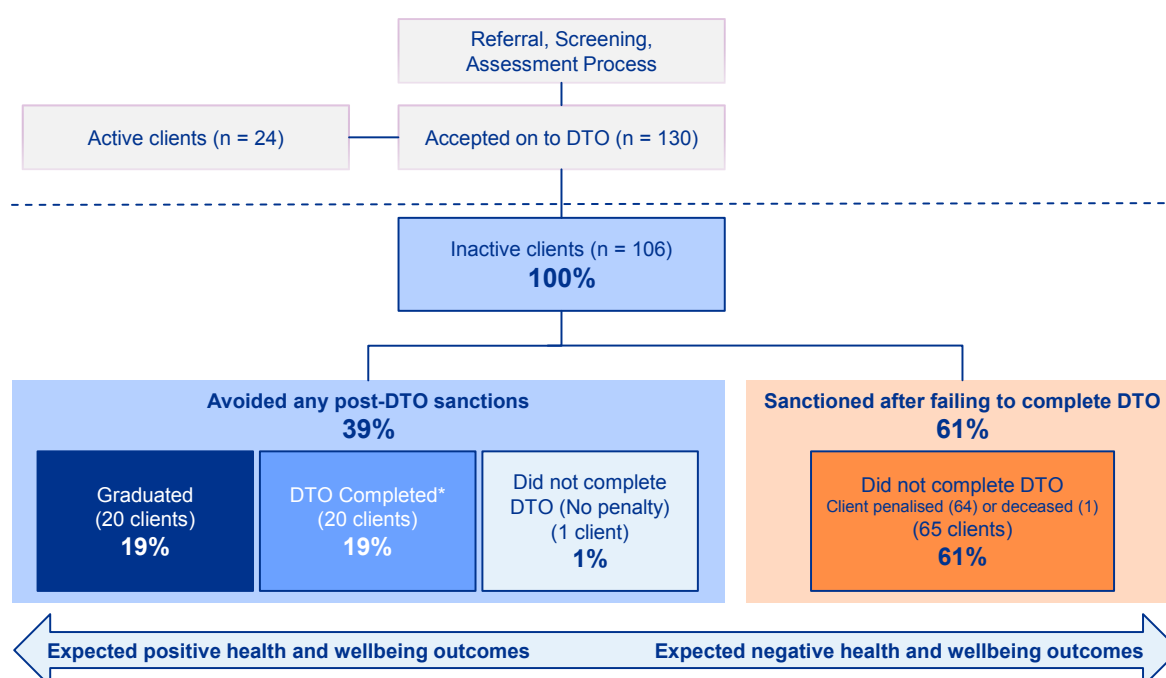
At intake, most DCV clients are living in stable accommodation with either family or friends, in private accommodation or public/community housing. The most common living arrangement amongst the 95 clients with their housing situation recorded was living with family/friends (42 clients, 44 per cent), followed by private/rental accommodation (19 clients, 20 per cent) and public/community housing (nine clients, nine per cent). A notable portion of DCV clients are living in unstable housing environments at intake, with 20 of 95 clients (21 per cent) recorded as homeless or at risk of homelessness.<sup>47</sup>

### 3.6.4. Completion and graduation trends

Since July 2010, 130 clients have been accepted onto a Drug Treatment Order (DTO), with 18 per cent of these clients still active (n = 24). Of the 106 clients who are no longer active, 38 per cent (n = 40) have completed the program and 19 per cent (n = 20) have successfully graduated. One additional client did not complete the program but succeeded in avoiding any further sanction.

Sixty-one per cent (n = 65 clients) of the clients who are no longer active failed to complete the DTO and were sanctioned with a term of imprisonment or suspended sentence. These outcomes are displayed in Figure 3-7.

Figure 3-7: Progression through DCV for clients accepted on to DTO between 1 July 2010 – 30 June 2013



Source: Data provided by DCV in e-mail dated 17 May 2014. \* refers to instances in which a participant has remained on a DTO for the requisite two-year period, however has not progressed through the DTO phases.

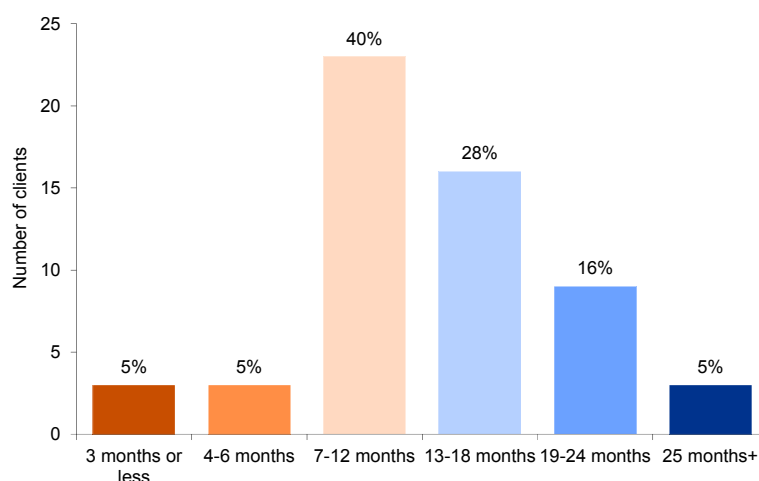
### Length of time before DTO cancellation

A more detailed analysis of the individual DCV clients who did not complete the DTO reveals notable trends. As displayed in Figure 3-7, 65 clients failed to complete their Drug Treatment Order as a result of the order being cancelled by the Magistrate. Of the 65 clients 57<sup>48</sup> received custodial sentences. Of these, just over half (51 per cent, n = 29) had managed to stay on the Order for at least 13 months, and slightly more than one in five (21 per cent, n = 12) had successfully remained on the Order for at least 18 months. Only six clients (10 per cent) failed to stay on the Order for at least six months. These outcomes are displayed in Figure 3-8.

<sup>47</sup> Drug Court of Victoria, *DRUIS Database Extracts* (1 July 2010 – 30 June 2013).

<sup>48</sup> One client did not have any data, the remainder received suspended sentences or a bond

Figure 3-8: Length of time on a DTO before cancellation for clients not completing (n = 57)



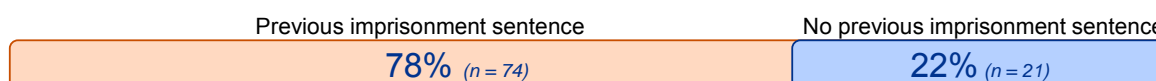
Source: Data provided by DCV in e-mail dated 17 May 2014. Note: The above data reflects the elapsed period between the date a client commenced a DTO and the date the DTO was officially cancelled by the Magistrate.

For the clients who were successful in remaining on the DTO for an extended period (e.g. greater than 13 months), it is likely that whilst they failed to complete the Order, these clients likely received some health and wellbeing benefit as a result of being on the Order for more than one year.<sup>49</sup> Health and wellbeing outcomes for DCV clients are explored in greater detail in Section 6.2.

### 3.6.5. Offending history

Most DCV clients are deeply entrenched in the criminal justice system, having often served multiple sentences of imprisonment before engaging with DCV. As displayed in Figure 3-9, of the 95 clients with their imprisonment history recorded, 78 per cent had served at least one previous sentence of imprisonment.

Figure 3-9: DCV clients' Imprisonment history at intake (2010-11 through 2012-13) (95 clients)



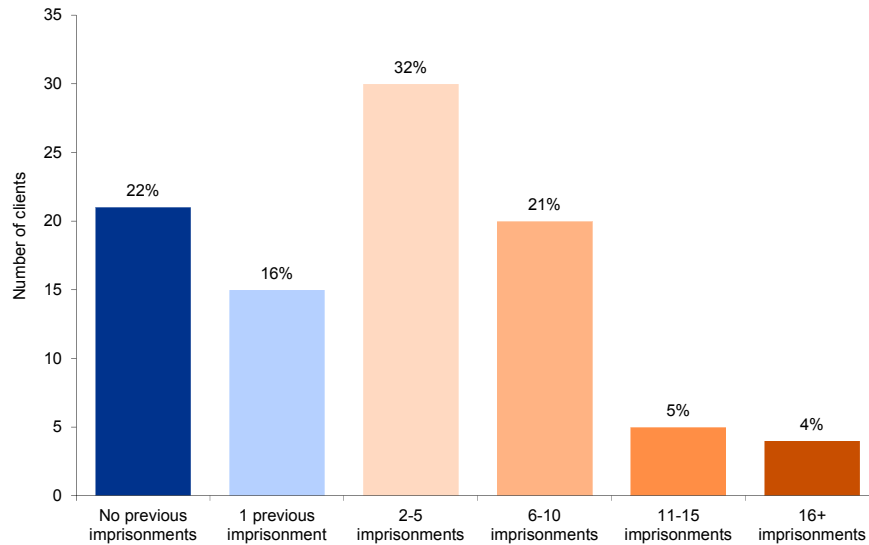
Source: Drug Court of Victoria, DRUIS Database Extracts (1 July 2010 – 30 June 2013).

The majority of DCV clients (59 of 95 clients, 62 per cent) had served multiple imprisonments prior to intake, with some serving as many as 28 previous sentences. Nearly one in three clients (n = 30) had served between two and five imprisonments, and more than one in five clients (n = 20) had served six or more previous sentences. A small proportion of clients (nine clients, nine per cent) are very deeply entrenched in the criminal justice system, having served more than 11 previous imprisonment sentences.<sup>50</sup> These proportions are displayed in Figure 3-10.

<sup>49</sup> This finding should be caveated by the fact that data is only available to identify the period of time between a DTO commencing and a DTO being cancelled by a Magistrate. Some DCV clients who abscond are issued with a warrant, however, their DTO would not be recorded as cancelled until they were arrested and brought before the Magistrate who may then formally cancel the DTO. As such, some clients may be recorded as being on a DTO for a longer period of time than they would be formally engaged with the DCV.

<sup>50</sup> Drug Court of Victoria, DRUIS Database Extracts (1 July 2010 – 30 June 2013).

Figure 3-10: Number of DCV clients' previous imprisonments at intake (2010-11 through 2012-13) (95 clients)

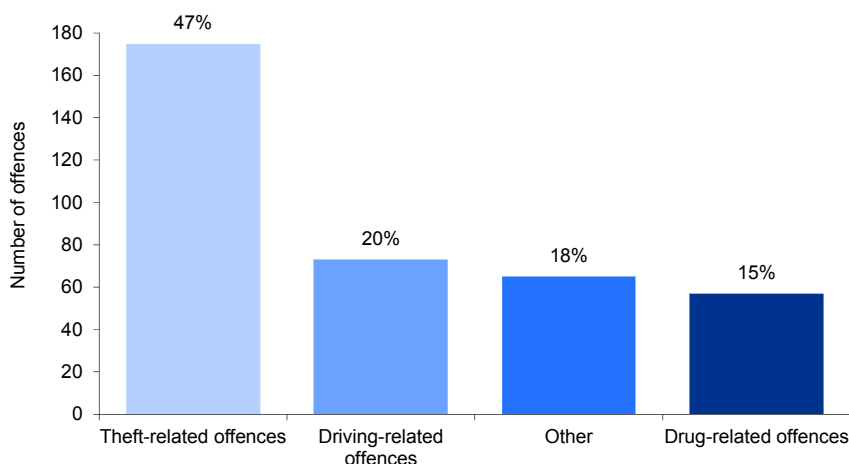


Source: Drug Court of Victoria, DRUIS Database Extracts (1 July 2010 – 30 June 2013).

The high proportion of DCV clients who have served multiple imprisonments prior to engaging with DCV is consistent with empirical and academic evidence with regards to the 'revolving door' effect.<sup>51</sup> This effect describes the pattern by which some offenders with substance use issues cycle in and out of prison as, once released, these offenders reoffend, often relatively quickly, as the prison sentence failed to rehabilitate their substance use pattern. These offenders resume both their offending behaviour, and substance use, upon release and cycle back into prison. This issue is explored further in Sections 4.1 and 5.1.

Complete offending history data including the type of offences is available for 95 clients. Of these clients, all had a previous imprisonment or community-based order. As displayed in Figure 3-11, the most common charges (175 of 370) were theft-related charges, which are frequently committed to support a drug and/or alcohol habit.

Figure 3-11: DCV clients' offences prior to DTO



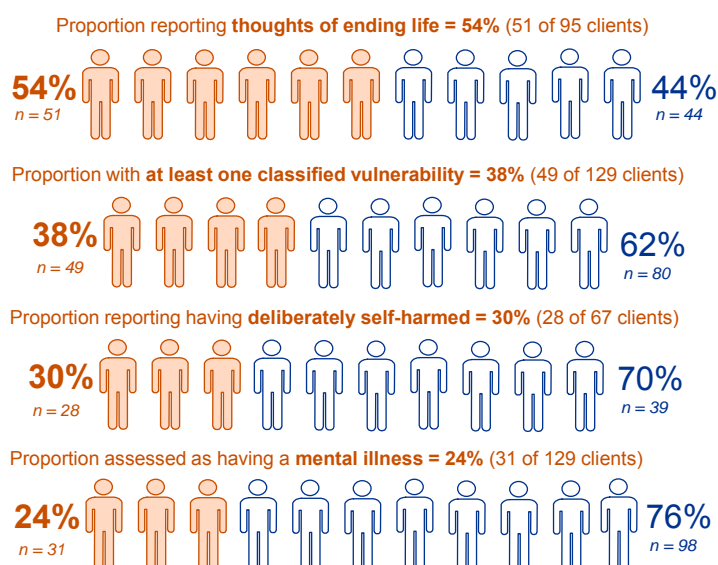
Source: Drug Court of Victoria, DRUIS Database Extracts (1 July 2010 – 30 June 2013). Note that discrepancies arise in relation to the number of participants for which data is available due to a high proportion of optional fields for completion in the DRUIS database.

<sup>51</sup> See, for example: Winick and Wexler quoted in Winick, B. (2002) *Therapeutic Jurisprudence and Problem-Solving Courts*. Fordham Urban Law Journal. 30 (3). p. 1056.

### 3.6.6. Vulnerabilities and disabilities

A significant portion of DCV clients had at least one classified vulnerability or disability recorded at intake. Of those screened, 49 of 129 (38 per cent) clients had at least one classified vulnerability or disability. Mental illness is the most common vulnerability, prevalent among 31 of 129 clients (24 per cent). Nearly one in five have another serious vulnerability (either in isolation or in addition to mental illness), however, the details of nature of the vulnerability have not been recorded in the database. These and other vulnerabilities are summarised in Figure 3-12.

Figure 3-12: Mental wellbeing of DCV clients (2010-11 through 2012-13)



Source: Drug Court of Victoria, DRUIS Database Extracts (1 July 2010 – 30 June 2013). Note that discrepancies arise in relation to the number of participants for which data is available due to a high proportion of optional fields for completion in the DRUIS database.

As outlined in Figure 3-12, a significant portion of DCV clients report low levels of mental wellbeing at intake, with over half reporting having had thoughts of ending their life and nearly one in three reporting having deliberately self-harmed. These findings are consistent with feedback from stakeholder consultations with regards to the multiple and complex needs of the DCV Cohort.

The high rates of mental illness amongst the DCV Cohort are not reflective of the broader Victorian population (which has rates of mental illness of approximately two per cent<sup>52</sup>), however, the prevalence is consistent with rates of vulnerability in the Victorian prison system. A 2011 study by the DoJ found 42 per cent of male prisoners and 33 per cent of female prisoners who had completed a comprehensive assessment had an acquired brain injury (ABI), although most ABIs were mild in nature.<sup>53</sup>

### 3.6.7. Drug and alcohol use

DCV staff record clients' substance use frequency, methods and drug type at the start of the DTO. Analysis of this data confirms the perception amongst stakeholders that DCV clients have deeply entrenched substance use issues, with the significant majority of clients being daily substance users and users of more than one substance.

As might be expected with the DCV Cohort, more than three in four (77 per cent) clients self-report being daily substance users at intake, as displayed in Figure 3-13.

<sup>52</sup> Australia Institute of Health and Welfare (2007) referenced in Magistrates' Court of Victoria (2011), *Acquired brain injury in the Victorian prison system*. Victorian Government, Melbourne.

<sup>53</sup> Magistrates' Court of Victoria (2011), *Acquired brain injury in the Victorian prison system*. Victorian Government, Melbourne.

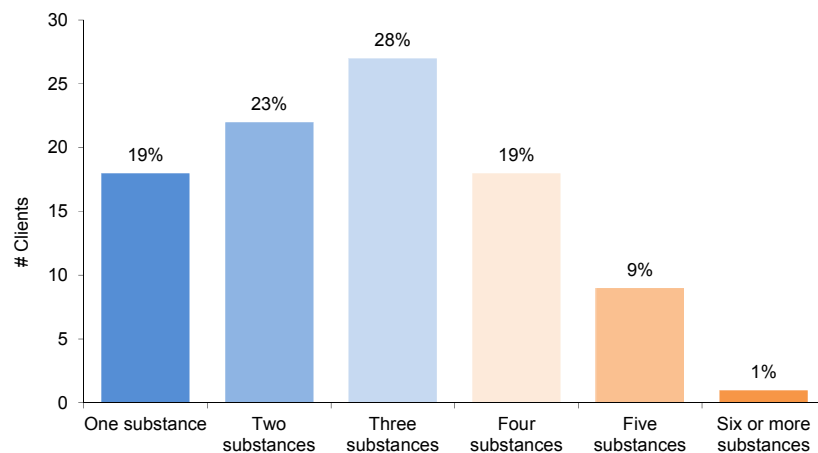
Figure 3-13: Frequency of substance use self-reported by clients' at intake (n = 95)



Source: Drug Court of Victoria, *DRUIS Database Extracts* (1 July 2010 – 30 June 2013).

In addition to being daily users, more than 80 per cent of clients (77 of 95) reported using more than one substance, with some reporting using six or more substances. The majority of clients (49 of 95) report using two or three substances. These proportions are summarised in Figure 3-14.

Figure 3-14: Number of substances clients' self-reported using at intake (2010-11 to 2012-13) (n = 95)

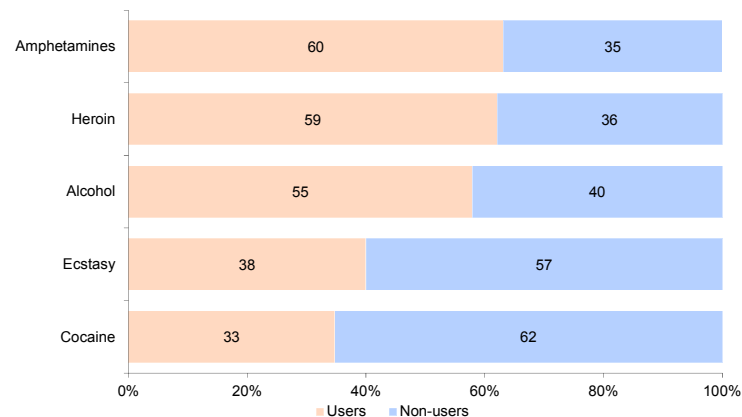


Source: Drug Court of Victoria, *DRUIS Database Extracts* (1 July 2010 – 30 June 2013).

#### Types of substances used at intake

DCV clients report using a broad range of substances at some interval. During the evaluation period, the most common substances used were amphetamines, followed by heroin, alcohol, ecstasy and cocaine. Nearly two-thirds of DCV clients reported using amphetamines and/or heroin at intake, as displayed in Figure 3-15.

Figure 3-15: Type of substances clients' self-reported using at intake (2010-11 to 2012-13) (n = 95)



Source: Drug Court of Victoria, *DRUIS Database Extracts* (1 July 2010 – 30 June 2013). Note: The five substances above represent only the most common type of substances clients' self-reported using



When performing drug testing, DCV records the specific type of amphetamine (of which there are three main types) present in urinalysis tests, however, DCV does not record the specific type used by defendants, at intake. Nevertheless, it can be assumed that the prevalence of amphetamine use amongst DCV clients can be attributed to the broader rise in methylamphetamine usage nationwide, particularly crystal methamphetamine hydrochloride ('ice'). The increasing proportion of clients presenting with ice issues was noted throughout stakeholder consultations.

The prevalence of amphetamine use by DCV clients is reflective of national trends. Surveys of injecting drug users have found that the proportion of users who use ice had increased from 39 per cent in 2010 to 54 per cent in 2012.<sup>54</sup> This increase follows trends in the growing supply of amphetamine-type stimulant in the market. In 2012-13, the number and weight of Australian border detections of amphetamine-type stimulants reached record levels, with 2,139 kg seized.<sup>55</sup>

Consultations revealed ongoing challenges facing DCV Case Workers as a result of treating the increasing number of ice-dependent clients. Comparative progression through the phases of the DTO for amphetamine and non-amphetamine users is explored in Section 6.2.1.3.

### Key findings

Analysis of the cohort accessing the DCV indicates:

- Deeply entrenched criminal behaviour, with 62 per cent having been imprisoned previously on multiple occasions.
- Multiple and complex vulnerabilities and support needs for the majority of participants.
- Higher than expected proportion of Australian-born and English-speaking population, which does not reflect the make-up of the community within Dandenong.

The DCV has consistently had 60 or more participants throughout the evaluation period, peaking at a maximum of 77, and only falling below 60 for six months in 2012, when there was a vacancy for the Magistrate.

<sup>54</sup> Australian Drug Foundation, *Fact Sheet: Ice (crystal methamphetamine)*, available at: <http://www.druginfo.adf.org.au/?ui=full-site>, accessed 28 October 2014).

<sup>55</sup> Australian Crime Commission, *Illicit Drug Data Report* (Australian Government 2013) p. 29.

## 4. Therapeutic jurisprudence and diversion in the criminal justice system

First emerging in the 1970-1980s, diversion acknowledges the negative consequences associated with entry, and deeper progression, into the criminal justice system, and, where appropriate, seeks to avoid this through a range of initiatives and programs.

The DCV is an example of a diversionary initiative at the later stage in the criminal justice system – and as a sentencing option, enables eligible offenders with a drug or alcohol misuse problem to avoid incarceration through a DTO.

As stated in Section 2.3, KPMG conducted a literature review as part of the evaluation to analyse the:

- the rationale for drug courts and the role of the Victorian Government in providing the DCV;
- the principles of therapeutic jurisprudence and how they are applied in drug courts; and
- the latest developments in design and delivery of drug courts, and how the DCV aligns to these developments.

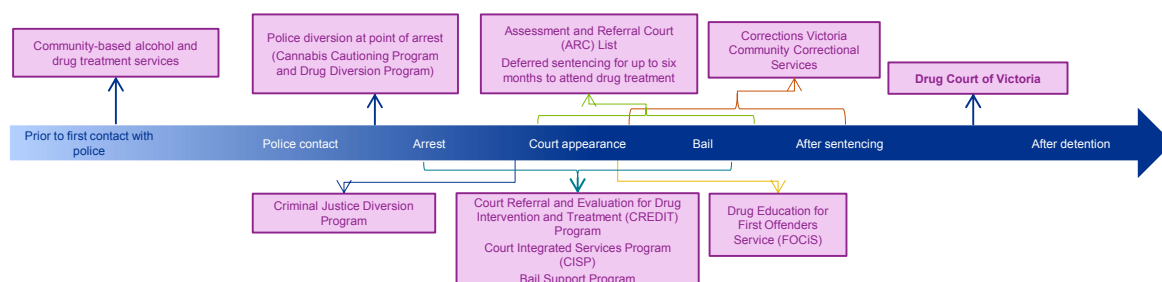
In researching and preparing the literature review, KPMG drew upon a range of national and international sources, including academic, government and non-governmental sources. This section describes the findings from this literature review.

### *Diversion in the criminal justice system*

Diversionary initiatives play an increasingly significant role in the criminal justice system, and are demonstrative of an approach evolving in Australian courts over the past 30 years away from retribution to one which uses judicial authority to address underlying social problems with the aim of fostering offender rehabilitation.<sup>56</sup>

Given the high economic and social costs of incarceration, diversion programs help to break the cycle of offending by addressing the underlying causes of crime and addiction.<sup>57</sup> As illustrated in Figure 4-1, diversion and non-custodial sentences for drug offences and individuals with alcohol and drug problems may be triggered at several points in the justice system – from first interaction with police through to court appearances and sentencing.

Figure 4-1: Spectrum of diversionary interventions in Victoria



Source: Magistrates' Court of Victoria, *Guide to Specialist Courts and Court Support Services* (Magistrates' Court of Victoria 2013); KPMG analysis.

The employment of a range of diversionary interventions across the criminal justice spectrum recognises that there are multiple points of contact in the criminal justice system that provide opportunities to:

<sup>56</sup> Strategic Edge Consulting, *Indigenous Participation in the Western Australian Diversion Project Evaluation – Barriers and Strategies to Participation in Adult Court Diversion Program: Final Report* Strategic Edge Consulting 2009) p. 87.

<sup>57</sup> D Marlowe, 'Integrating Substance Abuse Treatment and Criminal Justice Supervision' (2003) 2(1) *Science & Practice Perspectives* 4, p. 4.

- (1) break the cycle of offending; and
- (2) address an offender's alcohol and drug use.

In this regard, diversion is not only aimed at diverting offenders away from the criminal justice system, but of equal importance, diverting them to appropriate treatment options, education and information, withdrawal and rehabilitation programs.<sup>58</sup>

#### 4.1. The role of, and rationale for, drug courts

Drug courts (including the DCV) operate at the 'pointy end' of the diversion spectrum and are a pragmatic response to the realisation emerging in the 1980s that sentencing offenders with substance use problems to prison was a largely ineffective means of effecting long-term behavioural change.<sup>59</sup> In particular, the use of punitive sanctions, including imprisonment, was viewed as contributing to a 'revolving door effect', with the prison sentence failing to rehabilitate a portion of substance-using offenders who resumed both their offending behaviour, and substance use, upon release.<sup>60</sup>

Drug courts are an example of a practical application of therapeutic jurisprudence. Therapeutic jurisprudence, broadly defined as the 'study of the role of the law as a therapeutic agent', seeks to minimise the negative, anti-therapeutic effects of the law on psychological wellbeing, and use the law's authority to effect positive behavioural change.

Figure 4-2: Principles of therapeutic jurisprudence and their application in the DCV

Therapeutic jurisprudence principle	DCV application	Examples
<b>Focus on case outcomes which address underlying causes of offending</b>	✓	<ul style="list-style-type: none"> <li>Focus on both offence and (contributing) underlying problems</li> <li>Support provided to achieve other tangible outcomes (e.g. income and housing stability)</li> </ul>
<b>Ongoing judicial intervention and monitoring</b>	✓	<ul style="list-style-type: none"> <li>Focus on both offence and (contributing) underlying problems</li> <li>Support provided to achieve other tangible outcomes (e.g. income and housing stability)</li> </ul>
<b>Integration of treatment services with judicial case processing</b>	✓	<ul style="list-style-type: none"> <li>Counselling, rehabilitation and other services offered</li> <li>Stabilisation, intensive treatment and transition phases</li> </ul>
<b>Removal of formal, institutionalised and adversarial legal setting</b>	✓	<ul style="list-style-type: none"> <li>Non-adversarial approach adopted through collaboration between Victoria Police, defence counsel, Case Managers/Clinical Advisors, Victoria Legal Aid</li> </ul>
<b>Collaboration with community-based and government organisations</b>	✓	<ul style="list-style-type: none"> <li>Continuum of services available for participants through SEADS, Windana, Positive Lifestyle Centre, etc.</li> </ul>

Source: Winnick, B. and Wexler, D. (2001). *Therapeutic Jurisprudence and Drug Treatment Courts: A Symbiotic Relationship* in 'Principles of Addiction Medicine' (eds A. Graham and T. Schultz, 3<sup>rd</sup> ed).

Building on principles of therapeutic jurisprudence, drug courts are an example of 'problem solving courts' which recognise that offending behaviour may be caused by a range of social, economic, physical and psychological factors. In this regard, the drug courts operate on the premise that there is benefit in dealing with some offenders in a 'healing' or 'therapeutic' manner which uses the authority of the law and legal processes to address complex litigant and community problems in a

<sup>58</sup> Caitlin Hughes and Alison Ritter, 'A Summary of Diversion Programs for Drug and Drug-Related Offenders in Australia' (Drug Policy Modelling Program Monograph No 16, National Drug and Alcohol Research Centre 2008) p. 5.

<sup>59</sup> David Wexler and Bruce Winick quoted in Bruce Winick, 'Therapeutic Jurisprudence and Problem-Solving Courts' (2002) 30(3) *Fordham Urban Law Journal* 1056, p. 1056.

<sup>60</sup> Ibid.

way that is appropriate in light of the seriousness of the offence, and reduces the risks of harm to the community.<sup>61</sup> As such, drug courts play a dual role in:

- punishing criminal behaviour through a sentence; and
- coordinating services which assist in rehabilitating the offender and address their substance use.

Drug courts are based on the belief that courts have the capacity to be actively involved in the treatment and rehabilitation of offenders, and can serve as a forum to coordinate services to treat individuals, addressing their offending behaviour and substance use problems.<sup>62</sup> By addressing offenders' underlying drug and/or alcohol and problem(s) (through such services as detoxification, rehabilitation/counselling, urine testing) as well as related education, income, housing and/or health problems (through such services as skills training and housing support), drug courts address the underlying issues which are often directly linked to the offending behaviour, intervening in the 'revolving door' and preventing further interaction with the criminal justice system.

#### 4.1.1. Benefits of drug courts

**Problem-solving courts, of which drug courts are a key example, seek to use the authority of the law in a 'healing' or 'therapeutic' manner to address the underlying causes of offending behaviour.**

**In doing so, drug courts provide an alternative to more punitive sanctions, seeking to address complex social, economic, physical and psychological factors which contribute to offending behaviour and drug and alcohol misuse.**

In diverting offenders with drug and alcohol use problems from further periods of imprisonment, and addressing identified offender needs through the provision of support and opportunities to address the underlying causes of their offending behaviour (including alcohol and drug use, long-term unemployment, homelessness and other criminogenic risks), drug courts seek to:

- minimise (or prevent) an individual's involvement in, and further potential progression into, the criminal justice system;
- reduce the number of people cycling through courts and prisons, thereby easing case loads and reducing delays in the legal system, as well as decreasing the costs of associated incarceration;
- provide appropriate treatment options to offenders who are in need of specific, identifiable services; and<sup>63</sup>
- where possible, avoid the negative labelling and stigma attaching to the individual that is associated with criminal conduct and contact with the criminal justice system.

Collectively, such therapeutic social interventions are considered to be more effective and economically viable than punitive responses such as incarceration.<sup>64</sup>

#### *Evidence from other jurisdictions*

Drug courts have also been considered as a more constructive and cost-effective alternative to imprisonment and a method of stemming the flow of drug and alcohol-related offences in courts. Evidence of their success has been accumulating over time, for example:

<sup>61</sup> The University of Western Australia Crime Research Centre, *WA Diversion Program – Evaluation Framework (POP/STIR/IDP): Final Report* (The University of Western Australia 2007) pp. 19-20.

<sup>62</sup> Frieberg, A. (2001) *Problem-Oriented Courts: Innovative Solutions to Intractable Problems?* Journal of Judicial Administration. (11). p. 8-27.

<sup>63</sup> Strategic Edge Consulting, *Indigenous Participation in the Western Australian Diversion Project Evaluation – Barriers and Strategies to Participation in Adult Court Diversion Programs: Final Report* (Strategic Edge Consulting 2009) p. 90.

<sup>64</sup> Strategic Edge Consulting, *Indigenous Participation in the Western Australian Diversion Project Evaluation – Barriers and Strategies to Participation in Adult Court Diversion Programs: Final Report* (Strategic Edge Consulting 2009) 90; D Marlowe, 'Integrating Substance Abuse Treatment and Criminal Justice Supervision' (2003) 2(1) *Science & Practice Perspectives* 4, p. 4.

- A 1999 meta analysis study, which reviewed the first decade of drug court operations in the United States, found drug use amongst drug court participants was substantially reduced and eliminated entirely amongst program graduates. Furthermore, the courts were found to be very cost effective, producing an average of \$5,000 in prison bed days savings per defendant.<sup>65</sup>
- A 2005 assessment of 23 drug court programs by the United States Government Accountability Office found lower rates of re-arrests, reconvictions and recidivism events amongst drug court participants compared to comparison group members.<sup>66</sup>
- A 2009 evaluation of the New South Wales (NSW) Magistrates Early Referral into Treatment (MERIT) drug diversion program, which provides defendants with illicit drug problems three months of pre-sentencing treatment, reduced recidivism amongst participants completing the program by 12 percentage points when compared to a control group.<sup>67</sup>
- A 2011 meta analysis, which reviewed 154 independent evaluations of drug courts in the United States, Canada, Australia, New Zealand and Guam found the vast majority of adult drug court evaluations confirm that drug court participants have lower recidivism rates than non-participants, with the average effect being a drop from 50 per cent to 38 per cent, with the effect lasting up to three years.<sup>68</sup>

This evidence has increased the attractiveness of drug courts and thousands of court programs have now been implemented or trialled around the world, including courts or pilot programs in every Australian jurisdiction.<sup>69</sup> In NSW, drug courts have been expanded since the first drug court program was established in 1999 in Parramatta. The state has recently established two new drug court programs in Toronto (NSW) in 2011 and Sydney in 2013. This expansion was partly due to evaluation findings which showed that participants in NSW drug courts were 17 per cent less likely to be reconvicted when compared to a control group.<sup>70</sup> Western Australia has also recently announced plans to expand the Pre-sentence Opportunity Program (POP), a diversionary program for offenders with drug and alcohol-related problems. In operation since 2000, POP is a pre-sentence early intervention program for offenders with illicit drug-related problems. In 2013, the court implemented a pilot program at the Perth Magistrate Court which extended the POP program to include offenders with alcohol-related problems. The POP program for offenders with alcohol-related problems will now be extended to cover all of metropolitan Perth.<sup>71</sup>

In the United States, drug courts continue to expand and grow in number across the country. In Kentucky, drug courts now operate in 115 of 120 counties and serve over 2,600 participants per month.<sup>72</sup> Evaluations of the Kentucky courts have found the court programs significantly reduce reoffending amongst participants and save the state \$2.72 for every dollar invested. Across the United States, there are now more than 2,500 courts in operation, with courts planned or established in all 50 states and covering 47 per cent of all US counties.<sup>73</sup>

<sup>65</sup> Drug Court Clearinghouse & Technical Assistance Project (1998) *Looking at a Decade of Drug Courts*. Drug Courts Program Office, U.S. Department of Justice. Accessed at: <<https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=171140>> (23 January 2014).

<sup>66</sup> United States Government Accountability Office (2005) *Adult Drug Courts: Evidence Indicates Recidivism Reductions and Mixed Results for Other Outcomes*. Accessed at: <<http://www.gao.gov/new.items/d05219.pdf>> (29 January 2014).

<sup>67</sup> Lulham, R. (2009). *The Magistrate Early Referral Into Treatment Program: Impact of Program Participation on Re-offending by Defendants with a Drug Use Problem*. Crime and Justice. 131. p. 1.

<sup>68</sup> Mitchell et. al (2012) *Assessing the Effectiveness of Drug Courts on Recidivism: A Meta-Analysis of Traditional and Non-Traditional Drug Courts*. Journal of Criminal Justice. (40). p. 60.

<sup>69</sup> Blagg, H. (2008) *Problem- Oriented Courts*. Law Reform Commission of Western Australia. Project 96. p. 20.

<sup>70</sup> Weatherburn et al. (2008) *The NSW Drug Court: A re-evaluation of its effectiveness*. NSW Bureau of Crime Statistics and Research. No. 121. p. 1.

<sup>71</sup> Hon. Helen Morton and Hon. Michael Mischin. (20 March 2014) *Treatment Program Expanded Across Perth*. Media Statements: Government of Western Australia. Accessed at: <<http://www.mediastatements.wa.gov.au/pages/StatementDetails.aspx?listName=StatementsBarnett&StatId=8178>> (23 March 2014).

<sup>72</sup> Kentucky Drug Court (2011) *Kentucky Drug Court: Saving Costs, Saving Lives*. Administrative Office of the Courts. Available at: <<http://courts.ky.gov/resources/publicationsresources/Publications/P28DrugCourtGeneralBrochure811.pdf>> (28 February 2014).

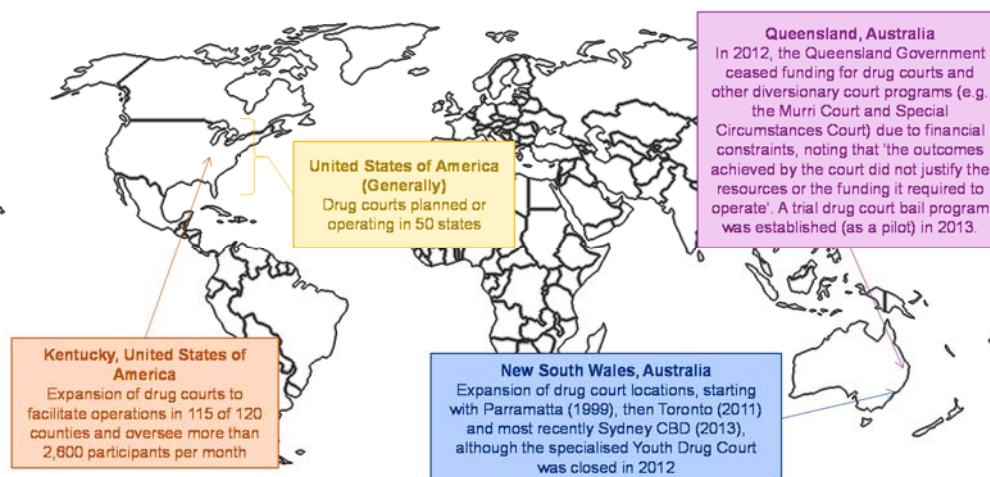
<sup>73</sup> Office of National Drug Control Policy. (2011) *Drug Courts: A Smart Approach to Criminal Justice*. Executive Office of the President. Accessed at: <[http://www.whitehouse.gov/sites/default/files/ondcp/Fact\\_Sheets/drug\\_courts\\_fact\\_sheet\\_5-31-11.pdf](http://www.whitehouse.gov/sites/default/files/ondcp/Fact_Sheets/drug_courts_fact_sheet_5-31-11.pdf)> (28 February 2014).



Drug courts have also been endorsed by the United Nations as an effective method for reducing recidivism and underlying substance use issues as well as for providing closer and more comprehensive supervision and monitoring than other forms of community supervision.<sup>74</sup>

In contrast to global trends and the Western Australia and NSW experience, Queensland has recently cancelled funding for drug courts, in addition to other diversionary court programs such as the Murri and Special Circumstances Court. The Queensland Government justified this decision on financial grounds, stating the court was too expensive within the current fiscal environment and arguing "the outcomes achieved by the court did not justify the resources or the funding it required to operate."<sup>75</sup> Figure 4-3 displays geographically some of the above noted drug courts.

Figure 4-3: Selected drug courts around the world



#### 4.1.2. Challenges of drug courts

Extensive research and evaluation in the problem-solving court sector has established a strong evidence base showing the effectiveness of drug courts and therapeutic jurisprudence in reducing recidivism (as outlined in Section 4.1.1). In addition, there is general agreement in the literature that traditional criminal justice interventions are of limited effectiveness when applied to offenders with complex needs. Notwithstanding this, drug courts present theoretical and practical challenges, particularly in relation to the funding, design and delivery of drug courts. For example:

- Problem-solving and drug courts are resource-intensive, requiring significant funding, specialised services and staff, and access to health and social services not traditionally provided by the justice system. They also typically require a high number of contact hours between participants and magistrates/judges, whose time is scarce and expensive. Traditional criminal justice courts commonly argue that, given the same level of resources, they could achieve similar results.<sup>76</sup>

<sup>74</sup> United Nations Office on Drugs and Crime (1999) *Informal Working Group on Drug Treatment Courts*. United Nations: Vienna. p. 1-40 and United Nations Office on Drugs and Crime (2005) *Drug Treatment Courts Work!* Accessed at: <[http://www.unodc.org/pdf/drug\\_treatment\\_courts\\_flyer.pdf](http://www.unodc.org/pdf/drug_treatment_courts_flyer.pdf)> (4 February 2014).

<sup>75</sup> Hon. Jarrod Bleijie quoted in Moore, T. (13 September 2012) *Diversionary Courts Fall Victim to Funding Cuts*. Brisbane Times. Accessed at: <<http://www.brisbanetimes.com.au/queensland/diversionary-courts-fall-victim-to-funding-cuts-20120912-25sj5.html>> (28 February 2014).

<sup>76</sup> Bartels, L. (2009). *Challenges in Mainstreaming Speciality Courts*. Trends & Issues in Crime and Criminal Justice. No. 383. p. 3; Freiberg, A. (2002) *Soecialised Courts and Sentencing*. Paper presented at the Probation and Community Corrections: Making the Community Safer Conference Convened by the Australian Institute of Criminology and the Probation and Community Corrections Officers' Association Inc. (23-24 September 2002). p. 10

- The intense monitoring and deeply interventionist nature of therapeutic jurisprudence can result in sanctions more onerous than traditional penalties and can be potentially disproportionate to the offence.<sup>77</sup>
- There is currently inequity of access to drug and other problem-solving courts. Despite the growing prevalence of drug courts and other problem-solving courts, the majority of defendants do not have access to these programs for reasons of ineligibility (e.g. geographic location, nature of alleged offence etc).<sup>78</sup>
- Therapeutic jurisprudence and problem-solving courts have been labelled as too narrow in their approach. When reviewing a case, these courts typically view the offence as a symptom and pre-suppose the existence of an underlying problem. In the case of drug courts, the cause of problem-behaviour is usually seen as the substance use issue; however, this issue may itself be precipitated by a variety of other psychological, personal or medical issues. Successfully rehabilitating the offender is dependent on accurately diagnosing the precipitating root cause(s) of the problem, which may extend well beyond the drug or alcohol use issue itself.<sup>79</sup>
- Courts based on therapeutic jurisprudence can be paternalistic in their approach, with strict boundaries and directives limiting decision-making afforded to participants. This can potentially disempower participants, reduce their autonomy and lead to anti-therapeutic consequences.<sup>80</sup>
- Problem-solving and drug courts often require defendants to plead guilty in order to be eligible to participate in the diversion program. This establishes a criminal record while removing judicial oversight and scrutiny of police behaviour and circumstances of the arrest. This can have the effect of limiting police accountability.<sup>81</sup>

These challenges are not unique to drug courts, but are reflective of the theoretical and philosophical difficulties therapeutic jurisprudence approaches pose to traditional adversarial legal systems and their broader operational environment. Such challenges do not inhibit the ongoing operations of drug courts (or problem-solving courts more broadly), but rather must be carefully assessed and balanced against competing priorities in order to facilitate equality of access to, and appearance before, the law.

## 4.2. Contemporary approaches to managing offenders with drug and alcohol problems and the design and delivery of drug courts

### 4.2.1. What are the leading practice approaches in managing offenders with drug and alcohol problems?

The United Nations has identified several leading practice principles for managing offenders with drug dependencies, including the consideration that offenders with drug use problems “should be treated in the health care system rather than in the criminal justice system where possible.”<sup>82</sup> Interventions for offenders with drug use problems who come into contact with the criminal justice

<sup>77</sup> Freiberg, A. (2002) *Specialised Courts and Sentencing*. Paper presented at the Probation and Community Corrections: Making the Community Safer Conference Convened by the Australian Institute of Criminology and the Probation and Community Corrections Officers' Association Inc. (23-24 September 2002). p. 10

<sup>78</sup> Bartels, L. (2009). *Challenges in Mainstreaming Speciality Courts*. Trends & Issues in Crime and Criminal Justice. No. 383. p. 2.

<sup>79</sup> Freiberg, A. (2002) *Soecialised Courts and Sentencing*. Paper presented at the Probation and Community Corrections: Making the Community Safer Conference Convened by the Australian Institute of Criminology and the Probation and Community Corrections Officers' Association Inc. (23-24 September 2002). p. 10.

<sup>80</sup> Bartels, L. (2009). *Challenges in Mainstreaming Speciality Courts*. Trends & Issues in Crime and Criminal Justice. No. 383. p. 4.

<sup>81</sup> Sarteschi et al (2011) *Assessing the Effectiveness of Mental Health Courts: A Quantitative Review*. Journal of Criminal Justice. 39. p. 13; Walsh, T. (2011) *Defendants' and Criminal Justice Professionals' Views on the Brisbane Special Circumstances Court*. Journal of Judicial Administration. 21 (93).

<sup>82</sup> United Nations Office on Drugs and Crime and World Health Organization (2008) *Principles of Drug Dependence Treatment: Discussion Paper*. Available at: <<http://www.unodc.org/documents/drug-treatment/UNODC-WHO-Principles-of-Drug-Dependence-Treatment-March08.pdf>> (Accessed 4 February 2014). p. 14.



system should focus on treatment as opposed to imprisonment.<sup>83</sup> The United Nations also identifies leading practice as ensuring that continuous care in the community for offenders with drug use problems is available post-release, as a lack of skills training, education, housing, employment and health care access all increase the risk of the offender relapsing or committing further crimes.<sup>84</sup>

Other evidence indicates that the most consistently successful approaches for managing offenders with substance abuse issues are those that integrate public health and public safety strategies through a combination of community-based substance abuse treatment and ongoing judicial supervision.<sup>85</sup> Approaches that focus either exclusively on a public health treatment strategy or a public safety approach have been shown by research to be less effective than integrated approaches to rehabilitating offenders and preventing further criminal justice involvement.<sup>86</sup> Specific successful features of these integrated programs include:

- placing substance abuse treatment at the centre of the intervention, rather than at the periphery of a mostly traditional, criminal justice approach;<sup>87</sup>
- providing the intervention in the participant's home community, where family and social networks can be maintained and the participant can seek employment, education and skills training;<sup>88</sup>
- assigning responsibility for ensuring compliance with the terms of the intervention (e.g. urinary testing) with the criminal justice system, which has the authority to respond quickly to non-compliance;<sup>89</sup> and
- close supervision of participants and certain, consistent and immediate positive incentives for compliance (through a series of rewards, including avoiding re-incarceration), together with negative consequences for non-compliance (through a series of escalating sanctions, including incarceration).<sup>90</sup>

#### 4.2.2. What are current leading practice approaches to the design and delivery of drug courts?

Drug courts have been in existence for over two decades now and most operate on the basis of the 10 key principles defined by the National Association of Drug Court Professionals and U.S. Department of Justice in 1997.<sup>91</sup> Since these principles were documented, hundreds of evaluations of drug courts have taken place and an evidence base now exists to evaluate the key characteristics of effective drug courts. This section outlines the evidence of contemporary leading practice in the design and delivery of drug courts and considers how the current DCV aligns to these practices.

A 2012 study by Carey et al. reviewed 69 U.S. drug court studies between 2000 and 2010 to identify which features and practices of drug court design and delivery resulted in the largest impact in terms of reductions in participant recidivism (defined as the number of participant re-arrests over two years from program entry) and in terms of accruing cost savings for society. Seven of the key findings are outlined below:

- Drug courts with **smaller participant case loads** (fewer than 125 participants) had more than five times greater recidivism reductions than larger programs. The effect was very significant,

<sup>83</sup> United Nations Office on Drugs and Crime and World Health Organization (2008) *Principles of Drug Dependence Treatment: Discussion Paper*. Available at: <<http://www.unodc.org/documents/drug-treatment/UNODC-WHO-Principles-of-Drug-Dependence-Treatment-March08.pdf>> (Accessed 4 February 2014). p. 14.

<sup>84</sup> Ibid., p. 14.

<sup>85</sup> Marlowe, D. (2003) *Integrating Substance Abuse Treatment and Criminal Justice Supervision*. Science & Practice Perspectives. 2 (1), p. 4.

<sup>86</sup> Ibid. p. 4.

<sup>87</sup> Ibid. pp. 7-8.

<sup>88</sup> Ibid. pp. 7-8.

<sup>89</sup> Ibid. pp. 7-8.

<sup>90</sup> Ibid. pp. 7-8.

<sup>91</sup> Bureau of Justice Assistance (2004) *Defining Drug Courts: The Key Components*. U.S. Department of Justice: Drug Courts Resource Series. Available at: <<https://www.ncjrs.gov/pdffiles1/bja/205621.pdf>>

with smaller programs averaging 40 per cent reductions in recidivism while larger programs (more than 125 participants) averaged only six per cent.<sup>92</sup>

- Courts where participants were required to **maintain at least 90 days of sobriety** (negative drug and/or alcohol tests) in order to graduate had 164 per cent larger reductions in participant recidivism compared to drug courts with shorter sobriety standards.<sup>93</sup>
- The length of judge-participant court hearings directly correlates with recidivism reductions. Programs where **judges spent three minutes or longer with each participant** had 153 per cent greater recidivism reductions than courts where interactions were less than three minutes. Where judges spent seven minutes or more with each participant, the impact on recidivism was 300 per cent larger than courts with less than three minute interactions.<sup>94</sup>
- Where **treatment provider representatives attend drug court team meetings** the impact on recidivism was 105 per cent greater than programs where the provider does not attend. Similarly, when the **treatment representative attends court hearings**, programs achieved 100 per cent greater recidivism reductions and 81 per cent greater cost savings. Attending meetings facilitates good team communication and attending court sessions ensures participants cannot tell different stories to the court and the treatment provider. It also demonstrates to participants that decisions about their care are made by the entire team and are intended to be therapeutic.<sup>95</sup>
- Courts with **law enforcement personnel on the program team** achieved 88 per cent greater recidivism reductions than drug courts that did not. Additionally, programs which had **law enforcement representatives attending court sessions** achieved 64 per cent greater cost savings than those that did not. Law enforcement personnel are often more aware of participants' lives on the street and in the community, which adds insight and value to the court. Conversely, by participating directly in the program team, law enforcement personnel gain awareness of the court perspective which promotes better understanding of the value of the drug court among the wider law enforcement community.<sup>96</sup>
- Drug courts that emphasise the **internal electronic collection and review of program data and statistics**, which is then used as an evidence base for making adjustments to the program, had 105 per cent greater recidivism reductions and 131 per cent higher cost savings than programs that did not.<sup>97</sup>
- Courts that went through **independent evaluations and used this information to modify the design and delivery** of the program achieved 85 per cent greater recidivism reductions and 100 per cent greater cost savings than courts that did not.<sup>98</sup>

#### 4.2.3. How does the DCV align to these leading practice principles?

Table 4-1 outlines how the DCV aligns to the leading practice principles outlined in 4.2.2.

Table 4-1: Leading practice principles of drug courts and their application in the DCV

Leading practice principle	DCV Application	Explanation
Participant case loads of less than 125 participants	✓	The DCV oversees approximately 60 offenders on DTOs at any one time, and therefore manages a case load of approximately 50 per cent less offenders than the leading practice principle.

<sup>92</sup> Carey, S. et al. (2012) *What Works? The Ten Key Components of Drug Court: Research-Based Best Practices*. In National Drug Court Institute. *Best Practice in Drug Courts*. Vol. 3 (1). p. 22.

<sup>93</sup> Ibid. p. 24.

<sup>94</sup> Ibid.

<sup>95</sup> Ibid. p. 25.

<sup>96</sup> Ibid. p. 27.

<sup>97</sup> Carey, S. et al. (2012) *What Works? The Ten Key Components of Drug Court: Research-Based Best Practices*. In National Drug Court Institute. *Best Practice in Drug Courts*. Vol. 3 (1). pp. 24-28.

<sup>98</sup> Ibid. pp. 27-28.

Leading practice principle	DCV Application	Explanation
Participants are sober at least 90 days in order to graduate		DCV requires participants to submit to 12 weeks (84 days) of clear and undiluted drug tests to be eligible to graduate; this is slightly less than leading practice recommendation
Judges spend at least three minutes with each participant at hearings	✓	Data provided by MCV for the period November 2013 – February 14 indicates the average time per case in open court is between eight and 10 minutes <sup>99</sup>
Treatment provider representatives attend drug court team meetings and court sessions	✓	Each DCV participant is assigned a Clinical Advisor who is a member of the DCV Team  The DCV Team attends all court hearings
Law enforcement representatives are a part of program team and attend court sessions	✓	DCV has a Victoria Police Community Liaison Officer, Corrections Victoria Case Manager and Victoria Police Prosecutor as part of the program team and attending all court sessions
Emphasise electronic data collection and analysis and use this evidence to modify program design	✓	DCV Policy No. 15 – 3.1 – outlines the role of DCV Action Research using its DRUIS case management database as its evidence base
Independent evaluation of program and using the analysis to modify program design	✓	A cost-benefit analysis of the DCV was undertaken in 2005, and an evaluation of MCV's broader diversion programs (including the DCV) was undertaken in 2004. Both reports have been used to inform and further develop the DCV's operations.

Source: Stakeholder consultations, DCV, *Drug Court Participant Manual* (DCV, undated), DCV, *Drug Court Policy No. 15*. Principles sourced from Carey, S. et al. (2012) *What Works? The Ten Key Components of Drug Court: Research-Based Best Practices*. In National Drug Court Institute. *Best Practice in Drug Courts*. Vol. 3 (1).

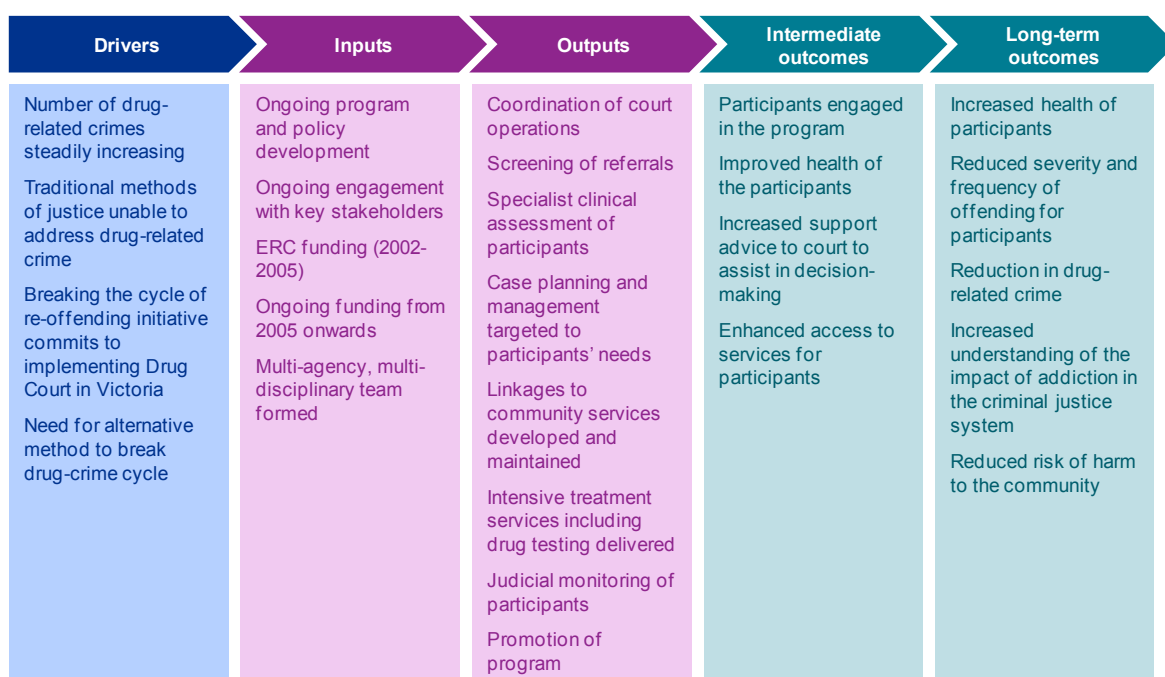
Overall, the current DCV model and operations reflect a strong degree of alignment with contemporary leading practice approaches to the design and delivery of drug courts. Some discrepancies are noted in relation to optimal participant case loads, although it is acknowledged that increasing participant numbers is likely to be contingent on resourcing availability and must be considered in light of a desire to maintain (if not improve) existing service delivery levels. Notwithstanding this, on the basis of available literature, it appears that the DCV is operating in line with international leading practice principles.

#### 4.3. Policy priorities informing the DCV's operations

The DCV builds on these theoretical perspectives, and seeks to provide a 'multi-disciplinary and multi-departmental' response to drug dependence and drug related crime through application of therapeutic jurisprudence principles in a specialised, problem-solving court. As illustrated in the DCV Program Logic below, the Court incorporates intensive judicial supervision, specialist clinical support and case management, regular drug and alcohol screening and linkages to the community.

<sup>99</sup> Data received from MCV in e-mail dated 18 March 2014.

Figure 4-4: DCV program logic



Source: Department of Justice, *Evaluation of the Drug Court of Victoria – Program Logic* (Department of Justice 2013) 22.

### Key findings

- A review of available literature has outlined significant academic and policy evidence that demonstrates that:
  - there is an ongoing role and need for an intervention such as the drug court, as evidenced by increases in usage rates of certain drugs and persistently high alcohol-abuse related statistics, together with strong evidence of links between crime and substance misuse; and
  - traditional criminal justice approaches in isolation have been shown to be mostly ineffective in breaking the revolving door cycle of drug and alcohol misuse, crime, incarceration and continuing substance misuse. Twenty years of evidence has shown that well designed and delivered drug courts can effectively reduce recidivism and produce cost savings when compared to traditional approaches.
- At this juncture, available evidence supports the continued application of drug courts as an integral part of an effective criminal justice system.

## 5. Justification/problem

Available evidence suggests that traditional punitive sanctions are largely ineffective in effecting behavioural change in the cohort targeted by the DCV. Given the frequency and severity of offending amongst this cohort, and acknowledgement that imprisonment is the only alternative sanction, there is a need for a court-based initiative which provides both punishment for the offence committed, and access to supports and services to address the underlying issues contributing to offending behaviour.

### 5.1. Is there a continuing and demonstrable need for the DCV?

All stakeholders consulted considered that there was a continuing and demonstrable need for a court-based response to particularly serious, systemic offenders with significant drug and alcohol use issues. In considering this, stakeholders noted that traditional criminal justice system approaches to offending of this nature have been largely ineffective as:

- the offending cohort at which the DCV is targeted are generally long-term recidivist offenders for whom punitive sanctions are both ineffective in rehabilitation and do not provide an effective deterrent; and
- the current prison system does not provide adequate supports and/or treatment which enable offenders to address the underlying issues contributing to their offending behaviour (particularly alcohol and drug use, homelessness and conflict resolution/family violence) meaning that, upon release, this cohort is highly likely to reoffend.

This stakeholder consultation feedback is consistent with research relating to drug courts and the use of therapeutic jurisprudence from other Australian and international jurisdictions. Such research has noted that:

- drug and alcohol-related offending (whether commissioned whilst under the influence of alcohol or drugs, or to support a drug and/or alcohol habit) is often caused by a range of social, economic, physical and psychological factors;<sup>100</sup>
- sentencing offenders with substance use problems to prison is a largely ineffective means of effecting long-term behavioural change;<sup>101</sup> and
- the use of punitive sanctions, including imprisonment, is viewed as contributing to a 'revolving door effect', with prison sentences failing to rehabilitate a portion of substance-using offenders who resume both their offending behaviour, and substance use, upon release.<sup>102</sup>

In addition to these considerations, it is noted that for this cohort targeted by the DCV, given the serious nature of the offences committed, the only alternative sentencing option (beyond the DTO) is imprisonment.

Research suggests that engagement in the prison system attracts negative labelling and stigma to the individual – and progression into the prison system can result in a greater level of entrenchment in the criminal justice system rather than rehabilitation.<sup>103</sup> Given these concerns, available evidence suggests that there is a need for a non-prison based sentencing alternative which:

- punishes criminal behaviour in a manner which is appropriate in light of the seriousness of the offence and the risk of harm the offender presents to the community; and

<sup>100</sup> Joy Wundersitz, *Criminal Justice Responses to drug and drug-related offending: are they working?* Australian Institute of Criminology Technical and Background Paper No. 25 (Australian Institute of Criminology 2007) p. 31.

<sup>101</sup> David Wexler and Bruce Winick quoted in Bruce Winick, 'Therapeutic Jurisprudence and Problem-Solving Courts' (2002) 30(3) *Fordham Urban Law Journal* 1056, 1056; D Marlowe, 'Integrating Substance Abuse Treatment and Criminal Justice Supervision' (2003) 2(1) *Science & Practice Perspectives*, p. 4.

<sup>102</sup> David Wexler and Bruce Winick quoted in Bruce Winick, 'Therapeutic Jurisprudence and Problem-Solving Courts' (2002) 30(3) *Fordham Urban Law Journal*, p. 1056.

<sup>103</sup> Strategic Edge Consulting, *Indigenous Participation in the Western Australian Diversion Program – Barriers and Strategies to Participation in Adult Court Diversion Programs: Final Report* (Strategic Edge Consulting 2009) p. 90.

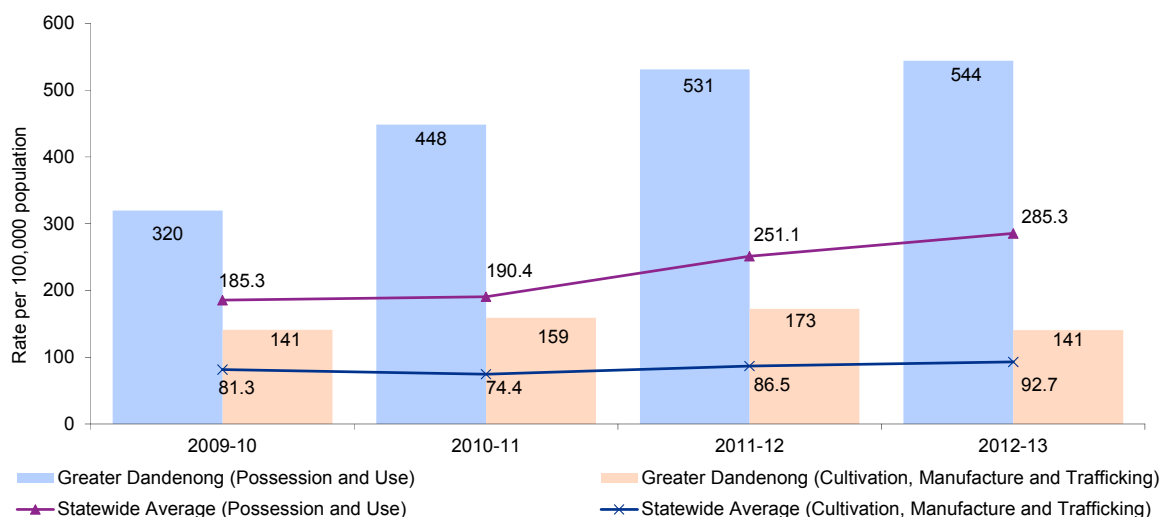


- enables the coordination of services and supports that seek to address the underlying causes of offending behaviour such as drug and alcohol misuse, homelessness, lack of employment/education/skills and health and medical concerns.

Particular reference was made to the fact that there continues to be a high level of need in the Dandenong area for the DCV due to issues of high rates of drug-related crime, entrenched disadvantage and low socio-economic status (SES). Analysis of Victoria Police and Australian Bureau of Statistics (ABS) data confirms this, particularly:

- the number of drug possession and use offences recorded by Victoria Police increased by 79 per cent between 2009-10 and 2012-13 (from 440 offences in 2009-10 to 789 in 2012-13);<sup>104</sup>
- in 2012-13, the rate (per 100,000 population) of drug possession and use in the Greater Dandenong Local Government Area (LGA) was 1.9 times higher than the Victorian statewide average;<sup>105</sup> and
- analysis of the Socio-Economic Indexes for Areas (SEIFA) for the Greater Dandenong LGA indicates it had a SEIFA index of 914 in 2006 which deteriorated to 905 in 2011. On the basis of 2011 data, Greater Dandenong was the second most disadvantaged LGA in Victoria (according to SEIFA index).<sup>106</sup>

Figure 5-1: Drug possession, use, cultivation, manufacture and trafficking offences recorded (rate per 100,000 population), 2009-10 to 2012-13



Sources: Victoria Police, *Victoria Police 2010-11 Crime Statistics* (Victoria Police 2010); Victoria Police, *Victoria Police 2012-13 Crime Statistics* (Victoria Police 2013).

Analysis of the rate of drug-related crime in the Dandenong area indicates that there is an ongoing need for the DCV in this location. Victoria Police statistics indicate that in 2012-13, the rate of drug possession and use offences recorded was almost double that of the statewide average (and is continuing to grow), whilst the rate of drug cultivation, manufacture and trafficking offences recorded was approximately 1.5 times higher than the statewide average – although it appears to be in decline, and has returned to 2009-10 levels.

## 5.2. Other options considered

While a range of locations for the DCV were considered (namely [the former] Preston, Dandenong and Sunshine Magistrates' Courts), the selected service design and delivery model was heavily informed by the *Ten Key Components* articulated by the National Association of Drug Court

<sup>104</sup> Victoria Police, *Victoria Police 2010-11 Crime Statistics* (Victoria Police 2010); Victoria Police, *Victoria Police 2012-13 Crime Statistics* (Victoria Police 2013).

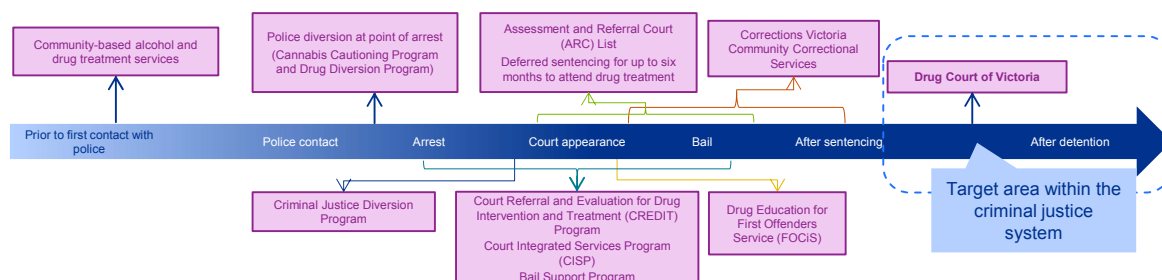
<sup>105</sup> Ibid.

<sup>106</sup> Australian Bureau of Statistics, *Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia 2011* (Cat. No. 2033.0.55.001) (Australian Bureau of Statistics 2013).

Professionals (USA) and leading practice approaches to the design and delivery of drug courts in other national and international jurisdictions at that time.<sup>107</sup> Since its establishment in 2002, the DCV model has remained largely unchanged.

Given the severity of the offences committed by offenders sentenced to DTOs (which are punishable upon conviction by imprisonment), it is recognised that the DCV is unique in that it operates in the post-sentence (cf pre-sentence) space, as displayed in Figure 5-2. All other diversionary initiatives which include judicial monitoring, including CISP, the ARC List and CREDIT/Bail Support provide pre-sentence support.

Figure 5-2: Spectrum of diversionary interventions in Victoria



Source: Magistrates' Court of Victoria, *Guide to Specialist Courts and Court Support Services* (Magistrates' Court of Victoria 2013); KPMG analysis.

For the offending cohort appearing before the DCV, given the severity of their offence(s), aside from imprisonment, a DTO is the only sentencing option available. This means that any alternative options to the DCV must operate in the sentence/post-sentence space.

### 5.3. Changes to economic, environmental and social conditions

Stakeholders reflected on the fact that (meth)amphetamine use, and in particular "ice", had increased significantly in recent years, contributing to:

- commission of more violent offences than seen previously, particularly due to the marked changes in mental state, aggression and confidence resulting from (meth)amphetamine use; and
- difficulties in designing and implementing appropriate treatment options for offenders who abuse or are dependent on (meth)amphetamines. It was noted that a range of high-quality, effective treatment models had been identified and applied in relation to heroin addiction and dependency (which was, anecdotally, previously a 'drug of choice' for the DTO cohort), however fewer options were available for offenders with ice dependencies.

Recent statistics relating to this purported increase in (meth)amphetamine use (particularly in the Dandenong area) do not appear to be available as the most recent Australian Institute of Health and Welfare *National Drug Strategy Household Survey* was completed in 2010. However, the former Victorian Government has recognised the problematic use of methamphetamines, establishing the *Inquiry into the Supply and Use of Methamphetamines, Particularly 'Ice' in Victoria* in September 2013.

In addition to the increased availability and use of (meth)amphetamines, stakeholders also considered changes to the socio-cultural composition of the Dandenong area to be pertinent. Particular attention was drawn to the fact that Dandenong is a highly multicultural area, with a higher proportion of newly arrived migrants than seen in the broader Victorian community. While this trend continues (as illustrated in the table below), it is also noted that indicators of disadvantage seen in Dandenong (including levels of unemployment which are higher than the statewide average, and lower levels of educational attainment) appear to be lessening over time. Table 5-1 summarises some of the key demographic indicators for Greater Dandenong.

<sup>107</sup> For further discussion see US Department of Justice (Office of Justice Programs – Bureau of Justice Assistance), *Defining Drug Courts: The Key Components* (US Department of Justice 1997).



Table 5-1: Dandenong socio-economic and socio-cultural indicators

Indicator	Dandenong			Victorian Average
	2001	2006	2011	2011
Proportion of population born outside Australia (%)	51	51	56	26
Proportion of population speaking a language other than English at home (%)	52	55	61	23
Unemployment rate (%; 15 years and older)	11.3	9.5	8.9	5.4
Proportion of population having attained a non-school qualification (%; 15 years and older)	24	28	34	46
Median weekly rent (\$)	135	160	250	300*

Source: Australian Bureau of Statistics, *Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia 2011* (Cat. No. 2033.0.55.001) (Australian Bureau of Statistics 2013). \* Note that this figure has been drawn from the Melbourne Greater Capital City Statistical Area median weekly rental amount to provide a more comparative benchmark which excludes regional/rural areas.

Key demographic indicators related to disadvantage appear to lessening over time, however, levels of disadvantage in Greater Dandenong remain above the Victorian average across a number of areas.

#### 5.4. Can the market deliver the DCV?

There are two key components of the DCV: court-based judicial monitoring, and support services such as counselling, accommodation access and drug and alcohol rehabilitation. Neither of these components can be outsourced or facilitated for the reasons outlined in Table 5-2.

Table 5-2: Components of the DCV

DCV Component	Description
<b>Judicial monitoring</b>	<ul style="list-style-type: none"> <li>The DTO (administered and overseen by the DCV Magistrate) is a sentence, the administration of which cannot be outsourced or facilitated through a market-based option. In addition, case management services are provided by Corrections Victoria, which oversees an offender's compliance with their DTO, an executive function.</li> <li>Professional stakeholders viewed regular hearings and appearances before the magistrate as a key component of the DCV's effectiveness which improved an offender's accountability and responsibility for their actions. These views were reinforced by DCV participants, who expressed a desire 'not to let the magistrate down', and considered opportunities to interact and build rapport with the magistrate to be a pertinent factor in their continuing involvement in the DCV.</li> </ul>
<b>Support services</b>	<ul style="list-style-type: none"> <li>The support services provided through the DCV are facilitated by a number of agencies, including legal support through Victoria Legal Aid, housing support through WAYSS and drug and alcohol counselling through the Positive Lifestyle Centre and South East Alcohol and Drug Services (SEADS).</li> <li>Whilst it is acknowledged that the market provides a range of these services, the costs associated with access to these services are likely to be prohibitive to the DCV client cohort (78 per cent of whom are unemployed at intake). In addition, it was acknowledged that the DCV client cohort is unlikely to access such support services of their own will and volition – meaning that the mandating engagement with these services via the DTO is necessary component in ensuring that participants access the necessary supports required to address their criminogenic risk factors.</li> </ul>

## 5.5. Are similar services provided by the Victorian Government, Commonwealth Government or Non-Government Organisations?

The DCV is a specialised, problem-solving court that cannot be delivered through other Victorian or Federal Government departments or Non-Government Organisations (NGOs). As articulated in the *Sentencing Act 1991*, the judicial oversight and monitoring component of the DTO must occur within a court framework and can only be undertaken by a magistrate. Such functions cannot be delegated to another authority figure within the Victorian Government or an NGO.

The support services provided by the DCV are available through a range of MCV programs, such as CISP, CREDIT/Bail Support and COATS which provide access to housing support, drug and alcohol treatment programs and counselling. However, these programs differ to the DCV in that:

- they largely operate in the pre-sentence space, unlike the DTO which is a sentencing option;
- the intense level of judicial monitoring and oversight, along with regular urinalysis and drug testing employed in the DCV is not seen in these programs; and
- they do not offer the level of linkages and support seen in the DCV, resulting in a lesser degree of engagement between offenders, the magistrate and service providers.

These factors considered, these programs do not adequately address the multiple and complex needs of the DCV Cohort, and are unlikely to provide the same level of support for offenders – meaning that they are unlikely to realise the same level of benefits for offenders.

## 5.6. Capacity and capability to continue

Available evidence and stakeholder consultation feedback indicates that the DCV has both the capacity and capability to continue delivery of the current drug court model.

At present, the DCV has approximately 61 active DTOs. This is slightly in excess of the target capacity of 60 active participants. Recognising potential capacity constraints, a waiting process was implemented in response to referral requests in October 2013. This process considers the DCV's existing capacity, relevant legislation and the needs of potential participants to prioritise the number of DTOs imposed. At present, if the DTO structure and level of service is to be maintained without additional resourcing (particularly in light of Case Manager and Clinical Advisor case loads), it is unlikely that the DCV will be able to accommodate growth in demand unless a reduction in service delivery levels is introduced. Adjusting the intensity of the DTO through, for example, changes in the frequency of appointments or urinalysis testing, may allow the DCV to increase case loads within existing resources. Such adjustments would have to be carefully considered and close monitoring of any impact on client outcomes would be required. Another potential alternative to coping with demand within existing resources and DTO structures and retaining current service levels may be to introduce a cap on the number of participants at any one time with a lottery system for eligible and suitable referrals to decide who takes the available places (as in the NSW Drug Court).

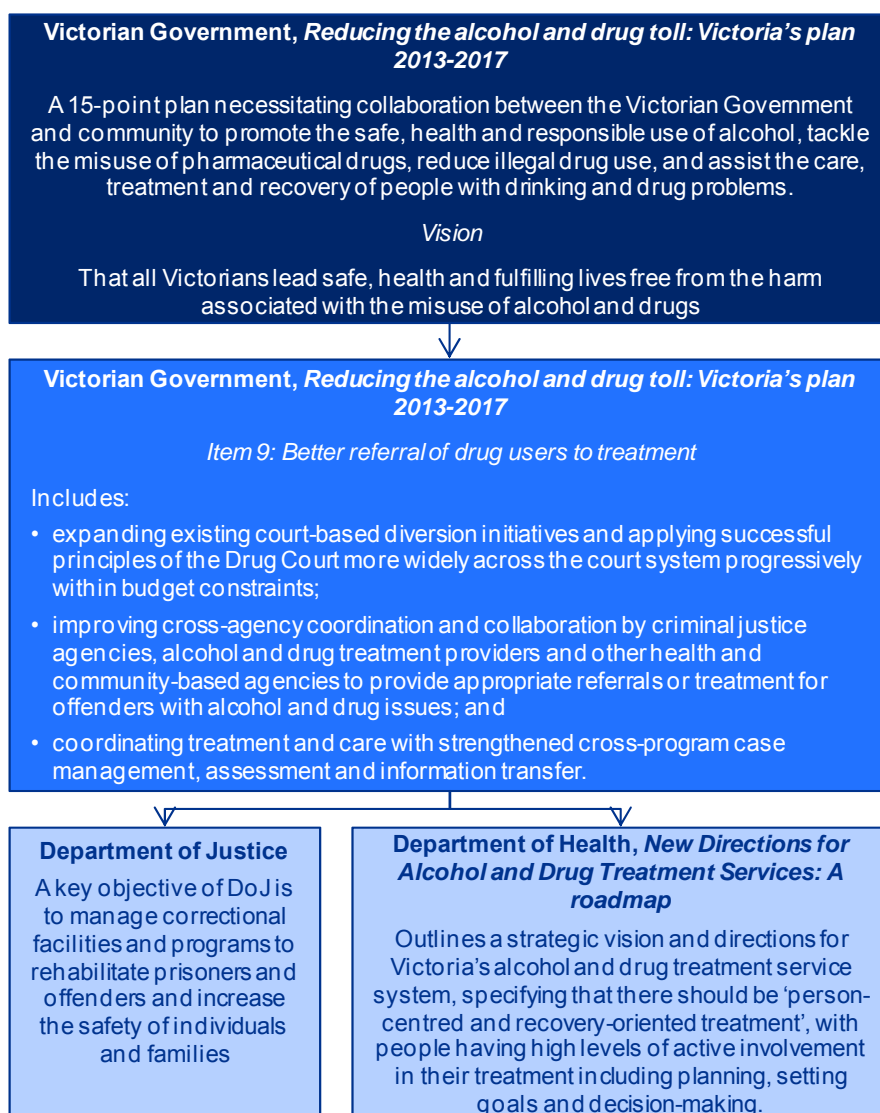
It is also noted that a key component of the DCV's service delivery model includes the provision of Drug Court House, a nearby facility which enables the provision of counselling services, attendance at Case Manager and Clinical Advisor appointments and provision of urinalysis away from the Dandenong Magistrates' Court (and therefore not in a court environment). The lease for the Drug Court House has been recently renewed for another three years enabling the DCV to continue to deliver services within the current model.

## 5.7. Alignment between stated objectives, outputs and broader Departmental and government priorities

The DCV is strongly aligned to the whole-of-government approach to preventing and addressing alcohol and drug misuse. The Court contributes to a range of actions identified in the report *Reducing the alcohol and drug toll: Victoria's plan 2013-17*, and assists in facilitating a tailored, individualised response which uses cross-agency collaboration to deliver holistic, integrated services for participants.

In bringing together the MCV, Victoria Police, community organisations, Corrections Victoria and Victoria Legal Aid in the DCV Team, the Court facilitates a high level of cross-agency collaboration, enabling holistic case management, provision of treatment and care. Further, in providing individually tailored drug and alcohol treatment services as a key component of an offender's Drug Treatment Order (DTO), the Court contributes to the rehabilitation of offenders, as well as accountability through a system of sanctions and rewards, delivering on objectives of both MCV and the Department of Health articulated in Figure 5-3. The services offered through the DCV and its approach to case management and cross-agency collaboration demonstrate alignment with Victorian Government priorities and, as such, the Court is contributing to achievement of the priorities articulated in *Reducing the Alcohol and Drug Toll 2013-17*.

Figure 5-3: Alignment of the Drug Court of Victoria with government objectives, outputs and broader Departmental and government priorities



Sources: See identified documents noted above.

The former Victorian Government noted that 'tackling alcohol and drug misuse in the community is a high priority',<sup>108</sup> which involves whole-of government collaboration with the community to develop a cohesive, holistic approach to preventing and addressing alcohol and drug misuse.

<sup>108</sup> Department of Health, *New Directions for Alcohol and Drug Treatment Services: A framework for reform* (Victorian Government 2012) p. 1.

*Reducing the alcohol and drug toll: Victoria's Plan 2013-17* is the overarching policy framework which articulates the whole-of-government approach to addressing drug and alcohol misuse. The DCV contributes to priorities and actions outlined under the framework through:

- reducing drug and alcohol-related offending through active judicial supervision of offenders and intensive treatment/rehabilitation;
- improving offenders' health and wellbeing through the provision of housing, employment, education and social services;
- facilitating cross-agency collaboration between the Magistrates' Court of Victoria, Victoria Police, community organisations, Corrections Victoria, Victoria Legal Aid and health, medical and social services professionals; and
- providing individually tailored drug and alcohol treatment services, as well as individual accountability through a structured system of sanctions and rewards.

#### Key findings

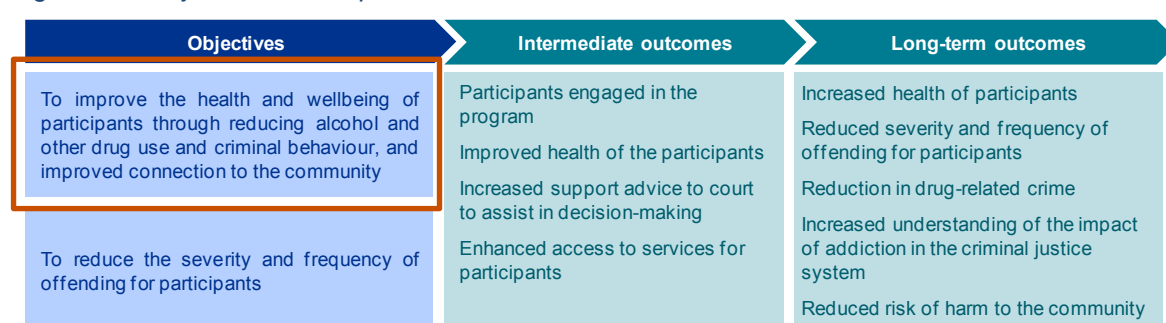
- There continues to be a need for an alternative to imprisonment for drug-related offences to stem the "revolving door" cycle for offenders with substance use issues.
- Dandenong as an area continues to display almost double the state-wide average for offences related to drug possession and use and a significantly higher than state-wide average for drug cultivation, manufacture and trafficking offences, indicating that the location of the DCV remains appropriate.
- The existing model of the DCV is broadly consistent with national and international leading practice drug court principles.
- No alternative services delivered within Victorian government exist that could deliver the judicial monitoring which is an integral part of the DTO. Whilst other rehabilitation and support services could be provided through the market (such as homelessness services, or counselling for substance abuse), a lack of motivation to access them would be an insurmountable barrier for the target cohort.
- The DTO is one of few suitable post-sentence options for the particular offending cohort targeted by the DCV.
- The DCV is able to continue delivery of the DTO within existing targets, with the main constraint on expansion being case management loads and magistrates' time. Continued access to suitable accommodation, including the Drug Court House, is also integral to effective delivery.

## 6. Effectiveness of the DCV in improving the health and wellbeing of participants

The DCV aims to use the principles of therapeutic jurisprudence to achieve positive health and wellbeing outcomes for participants, as well as reductions in criminal activity. Traditional adversarial legal measures, such as mandatory urinalysis and attendance at review hearings, Clinical Advisor and Case Manager appointments, are realised through a DTO, which is used as a vehicle to facilitate offender accountability and compliance.

This section of the evaluation draws on the evidence base described in Figure 2-1 to examine the overall effectiveness of the DCV as measured against its stated objectives and expected outcomes. The objectives and expected outcomes of the DCV are in Figure 6-1.

Figure 6-1: Objectives and expected outcomes of the DCV



Source: Adapted from Department of Justice, *Evaluation of the Drug Court of Victoria – Program Logic* (Department of Justice 2013) p. 22.

This section of the report evaluates the effectiveness of the DCV in achieving its first stated objective related to improving the health and wellbeing of participants through reduced drug use and criminal behaviour and improved connection to the community.

### 6.1. Data sources and limitations

Assessment of the DCV's progress towards its first stated objectives and expected outcomes has been informed by:

- professional stakeholder consultation feedback (an overview of stakeholders consulted is available in Appendix A);
- interviews with 13 current DCV participants (representing approximately 21 per cent of current DCV participants);
- results from DCV participant feedback surveys conducted in March 2012, September 2012 and April 2013; and
- analysis of DCV participant data contained in the DCV's DRUIS database over the period 1 July 2010 to 30 June 2013.

It is noted that the findings provided are limited due to:

- robustness and reliability of DRUIS data (for example, a number of data entry fields are non-mandatory, meaning that the progress of the entire DCV Cohort over the 1 July 2010 to 30 June 2013 period is not available, and there are variances in participant numbers for which data is available);
- a small sample size of clients in the evaluation period; and
- a lack of longitudinal data relating to DCV participant health, welfare and offending behaviour following completion of their Drug Treatment Order (DTO).

These limitations mean the results of the effectiveness evaluation must be treated with an appropriate degree of caution, and, while available information provides an indication of outcomes, further analysis of long-term effectiveness of the DCV in relation to participant health and wellbeing would be beneficial.

## 6.2. Objective one: to improve the health and wellbeing of participants through reducing alcohol and other drug use and criminal behaviour, and improved connection to the community

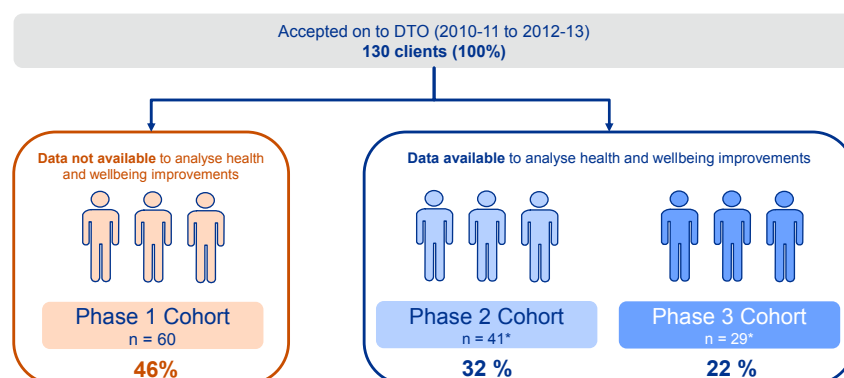
The DCV aims to achieve this objective is through the provision of:

- case management services;
- drug and alcohol counselling;
- clinical advisory services;
- health (including mental health) and medical services (by referral);
- housing, legal and income support (through referral);
- frequent urinalysis testing; and
- other courses and activities (e.g. community gardening).

In accordance with the principles of therapeutic jurisprudence and problem-solving courts outlined in Section 4.1, it is considered that addressing the underlying issues contributing to offending behaviour such as homelessness, lack of employment/education, drug and/or alcohol use, etc, will assist in reducing criminal activity and promote more pro-social behaviours.

It is important to note that only a small majority (70 of 130) of participants progressed to Phase 2 of their Drug Treatment Order (DTO) during the evaluation period and a minority of participants (29 of 130) progressed to Phase 3. Consequently, the health and wellbeing changes associated with DTO phase progression cannot be extrapolated to the broader DCV Cohort, given that only 54 per cent of participants progress beyond phase one. For this reason, only the clients who progressed to Phase 2 or Phase 3 for whom complete DRUIS data is available (referred to separately as the 'Phase 2 Cohort' and 'Phase 3 Cohort' in this section) are included in the following analysis. Improvements in participant health and wellbeing observed in these cohorts and noted in this section are often to be expected as they are necessary to progress to latter DTO phases (see Section 3.4.1). Figure 6-2 displays graphically the phase progression by the participants and availability of health and wellbeing data.

Figure 6-2: Phase progression by DCV clients and availability of health and wellbeing data (2010-11 through 2012-13)



Source: Drug Court of Victoria, *DRUIS Database Extracts (1 July 2010 – 30 June 2013)*. Note that discrepancies arise in relation to the number of participants for which data is available due to a high proportion of optional fields for completion in the DRUIS database. Discrepancies sometimes also arise as clients can progress to a higher phase and then be demoted back to a lower phase. Note 2: Phase 1 Cohort refers to clients who did not progress beyond Phase 1 during the evaluation period. Phase 2 Cohort refers to clients who progressed to Phase 2 but did not progress to Phase 3. Phase 3 clients refers to participants who progressed to Phase 3 and includes clients who have still active, graduated or completed the DTO.



Changes in health and wellbeing for the Phase 1 cohort cannot be analysed as data on changes to their health and wellbeing is not available.

### 6.2.1. Health

Improving the overall health of participants in the intermediate and long-term is an expected outcome of the DCV. Clinical advisory services, health (including mental health) and medical services (by referral), together with intensive case management and frequent urinalysis testing to reduce overall drug and alcohol use are the primary services provided to DCV clients to improve their overall health. Health improvements are evidenced by:

- reduced medical risks;
- reduced psychiatric risks; and
- reduced drug and alcohol risks.

The DCV monitors clients overall level of risk (classified as either 'high', 'medium' or 'low') across each of these health categories throughout their DTO. DCV Clinical Advisors and Case Managers are each responsible for interviewing and assessing DCV clients throughout the DTO using a combination of assessment tools and professional discretion, as outlined in Table 6-1.

Table 6-1: Method of assessment of DCV client health risk

Health indicators	Assessment by	Method of assessment
Client medical risk	DCV Clinical Advisors	Combination of DSM V, DAS 21 (Depression, Anxiety, Stress Scale from the Black Dog Institute), together with professional discretion
Client psychiatric risk	Corrections Case Managers	Victorian Intervention Screening Assessment Tool (VISAT)
Client alcohol and drug risk	DCV Clinical Advisors	Combination of DSM V together with professional discretion

Source: E-mails to KPMG from DCV A/Program Manager received 15 April 2014.

Collectively, a reduction in each of these risk factors reduces an offender's overall criminogenic risks and therefore their propensity to engage in criminal behaviours. In order to assess health improvements, KPMG has utilised these assessment values to track overall changes in health risk amongst the Phase 2 and Phase 3 Cohorts, coupled with feedback from DCV participant interviews. It is important to note that KPMG conducted interviews with a range of DCV clients, including some who were only in Phase 1 of their DTO.

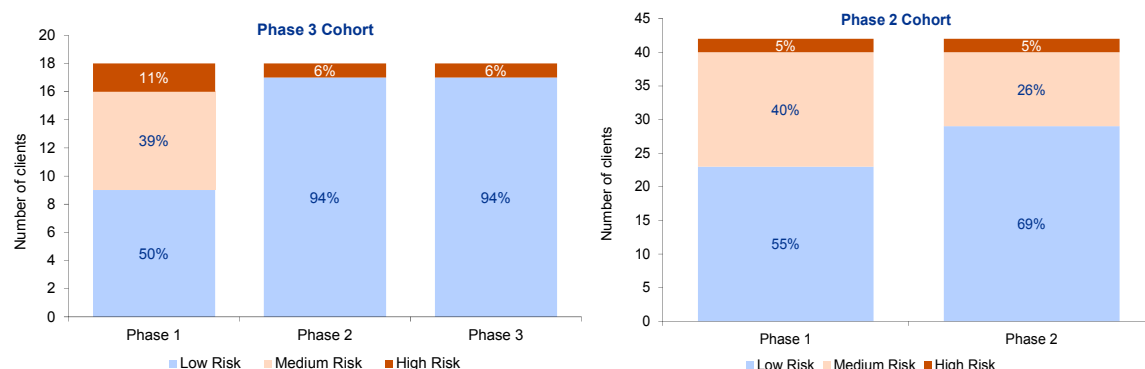
Across each of the health risk areas assessed (medical, psychiatric and alcohol and drugs), significant progress can be observed in terms of reductions in risk levels across both the Phase 2 and Phase 3 Cohorts. In general, the Phase 3 Cohort is assessed as being at a higher baseline in Phase 1 (with the exception of medical risk), with a smaller proportion of clients assessed as being at medium or high risk. Improved risk levels are consistently more pronounced for the Phase 3 Cohort than the Phase 2 Cohort. Client progress for the Phase 3 and Phase 2 Cohorts is explored in greater detail in the following sub-sections.

#### 6.2.1.1. Medical Risk

Changes in medical risk amongst the Phase 3 and Phase 2 cohorts is displayed in Figure 6-3.



Figure 6-3: Phase 2 (42 clients) and Three (18 clients) Cohort medical risk at each phase of DTO (2010-11 to 2012-13)



Source: Drug Court of Victoria, *DRUIS Database Extracts (1 July 2010 – 30 June 2013)*. Note that discrepancies arise in relation to the number of participants for which data is available due to a high proportion of optional fields for completion in the DRUIS database.

Amongst the client cohort successful at progressing to Phase 3, 50 per cent begin their DTO at medium or high risk and significant improvements in this group's overall level of medical risk are observed as they progress through the DTO phases. The reductions in medical risk amongst the Phase 3 Cohort are entirely present by Phase 2, where 94 per cent (n = 17) of clients are assessed as at low medical risk. In addition, for those clients who begin their DTO at low medical risk (n = 9), all are successful in maintaining this status throughout the course of their DTO. One client in the Phase 3 Cohort was not successful in improving their level of medical risk, however, still managed to progress to Phase 3, presumably due to improvements in other areas.

Similar, but less pronounced, patterns of improvement in medical risk are observed amongst the Phase 2 Cohort (n = 42). The Phase 2 Cohort commence their DTOs at a similar base, with 23 clients (55 per cent) assessed as at high medical risk in Phase 1. Significant, although less pronounced, improvements in medical risk can be observed in the Phase 2 Cohort as they progress from phases one to two. By Phase 2, 31 clients (69 per cent) have reduced levels of medical risk and are assessed as low risk, however, nearly one in three clients (31 per cent, n = 14) remain at either medium or high medical risk.

Interviews with DCV participants were consistent with the above assessment trends in reduced medical risk, with most participants stating that their overall health had improved since commencing their DTO. Table 6-2 outlines some of the statements by DCV participants related to their health.

Table 6-2: Feedback from DCV participants related to health

"I was in poor health at the start of my order but that's now improved."

"My overall health has improved. I have a lot more energy which makes me happy."

"My health has improved. I get around on my bike and riding my bike is good for my hips."

"Overall my health has improved. When I don't use my Hepatitis doesn't come up."

-DCV Participants

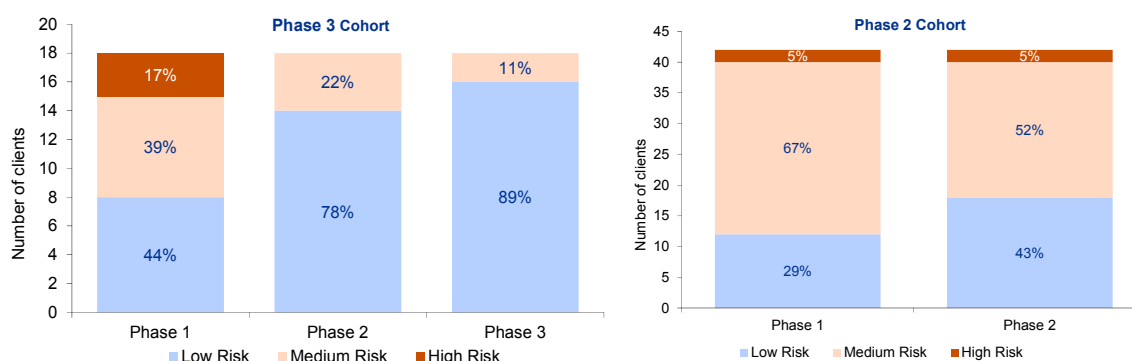
Source: KPMG consultations conducted with DCV participants in March 2014. Note: These statements are not isolated to participants at any particular stage of the DTO.

The above evidence from the medical risk assessments and client interviews indicate that the DCV program is very effective in reducing levels of medical risk amongst the 17 clients in the Phase 3 Cohort and 42 clients in the Phase 2 cohort.

### 6.2.1.2. Psychiatric Risk

As summarised in 3.6.6, DCV clients report very low levels of mental wellbeing at intake, with a significant portion acknowledging having had suicidal thoughts or thoughts of self-harm. Changes in levels of psychiatric risk amongst the Phase 2 and Three Cohorts is displayed in Figure 6-4.

*Figure 6-4: Phase 2 (42 clients) and Three (18 clients) Cohort psychiatric risk at each phase of DTO (2010-11 to 2012-13)*



Source: Drug Court of Victoria, *DRUIS Database Extracts (1 July 2010 – 30 June 2013)*. Note that discrepancies arise in relation to the number of participants for which data is available due to a high proportion of optional fields for completion in the DRUIS database.

A similar pattern of declining psychiatric risk is observed in both the Phase 3 and Phase 2 Cohorts, with the proportion of clients at low risk increasing consistently through the DTO phases.

In examining levels of psychiatric risk amongst the Phase 3 Cohort, we can observe significant improvements in levels of psychiatric risk across each stage of the DTO, and between phases one and Phase 2 in particular. In Phase 1, over half of the Phase 3 Cohort DCV clients (n = 10) are assessed as being at either medium or high psychiatric risk. By Phase 2, this proportion has reduced to just over one in five (3 clients, 22 per cent). A further, albeit smaller reduction in levels of psychiatric risk is seen between Phases 2 and 3, with nearly 90 per cent (16 of 18 clients) of the Phase 3 Cohort assessed as being at low psychiatric risk in Phase 3.

The Phase 2 Cohort starts from a slightly lower baseline with regards to levels of psychiatric risk. In Phase 1, more than two-thirds (n = 30) of the Phase 2 Cohort are assessed as being at medium or high psychiatric risk. By Phase 2, improvements in psychiatric risk are observed, however, the improvements are less pronounced in the Phase 2 Cohort as compared to the Phase 3 Cohort. While 78 per cent of the Phase 1 Cohort were assessed as being at low psychiatric risk by Phase 2, only 43 per cent of the Phase 2 Cohort reached the equivalent level. This difference is reflective of both the higher levels of psychiatric risk at baseline for the Phase 2 cohort as well as a smaller percentage improvement between Phases 1 and 2.

DCV participants interviewed were asked about their impression of their overall mental wellbeing and any changes they had observed since being on the DTO. Responses were mostly consistent with the above assessment trends in reduced psychiatric risk, with several participants stating that their mental wellbeing had improved somewhat since starting their DTO. A sample of response are contained in Table 6-3.

Table 6-3: Feedback from DCV participants related to mental wellbeing

"Before I was suicidal but I decided I'm a good person and I'm going to break this cycle...I feel good within myself. I've made a lot of changes."

"I cope with day to day life much better and have the motivation to keep going."

"I'm more relaxed than before...I've had depression in the past but I'm quite happy now."

"Sometimes I still get anxiety and depression."

"My outlook on life is just OK. But that's OK. It's OK to be OK."

-DCV Participants

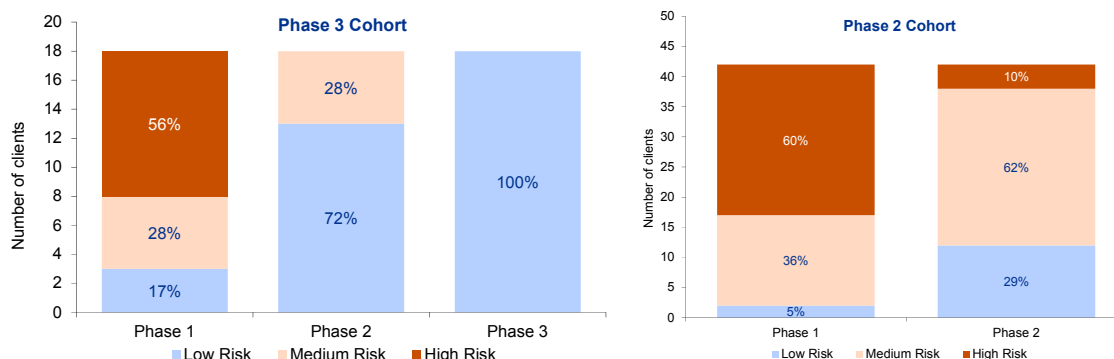
Source: KPMG consultations conducted with DCV participants in March 2014 Note: These statements are not isolated to participants at any particular stage of the DTO.

The findings from the data analysis and participant interviews indicate that the DCV program is effective in reducing levels of psychiatric risk amongst the clients in the Phase 3 and Phase 2 Cohorts, however, significant portions of the Phase 2 Cohort require further support in order to improve their mental wellbeing.

### 6.2.1.3. Drug and Alcohol Risk

The DCV Cohort presents with deeply entrenched substance use issues at intake, with most participants reporting being daily users, as was summarised in 3.6.7. Reducing the levels of drug and alcohol risk amongst DCV clients is central to achieving the objectives and outcomes of the DCV and is the subject of significant investment of the DCV resources. Figure 6-5 summarises the Phase 3 and Phase 2 Cohort's alcohol and drug risk as they progress through the DTO.

Figure 6-5: Phase 2 (42 clients) and Three (18 clients) Cohort drug and alcohol risk at each phase of DTO (2010-11 to 2012-13)



Source: Drug Court of Victoria, *DRUIS Database Extracts (1 July 2010 – 30 June 2013)*. Note that discrepancies arise in relation to the number of participants for which data is available due to a high proportion of optional fields for completion in the DRUIS database.

Analysis of the DCV assessments indicate that both the Phase 3 and Phase 2 cohort's drug and alcohol risk declines significantly through the DTO phases. This outcome is to be expected, however, as a reduction in drug and alcohol use is required in order for a client to progress to higher phases of the DTO. Compliance with this requirement is ensured through frequent urinalysis testing.

Amongst the Phase 3 Cohort, the majority of clients (56 per cent, n = 9) are assessed as being at high drug and alcohol risk in Phase 1 of the DTO, with an additional five clients assessed as being at medium risk. Interestingly, three clients are assessed as being at low drug and alcohol risk in Phase 1 of the DTO for reasons that are not immediately apparent.

By Phase 2, nearly three in four (72 per cent, 13 clients) of Phase 3 Cohort clients have successfully moved to being assessed as at low drug and alcohol risk and by Phase 3, 100 per cent of the cohort reach low risk. Once again, this outcome is to be expected in light of the progression criteria and urinalysis compliance testing.

Consistent with levels of medical and psychiatric risk, the Phase 2 Cohort is assessed as having a slightly lower baseline than the Phase 3 Cohort in regards to alcohol and drug risk, with all but two clients (95 per cent) assessed as being at either high (60 percent) or medium (36 per cent) drug and alcohol risk. Risk reductions are, once again, less pronounced in the Phase 2 Cohort in relation to drugs and alcohol. A significant proportion of Phase 2 Cohort clients progress from either medium to low risk or high to medium risk between Phases 1 and 2, however, the significant majority (72 per cent, 30 clients) remain at medium or high risk. This progress in regards to reductions in alcohol and drug risk leaves the Phase 2 Cohort at significantly higher risk in Phase 2 as compared to the Phase 3 Cohort in the same phase.

Interviews conducted with DCV participants included questions related to changes in drug and alcohol use patterns since engaging with DCV. Most clients stated that they had succeeded in reducing their drug and alcohol use, however, a significant number acknowledged that they had not yet managed to fully abstain from any substance use. A number of participants stated their drug use patterns had changed, from daily to less frequent use, and sometimes away from comparatively more addictive and dangerous substances (e.g. heroin, amphetamines) and towards comparatively less addictive and dangerous substances (e.g. marijuana). A sample of responses are summarised in Table 6-4.

Table 6-4: Feedback from DCV participants related to drug and alcohol use

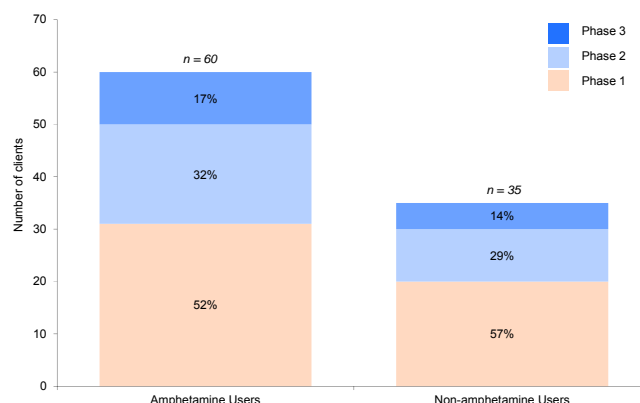
<p><i>"Before I was heavily into heroin but now my drug and alcohol use has stopped completely."</i></p> <p><i>"I've dramatically changed my drug and alcohol use. I don't do needles or powders anymore. I still occasionally smoke marijuana."</i></p> <p><i>"Before the DCV I've always had to rehabilitate myself...when I tried to get clean I would just give up and go and use but now I know it all comes down to me."</i></p> <p><i>"I've made big changes. Before I used pills nearly every day. Now I only use about once a month. I'm using the same drugs but not as much."</i></p> <p><i>"I'm now eight months clean. I've had trouble sacking the marijuana and haven't completely kicked it but my use is minimal compared to what it was."</i></p> <p><i>"I have made huge changes. I have stopped taking all drugs for six months now."</i></p>	-DCV participants
---	-------------------

Source: KPMG consultations conducted with DCV participants in March 2014. Note: These statements are not isolated to participants at any particular stage of the DTO.

#### DTO phase progression amongst amphetamine-using clients

Despite the challenges noted by Case Workers in treating clients using amphetamines (particularly ice), detailed analysis of amphetamine-using clients' progression through DTO phases does not provide evidence that amphetamine-using clients struggle to progress. As shown in Figure 6-6, amphetamine-using clients actually performed slightly better than non-amphetamine using clients during the evaluation period, with 17 per cent (10 of 60) of amphetamine-using clients reaching Phase 3 as compared to 14 per cent (5 of 35) of non-amphetamine using clients.

Figure 6-6: Progression through DTO phases - amphetamine vs. non-amphetamine users (2010-11 through 2012-13) (n = 95)



Source: Drug Court of Victoria, *DRUIS Database Extracts* (1 July 2010 – 30 June 2013).

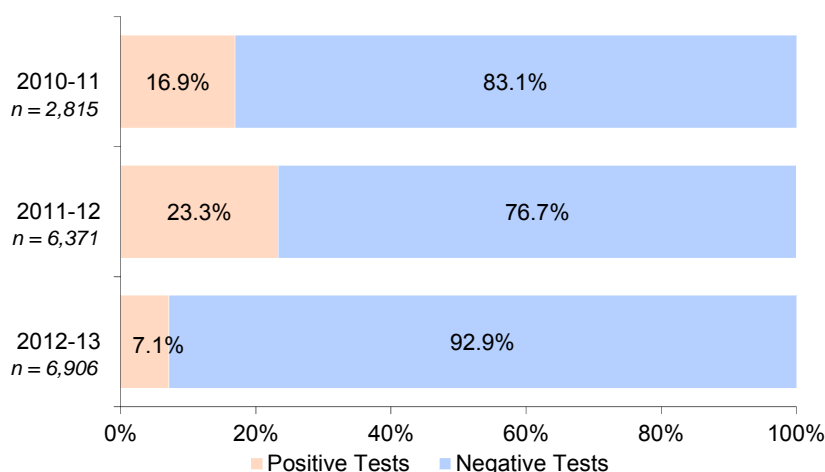
Although significant, this finding should be treated with caution due to the small number of participants included in the analysis, particularly of the non-amphetamine using client cohort. As stated in Section 3.6.7, the DCV does not currently collect data on the type of amphetamine clients report using at intake (although this data is collected during urinalysis tests). This limits the ability to directly compare DTO phase progression of ice-using and non-ice-using clients.

The evidence from the assessments and participant interviews indicate the DCV is effective in reducing levels of drug and alcohol risk, particularly amongst the Phase 3 Cohort. DCV is also effective in reducing levels of drug and alcohol risk amongst the Phase 2 Cohort, albeit to a lesser extent. Once again, these findings are to be expected given the nature of the phase progression criteria. A potentially more interesting finding is the lack of observable difference in phase progression rates amongst amphetamine and non-amphetamine using clients, which requires further analysis in order to fully evaluate.

#### 6.2.1.4. Overall Drug and Alcohol Use

As summarised in Section 6.2.1.3, analysis of drug and alcohol use amongst the Phase 2 and Phase 3 Cohorts shows declining substance risk at the individual level. Together with this, overall urinalysis tests across all clients shows an aggregate decline in positive urine tests in 2012-13 as compared to previous years. Analysis was conducted on the proportion of urine tests which tested positive for disallowed substances while on a DTO from 2010-2013. This analysis is summarised in Figure 6-7.

Figure 6-7: DCV client urinalysis results (2010-11 to 2012-13)



Source: Drug Court of Victoria, *DRUIS Database Extracts (1 July 2010 – 30 June 2013)*. 'Positive tests' include positive urinalysis tests for cannabinoids, codeine, morphine, amphetamine, methylamphetamine (ice), and other disallowed substances.

The above analysis shows an initial rise in positive tests, from 17 per cent in 2010-11 to 23 per cent in 2011-12. Following this, however, the number of positive urine tests for the selected drugs fell sharply to 7 per cent in 2012-13. This result shows increasing levels of compliance with DTO drug and alcohol conditions and increasing effectiveness in helping participants avoid drugs and alcohol. It is also worth noting the significant increase in testing, from just over 2,800 tests in 2010-11 to nearly 7,000 in 2012-13, which may also be associated with improved levels of compliance.

Several participants voiced their frustrations with the frequency of urinalysis testing and need to visit the Drug Court House so often. Feedback from some participants is summarised in Table 6-5.

Table 6-5: Feedback from DCV participants related to urinalysis testing

"I don't like the urines but know it's something I got to do."

"The worst thing about Drug Court is the urines."

"The best thing about the Drug Court is being made accountable for my actions...the urines are OK"

-DCV Participants

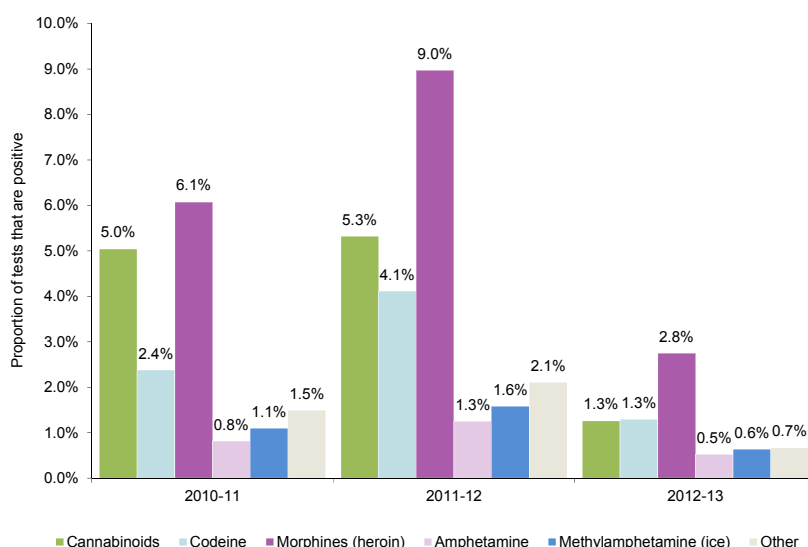
Source: KPMG consultations conducted with DCV participants in March 2014. Note: These statements are not isolated to participants at any particular stage of the DTO.

#### Trends in positive tests by drug type

Analysis of drug tests of individual drugs shows a common pattern, with positive tests of all substances rising from 2010-11 to 2011-12 before falling in 2012-13. Morphine use (the vast majority of morphine use is heroin) is consistently the most common positive drug test, however, overall positive morphine tests declined from just over six per cent in 2010-11 to just under three per cent in 2012-13. Cannabinoids remains the second most common positive drug test, however, positive tests have also declined from five- per cent in 2010-11 to slightly more than one per cent in 2012-13. Interestingly, while indicators of crystal methamphetamine (ice) use across Victoria have been increasing, positive tests for methamphetamine are comparatively low and declining amongst DCV clients. Only 0.6 per cent of total 2012-13 tests were positive for methamphetamine. These trends in positive tests are displayed in Figure 6-8.



Figure 6-8: Proportion of urinalysis tests confirmed as positive by major substance (2010-11 to 2012-13)



Source: Drug Court of Victoria, *DRUIS Database Extracts* (1 July 2010 – 30 June 2013).

The above analysis of overall urinalysis testing trends provides further evidence that the DCV is effective in reducing drug and alcohol usage and risk levels.

In summarising health impacts amongst the Phase 2 and Phase 3 cohort, the Phase 3 cohort is generally assessed as being at a higher baseline in Phase 1 in terms of risk levels across the health areas. Progress to higher risk levels also generally occurs more quickly for this cohort as compared to the Phase 2 Cohort. This comparatively faster progression is likely reflective of this higher baseline and comparatively less entrenched substance use and health problems.

The improvements in medical, psychiatric and drug and alcohol risk all contribute to improving overall health of participants. Reducing medical, psychiatric and drug and alcohol risk can lead to improved personal ability to meet commitments, reduced impulsivity, increased employability and potential for improved community connections. Altogether, these improvements reduce criminogenic risk factors and provide evidence of progress towards DCV's stated outcomes related to health and wellbeing and overall objectives.

### 6.2.2. Wellbeing

Improving the wellbeing of participants over the intermediate and long-term is another expected outcome of the DCV. Intensive case management services, housing, legal and income support (through referral), together with other courses and activities (e.g. community gardening) are the primary services provided to DCV clients to improve overall levels of wellbeing. Improvements to client wellbeing are evidenced by:

- Improved family and social relationships
- Improved education and employment
- Improved housing stability
- Improved client motivation to change
- High levels of appointment and hearing attendance.

As with health risks, the DCV monitors clients overall level of risk across each of these categories throughout their DTO. The wellbeing indicators and method of assessment are outlined in Table 6-6.



Table 6-6: Method of assessment of DCV client wellbeing risk

Wellbeing indicators	Assessment by	Method of assessment
Client family and social relationship risk	Corrections Case Managers	Victorian Intervention Screening Assessment Tool (VISAT) and professional discretion
Client education and employment risk	Corrections Case Managers	Victorian Intervention Screening Assessment Tool (VISAT) and professional discretion
Client housing stability risk	Corrections Case Managers	Victorian Intervention Screening Assessment Tool (VISAT) and professional discretion
Client motivation to change risk	DCV Clinical Advisors	Socrates stages of change and readiness for treatment measures and professional discretion

Source: E-mails to KPMG from DCV A/Program Manager received 15 April 2014.

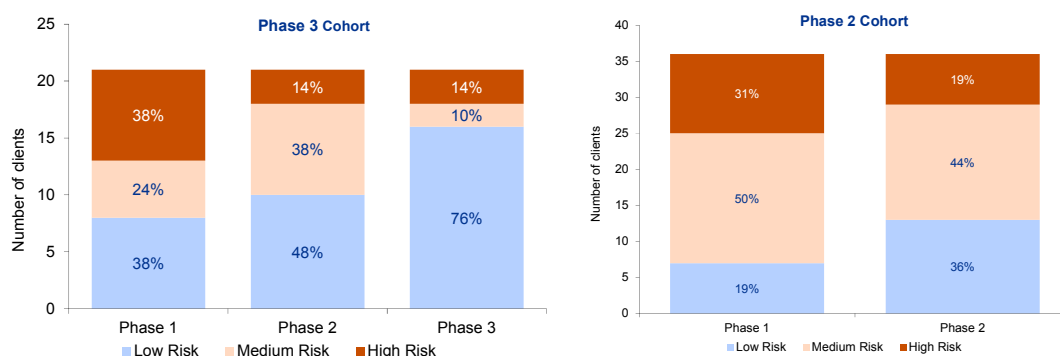
Minimising the risk factors associated with instability in each of these areas of a participant's life assists in reducing their identified criminogenic risks and propensity to engage in criminal activities. In addition, increasing motivation to change and indicators of strong appointment and hearing attendance would suggest a greater degree of self-empowerment and organisation amongst participants. As with health risks, in order to assess wellbeing improvements, KPMG has utilised the risk assessment values to monitor overall wellbeing improvements amongst the Phase 2 and Phase 3 Cohorts, together with feedback from DCV participant interviews and a review of client hearing and appointment attendance records.

Improvement in client wellbeing indicators for the Phase 2 and Phase 3 Cohorts can be observed, however, progress across the key indicators is more variable than with client health indicators. Client wellbeing is significantly improved for Phase 2 and Phase 3 Cohorts in relation to housing stability, improved in relation to family/social relationships, somewhat improved for education and employment risk, and a more inconclusive picture for client motivation to change. Clients also demonstrate the development of consequential thinking and comparably high levels of time management and accountability considering the vulnerabilities of the cohort. Changes in client wellbeing for the Phase 3 and Phase 2 Cohorts is explored in greater detail in the following sub-sections.

#### 6.2.2.1. Family and social relationships

In Phase 1, the majority of both the Phase 2 and Phase 3 Cohorts are assessed as being at either medium or high level of risk with regards to family and social relationships. This assessment is indicative of the low levels of positive and supportive relationships in many participants' lives at the start of the DTO. Deeply entrenched substance use issues coupled with frequent imprisonment sentences naturally challenges family and social relationships. While forging new positive relationships and strengthening family ties is a long-term process, improvements are observed in both cohorts as they progress through the DTO phases, as displayed in Figure 6-9.

Figure 6-9: Phase 2 (36 clients) and Three (21 clients) Cohort family/social relationship risk at each phase of DTO (2010-11 to 2012-13)



Source: Drug Court of Victoria, *DRUIS Database Extracts (1 July 2010 – 30 June 2013)*. Note that discrepancies arise in relation to the number of participants for which data is available due to a high proportion of optional fields for completion in the DRUIS database.

For the Phase 3 cohort, nearly two-thirds of participants are assessed as being at either medium or high risk in regards to their family and social relationships in Phase 1. By Phase 2, the proportion of clients assessed as being at high risk reduces significantly (from 38 per cent to 14 per cent), while the proportion of clients at low risk increases (from 38 per cent to 48 per cent). Into Phase 3, significant improvements in family and social relationships are observed, with more than three-quarters (76 per cent,  $n = 16$ ) assessed as being low risk in relation to their family and social relationships. A notable proportion of clients (14 per cent,  $n = 3$ ) remained at high risk throughout the DTO.

A higher proportion (81 per cent,  $n = 29$ ) of the Phase 2 Cohort is assessed as medium or high risk in regards to their family and social relationships in Phase 1 of the DTO as compared to the Phase 3 Cohort. The Phase 2 Cohort's progress in regards to improving their relationships is comparable to the Phase 3 Cohort's, with the proportion at low risk rising 89 per cent between Phase 1 and two (17 percentage points), and the proportion at high risk falling 39 per cent over the same period (17 percentage points).

Many clients interviewed during the evaluation noted having troubled family relationships and being largely involved only in social circles of drug users at intake. As a coping strategy for those clients previously engaged largely with circles of drug users, some clients reported isolating themselves from these groups. While this certainly seems appropriate, some of these clients reported not having any other relationships to fill the void, resulting in some experiencing loneliness and social isolation. Several clients reported improved family relationships, which contributed to increasing their motivation to reduce their substance use and offending behaviour. Table 6-7 outlines some of the feedback related to family and social relationships provided by DCV clients.

Table 6-7: Feedback from DCV participants related to family and social relationships

"I've restarted a relationship with my child. I want to be a good role model for them and a good influence for the family."

"Life in general is good at the moment. My newborn child has changed my life. I wouldn't even consider committing a crime now."

"I'm closer with my family but I still have a way to go before things are back to normal"

"I don't socialise with anyone anymore. My family relationships aren't so good either but they weren't good before. I don't get along with my mum or dad. They think I'm just a junkie."

"My parents are getting old. Me being clean has helped my relations with them."

-DCV participants

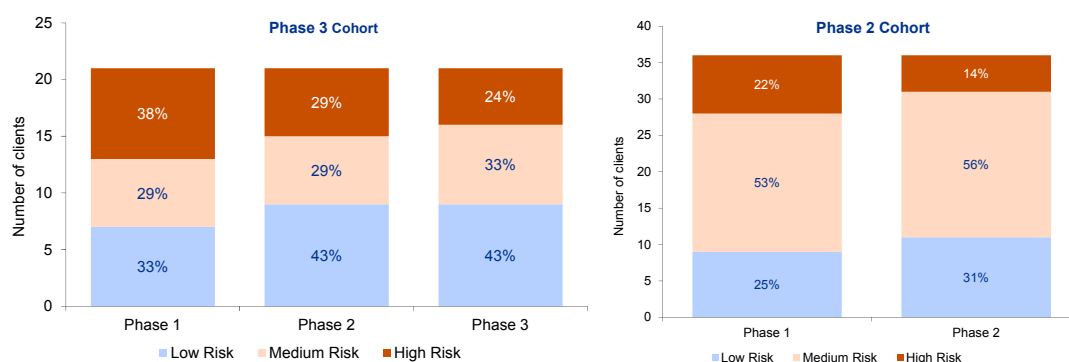
Source: KPMG consultations conducted with DCV participants in March 2014. Note: These statements are not isolated to participants at any particular stage of the DTO.

Findings from the analysis of risk assessments and participant interviews indicate that the DCV program is effective in improving family and social relationships amongst the clients in the Phase 3 and Phase 2 Cohorts. Despite this success, a significant proportion of both the cohorts remained at high risk in relation to family and social relationships throughout the DTO. This finding is reflective of the fact that rebuilding family and social relationships and reintegrating into the community is a long process. Given this, further longitudinal study of the family and social relationship risk of DCV participants would be appropriate.

#### 6.2.2.2. Education and employment

Section 3.6.3 outlined the low levels of education and high levels of unemployment amongst the entire DCV Cohort at intake. From this low baseline, slight improvements in education and employment risk are observed amongst the Phase 2 and Phase 3 Cohorts, however, a significant proportion of both cohorts do not succeed in reducing their level of education and employment risk, as summarised in Figure 6-10.

Figure 6-10: Phase 2 (36 clients) and Three (21 clients) Cohort education and employment risk at each phase of DTO (2010-11 to 2012-13)



Source: Drug Court of Victoria, *DRUIS Database Extracts (1 July 2010 – 30 June 2013)*. Note that discrepancies arise in relation to the number of participants for which data is available due to a high proportion of optional fields for completion in the DRUIS database.

Two-thirds of the Phase 3 Cohort (67 per cent, n = 14) are assessed as being at medium or high risk in relation to education and employment risk in Phase 1. This proportion decreases to 57 per cent moving into Phase 2, however, remains unchanged between Phase 2 and three.

A similar pattern of slight improvement can be seen amongst the Phase 2 Cohort. In Phase 1, three in four (n = 27) Phase 2 Cohort clients are deemed to be at either high or medium risk in regards to education and employment. Only three of 36 clients (8 per cent) succeeded in reducing their level of education and employment risk between Phase 1 and two amongst the cohort.

The incremental nature of education and employment risk reduction is most likely to indicative of the entrenched nature of the cohort's risk in each of these areas, as clients have low levels of education at intake, coupled with a history of unemployment and offending. DCV staff provide referrals to training and employment providers for clients as required, however, maintaining stable employment while being a daily substance user naturally presents significant barriers to employment. As such, the DCV program concentrates first on reducing drug and alcohol usage through intensive clinical and case management and compliance monitoring.

DCV participant consultations included questions related to education and employment and most clients expressed a desire to find employment and/or further their training. Several clients interviewed expressed frustration with the significant time commitment and high level of engagement required by the DTO, particularly during Phase 1. These clients noted it was nearly impossible for them to work while being on the Order due to the high number of appointments they are required to attend. One participant interviewed who was at a higher DTO phase noted he had been successful in finding full time employment, which had significantly improved his overall wellbeing. A sample of DCV participant responses related to education and employment are contained in Table 6-8.

Table 6-8: Feedback from DCV participants related to education and employment

"[DCV] has helped me with employment by teaching me how to look for work and how to do up a CV. I haven't had this help before."

"I had been unemployed for a long time. Since starting the DTO I got a job at x where I've been working ever since. I work on commission and am very competitive. I'm not useless."

"I want to go out and work but all these appointments means I can't."

"I now have enough confidence to go back to school and study at university."

"I'm seeing a worker over at REES who is looking into getting me work once I'm in Phase 2."

-DCV Participants

Source: KPMG consultations conducted with DCV participants in March 2014. Note: These statements are not isolated to participants at any particular stage of the DTO.

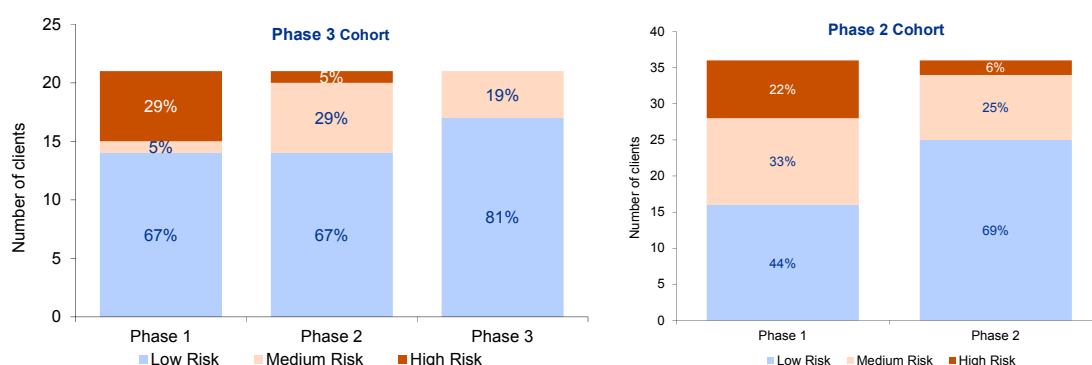
The high level of interaction and time commitment required by participating in a DTO makes it challenging for clients seeking to engage in employment or study. As a result, formal engagement in education and employment is often seen as a longer-term goal by DCV clients.

Evidence from assessment analysis and consultations indicate the DCV is only somewhat effective in reducing levels of education and employment risk amongst the Phase 2 and Phase 3 Cohorts. This finding is to be expected given the time commitment required while being on the DTO, entrenched nature of the DCV clients' education and unemployment history, and long-term nature of improving education and employability within the context of the DCV Cohort.

### 6.2.2.3. Housing stability

As was discussed in Section 3.6.3, a portion of the DCV Cohort are living in unstable housing situations and more than one in five (21 per cent) are at risk of homelessness at intake. Despite this proportion of high housing stability risk clients, the majority of DCV clients do have stable housing and are assessed as being at low risk at intake. For those clients living in unstable housing, DCV staff will provide referrals to WAYSS representatives in order to assist clients in securing stable housing. Changes in levels of housing risk across DTO phases are summarised in Figure 6-11.

Figure 6-11: Phase 2 (36 clients) and Three (21 clients) Cohort housing risk at each phase of DTO (2010-11 to 2012-13)



Source: Drug Court of Victoria, *DRUIS Database Extracts (1 July 2010 – 30 June 2013)*. Note that discrepancies arise in relation to the number of participants for which data is available due to a high proportion of optional fields for completion in the DRUIS database.

Across both the Phase 2 Cohort and Phase 3 Cohort, the significant majority of clients who are at high housing stability risk in Phase 1 succeed in reducing this level of risk to medium or low by Phase 2. Those in the Phase 3 and Phase 2 Cohorts beginning in Phase 1 at low housing stability risk are successful in retaining this level of risk.

Across the Phase 3 Cohort, a majority of clients (67 per cent, n = 14) begin their DTO at low housing risk in Phase 1 and are successful in remaining at this level. For the remaining Phase 3 Cohort, the

proportion of clients at high housing stability risk is reduced to zero by Phase 3 of the DTO due to interventions by Case Managers and WAYSS representatives.

Compared to the Phase 3 Cohort, a smaller proportion (44 per cent, n = 16) of the Phase 2 Cohort begin their DTO at low housing risk, however, similar improvements between DTO phases are observed. By Phase 2 the proportion recorded as being at low risk increases 25 per cent to 69 per cent (n = 25) of clients. A very small proportion of the cohort (two clients, six per cent) remain at high risk in Phase 2.

During the client interviews, participants were asked about their housing situation and any assistance they had received through the DCV. All clients reported either stable or improving housing situations, with a number of clients reporting that achieving housing stability away from negative influences (e.g. former partners, friends) was a highly positive step in terms of creating an environment for rehabilitation. A sample of DCV client feedback related to housing is contained in Table 6-9.

Table 6-9: Feedback from DCV participants related to housing

<p><i>"I was living with my partner and child in emergency shelters...the DCV helped me get into transitional housing."</i></p> <p><i>"WAYSS helped me get a house which was so empowering. I have bills in my name! I've achieved something."</i></p> <p><i>"DCV has helped me get a larger housing away from my ex-partner who was abusive."</i></p> <p><i>I was homeless before my DTO and in and out of transitional housing. I've got housing now through WAYSS."</i></p> <p><i>"Before DCV housing was my biggest problem."</i></p>
– DCV Participants

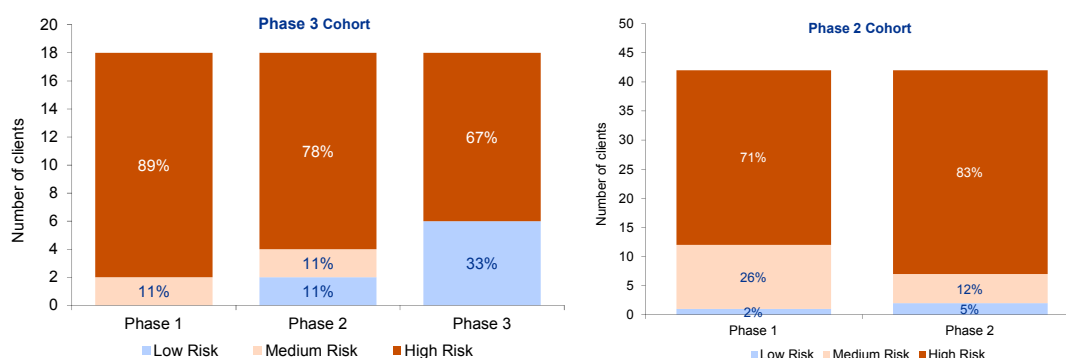
Source: KPMG consultations conducted with DCV participants in March 2014. Note: These statements are not isolated to participants at any particular stage of the DTO.

Evidence from this analysis indicate the DCV is effective in improving housing stability and reducing housing risk amongst the Phase 2 and Phase 3 Cohorts. As stable housing is a pre-requisite for many health and wellbeing improvements, the improved housing outcomes DCV has facilitated is a very positive finding.

#### 6.2.2.4. Motivation to change

DCV Clinical Advisors assess a client's motivation to change using the Socrates stages of change and readiness for treatment measures. Clients assessed as high risk can are unlikely to have requisite levels of motivation to change their offending and substance use behaviour, whilst low risk may refer to clients who are likely to be motivated to change. Changes in client motivation to change risk for the Phase 2 and Three Cohorts is displayed in Figure 6-12.

Figure 6-12: Phase 2 (42 clients) and Three (18 clients) Cohort motivation to change at each phase of DTO (2010-11 to 2012-13)



Source: Drug Court of Victoria, DRUIS Database Extracts (1 July 2010 – 30 June 2013). Note that discrepancies arise in relation to the number of participants for which data is available due to a high proportion of optional fields for completion in the DRUIS database.



In contrast to most of the other health and wellbeing indicators, the significant majority of DCV clients in both the Phase 3 and Phase 2 Cohorts are assessed as being at high risk in terms of their motivation to change in Phase 1 of the DTO. While the Phase 3 Cohort experiences some improvement in terms of the proportion who transition from high risk to low and medium risk, this improvement pattern cannot be observed amongst the Phase 2 Cohort.

The proportion of the Phase 3 Cohort at low risk in terms of motivation to change increases from zero per cent in Phase 1 to 33 per cent (n = 6) in Phase 3, however, the majority of the cohort remains at high risk in terms of motivation to change, regardless of DTO phase. Even in Phase 3, two-thirds (n = 12) of Phase 3 Cohort clients remain at high risk in terms of their motivation to change.

While the Phase 3 Cohort has a discernible trend of incremental improvement in terms of motivation to change, the Phase 2 Cohort actually displays higher motivation to change at Phase 1 as compared to Phase 2. In Phase 1, the significant majority (30 clients, 71 per cent) are assessed as being at high risk in terms of motivation to change. This proportion of high risk clients actually increases 12 per cent for the cohort to 83 per cent (n = 35) in Phase 2.

The above findings regarding consistently high proportions of clients being at high risk in terms of motivation to change is surprising, as being willing and motivated to engage with the DCV is a pre-requisite to entering the Program. Further examination of the reasons for these assessments would be beneficial.

Despite the high level of motivation to change risk across both Phase 2 and Phase 3 cohorts, all DCV clients interviewed made statements indicating a degree of motivation to change their substance use and offending behaviour. This may be an expected result given the nature of the interview setting, however, is noteworthy nonetheless. Several clients interviewed mentioned their family members when describing their motivation to change. A sample of some of these responses is contained in Table 6-10.

Table 6-10: Feedback from DCV participants related to motivation to change

*"I promised my family members not to return to prison. When I was arrested and in remand again I decided I'd lived the criminal lifestyle for too long."*

*"Before the DTO, my attitude was "I don't want to change"...I have to be on guard to make sure I don't slip."*

*"My behaviour has changed. I've never been given a chance like this before and I don't want to blow it. I got two years hanging over my head."*

*"I'm good person and I'm going to break this cycle."*

-DCV participants

Source: KPMG consultations conducted with DCV participants in March 2014. Note: These statements are not isolated to participants at any particular stage of the DTO.

Evidence from the assessment analysis and participant interviews does not indicate the DCV is particularly effective at improving Phase 2 and Phase 3 Clients motivation to change, however, the fact that these clients did progress to higher phases of the DTO indicates a minimum level of motivation which should not be discounted.

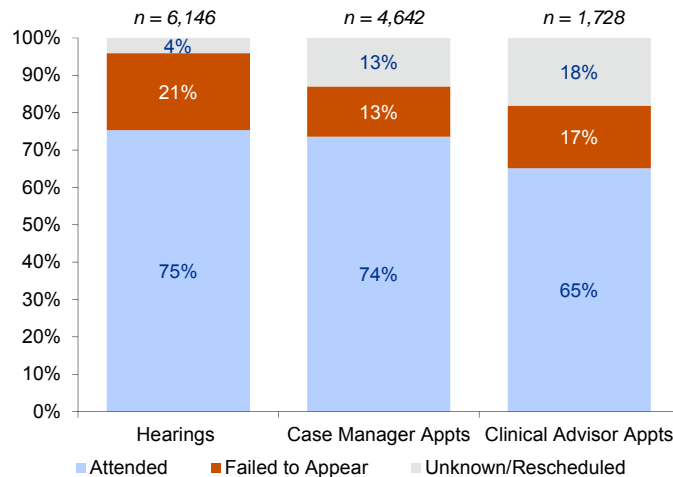
#### 6.2.2.5. Appointment and hearing attendance

As described in Section 3.4, the DTO involves clients attending the DCV regularly to attend hearings and appointments. The intensive nature of the DTO, especially during Phase 1, is designed to both ensure compliance with program requirements and provide structure for clients. DCV clients have to frequently attend three major appointment categories: court hearings, case manager appointments and clinical advisor appointments. KPMG analysed appointment and hearing attendance in order to determine levels of compliance with DTO attendance conditions, which is demonstrable of the development of consequential thinking and time management. Attendance also indicates client engagement with the program, which is a stated intermediate outcome of the DCV.



Overall appointment and hearing attendance is very strong across the entire DCV Cohort, especially considering the nature of the DTO cohort and entrenched vulnerabilities. Over the three year evaluation period, clients attended an average of 2.67 hearings per month and a less frequent number of case manager and clinical advisor appointments.<sup>109</sup> The large majority of clients interviewed reported that court reviews were 'useful' or 'very useful'.<sup>110</sup> Attendance rates for all DCV clients was between 65 per cent (Clinical Advisor appointments) and 75 per cent (hearings), as displayed in Figure 6-13.

Figure 6-13: Hearing and appointment attendance (130 clients) (2010-11 to 2012-13)



Source: Drug Court of Victoria, DRUIS Database Extracts (1 July 2010 – 30 June 2013).

#### 6.2.2.6. Development of consequential thinking

DCV participants interviewed noted that a key change affecting their behaviour was the development of consequential thinking, which enabled them to consider the implications of their actions, particularly in relation to criminal activity and drug and/or alcohol use.<sup>111</sup> Key indicators of this type of thinking included statements related to 'thinking before acting' and 'staying away from bad influences'. A sample of responses which evidence this consequential thinking is displayed in Table 6-11.

Table 6-11: Feedback from DCV participants related to consequential thinking

"I stay away from people who are bad influences."

"I don't involve myself with addicts anymore which helps me stay clean. I try and tell my using friends to get clean."

"I'm on an alcohol ban which I asked for. In the last five months I've only had four or five drinks. I know alcohol is one of my triggers."

"I think before I act now. Before I didn't do this I was just stoned all the time."

"I used to take drugs every day but now I take them less because I understand my problems and the drugs better."

"I avoid people I used to associate with. I think before I act and weigh the pros and cons."

"I've severed my ties with my negative brother who is a user and a bad influence. I've come good and I feel better. Now I tell him not to use in front of me and try and stay away from him. We're not

<sup>109</sup> Drug Court of Victoria, DRUIS Database Extracts (1 July 2010 – 30 June 2013).

<sup>110</sup> KPMG consultations conducted with DCV participants in March 2014.

<sup>111</sup> KPMG consultations conducted with DCV participants in March 2014.

*mates anymore. Sometimes when he tries and come over I play possum and turn off the lights and lock the doors."*

– DCV Participants

Source: KPMG consultations conducted with DCV participants in March 2014. Note: These statements are not isolated to participants at any particular stage of the DTO.

#### 6.2.2.7. Time management and accountability

While several participants noted their frustrations, particularly in regards to the barriers to employment that came with the intensive program, many also considered the structure and rigour of the DTO enabled development of time management skills and improved accountability to the DCV Magistrate, Case Managers and Clinical Advisors. Strong attendance rates across the DCV Cohort provide further evidence of well-developed time management skills and accountability. A sample of participant responses related to time management and accountability are contained in Table 6-12.

Table 6-12: Feedback from DCV participants related to time management and accountability

*"Appointments are a good use of my time. It makes you accountable. Before, you'd just go home and forget about life."*

*"Before I entered this program I had no hope. I actually wanted to become worse than I already was. Nothing mattered back then. My work didn't matter. Time didn't matter. Appointments didn't matter. I had no time management."*

*"The best thing about Drug Court is being made accountable for my actions...I used last week and the Magistrate made me write answers to four questions instead of giving me sanctions. This really helped."*

*"I still struggle a bit with drinking. When I first got my own place I was drinking a slab of beer a fortnight but after a couple of months I thought 'I don't need this'. I was worried I was replacing the drugs with alcohol so I stopped the drinking altogether."*

*"I know what's going to happen here. I know if I've been good or bad and know what to expect."*

– DCV Participants

Source: KPMG consultations conducted with DCV participants in March 2014. Note: These statements are not isolated to participants at any particular stage of the DTO.

#### 6.2.3. Community connection improvements

Improvements to client community connections are part of the overall objective of the DCV and are supported by the provision of, and client engagement with, various community activities offered by DCV (e.g. gardening, photography). Such opportunities enable participants to engage in pro-social activities and develop new, positive peer networks.

Two clients interviewed reported improved connections to community and positive experiences through participation in the Drug Court vegetable garden, which provides therapeutic gardening activities for clients and facilitates improved community linkages through the provision of vegetables to a local church.

*"I juggle my days between organising my house and my life, my appointments and the veggie garden at DCV... It's a small patch, I know, but I want to help get the veggies grown....I have to break years of patterns and the structure of DCV helps me."*

– DCV Participant<sup>112</sup>

Through participation in photography courses, one client reported positive experiences and improved self-esteem by having their photos displayed in the Drug Court in an annual photography competition

<sup>112</sup> KPMG consultations conducted with DCV participants in March 2014.

*"DCV has opened so many doors for me. They organised a three-month photography course for me and my photos were displayed at Drug Court House. I was amazed to see my photos on the wall. I've done some speeches at secondary schools speaking in front of 200 people. I've become a volunteer at Big Issue as well. I've started a lot of stuff I never thought I'd be doing."*

– DCV Participant<sup>113</sup>

The improvements in community connections indicates improved social attitudes and the development of pro-social behaviours. Such community connections create new, positive peer groups for DCV participants and assist in reducing their level of contact with (former) associates who may be involved in criminal activities or drug and/or alcohol use.

### 6.3. Case study analysis

As part of the evaluation, KPMG conducted consultations with thirteen active DCV participants and developed case studies based on these interviews. Excerpts from these interviews have been used as qualitative evidence to support findings throughout this report, particularly in relation to client health and wellbeing. Case studies reviewed generally report positive short-term outcomes for offenders participating in the DCV.

Following an offender's completion of their DTO, there is limited follow-up and assessment of ongoing health and wellbeing changes. These longer-term benefits are not recorded in any event, and would not necessarily be entirely attributable to a participant's involvement in the DCV. Five case studies summarising stakeholder consultations are presented in the tables below.

Table 6-13: DCV Case Study 1

Case Study 1: Participant #9	Key outcomes achieved
<p><b>Presenting history:</b> Prior to coming to drug court, the participant was a daily heroin and methamphetamine user, long-term unemployed, socialised with a circle of drug users, had difficult personal relationships and suffered from very low self-esteem.</p> <p><b>Support services accessed:</b> Drug and alcohol counselling, clinical advisory, legal aid, employment services.</p> <p><b>Outcomes:</b> Since coming to drug court, the participant has done exceedingly well, regularly attending appointments and progressing through the phases of the order. The participant is now sober and has managed to find full-time employment with the assistance of DCV. They also reported improved self-esteem and family relationships and credits the support of the DCV staff with their progress, stating <i>"DCV has changed the way I see being a bad person. I've seen the value in myself. Back then, I saw no value in myself...I see the value of working is much more rewarding than any hit of speed or ice."</i></p>	<ul style="list-style-type: none"> <li>✓ Engagement in full-time employment</li> <li>✓ Improved self-esteem and confidence</li> <li>✓ Improved family relationships</li> <li>✓ Improved health through no drug use</li> </ul>

Source: KPMG consultation with DCV participant in March 2014. Note: KPMG did not cross-reference the participant's feedback against DRUIS data.

Table 6-14: DCV Case Study 2

Case Study 2: Participant #12	Key outcomes achieved
<p><b>Presenting history:</b> The participant reported previously being a regular marijuana smoker and occasional methamphetamine user living in a poor environment with an abusive partner.</p> <p><b>Support services accessed:</b> Drug and alcohol counselling, medical support, clinical advisory, medication, housing and education services</p> <p><b>Outcomes:</b> Since beginning the DTO, the participant has stopped smoking marijuana and using ice and seen improvements in their overall</p>	<ul style="list-style-type: none"> <li>✓ Improved self-esteem and confidence</li> <li>✓ Improved family relationships</li> <li>✓ Improved health through reduced drug use</li> </ul>

<sup>113</sup> KPMG consultations conducted with DCV participants in March 2014.

health. They report improved relationships with their family and children and credit the DCV with helping them find a new home, away from their abusive partner and with adequate space for their family. The participant also reports improved self-esteem and confidence, stating <i>"My whole life has changed, my kids are happier and I see my family more often...I now have enough confidence to go back to school and study at university."</i>	✓ Provision of stable accommodation
---	-------------------------------------

Source: KPMG consultation with DCV participant in March 2014. Note: KPMG did not cross-reference the participant's feedback against DRUIS data.

Table 6-15: DCV Case Study 3

Case Study 3: Participant #2	Key outcomes achieved
<b>Presenting history:</b> At intake, the participant was a regular heroin and cannabis user with unstable housing and marginal health.	✓ Improved health through reduced drug use
<b>Support services accessed:</b> Drug and alcohol counselling, housing services, clinical advisory, employment and legal services.	✓ Improved self-esteem and mental health
<b>Outcomes:</b> Since commencing their DTO, the participant reports having stopped using heroin and cannabis for six months. They have also ceased drinking alcohol but admitted to still occasionally using benzodiazepines. They report overall health improvements, improved sleeping and eating patterns and improved relations with their partner. In addition, the participant has found stable housing through a referral to WAYSS. The participant also has experienced positive mental health and self-esteem improvements, stating <i>"I am much more positive now. I wake up feeling I have a purpose. I feel wanted and needed...My relations with my partner are better now as well. Before, when I was using, I put her through hell."</i>	✓ Improved family relationships ✓ Provision of stable accommodation

Source: KPMG consultation with DCV participant in March 2014. Note: KPMG did not cross-reference the participant's feedback against DRUIS data.

Table 6-16: DCV Case Study 4

Case Study 4: Participant #4	Key outcomes achieved
<b>Presenting history:</b> Prior to commencing the DTO, the client was a regular heroin and amphetamine user who was homeless and in and out of remand and transitional housing.	✓ Provision of stable accommodation
<b>Support services accessed:</b> Drug and alcohol counselling, clinical advisory, mental health and housing services.	✓ Reduced drug use
<b>Outcomes:</b> Since coming to drug court the participant has significantly reduced their drug consumption, from heavy daily use to only occasional heroin and methamphetamine use. The participant has secured stable housing through a referral to WAYSS and their relationship with their parents and children has improved. They also report improved self-awareness since beginning the DTO, speaking knowledgeably about the cycle of drugs and crime they were previously in and acknowledging that <i>"before, when I tried to get clean I would just give up and go and use but now I know it all comes down to me, I know myself a bit better."</i>	✓ Improved family relationships ✓ Improved self-awareness

Source: KPMG consultation with DCV participant in March 2014. Note: KPMG did not cross-reference the participant's feedback against DRUIS data.

Table 6-17: DCV Case Study 5

Case Study 5: Participant #10	Key outcomes achieved
<p><b>Presenting history:</b> At intake the participant was a regular heroin, cannabis, alcohol and painkiller abuser who had been out of the workforce and living with another drug user.</p> <p><b>Support services accessed:</b> Drug and alcohol counselling, clinical advisory, medication, employment services and the gardening program.</p> <p><b>Outcomes:</b> The participant is currently on their second DTO having previously failed to complete the program and has continued to struggle with drug use. They have managed to eliminate their heroin and cannabis use and reduced their use of alcohol and painkillers; however, they continue to struggle with substance use. The client reports that their overall health and self-esteem has improved as a result of reduced drug use, improved eating habits and counselling services. They have also commenced preparations to find employment through support provided by REES. Unfortunately, the participant continues to live with a drug user and has not yet been able to improve any family relationships. <i>"When case workers applaud you, you walk away on a high. You know you've achieved something and that helps you get through the next day... I've stopped using marijuana and have been taking way less pills but I still struggle to get past 10 days clean."</i></p>	<ul style="list-style-type: none"> <li>✓ Improved health through reduced drug use</li> <li>✓ Improved self-esteem and mental health</li> </ul>

Source: KPMG consultation with DCV participant in March 2014. Note: KPMG did not cross-reference the participant's feedback against DRUIS data.

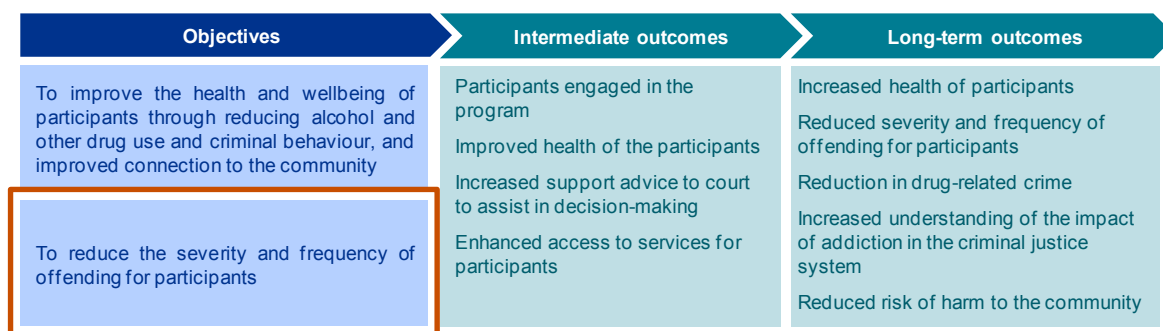
### Key findings

- For the cohort of participants who progress through to Phases 2 and 3 of the DTO, and/or graduate, there is evidence that DCV is effective in improving health and well-being through the reduction in criminogenic risk factors.
- There is evidence of significant reductions in drug and alcohol risk and use for the cohort of participants who progress through to Phases 2 and 3 of the DTO, and/or graduate.
- Although motivation to change was identified by case managers as a key attribute for acceptance on to the program, this is still assessed as relatively high risk even for participants who have progressed to Phase 3 (67 per cent rated high risk).
- Participants and case managers reported improvements in other life skill areas such as consequential thinking and time management.
- High levels of appointment attendance indicates the development of personal organisational skills, which enhances employment prospects and overarching life skills.

## 7. Effectiveness of the DCV in reducing the severity and frequency of reoffending for participants

This section of the report evaluates the effectiveness of the DCV in achieving its second stated objective related to reducing the severity and frequency of reoffending for participants. The objectives and expected outcomes of the DCV are re-stated for reference in Figure 7-1.

Figure 7-1: Objectives and expected outcomes of the DCV



Source: Adapted from Department of Justice, *Evaluation of the Drug Court of Victoria – Program Logic* (Department of Justice 2013) p. 22.

Evaluating the effectiveness of this objective has been informed by:

- analysis of DCV participant data contained in the DCV's DRUIS database over the period 1 July 2010 to 30 June 2013; and
- results of a recidivism study conducted by DoJ.

### 7.1. Objective two: To reduce the severity and frequency of offending for participants

The DCV aims to achieve this objective through the provision of:

- regular hearings with the Magistrate accompanied by a system of sanctions and rewards which support offender accountability and positive behavioural changes; and
- wrap-around case management services which seek to address underlying issues associated with offending behaviour.

#### *DoJ recidivism study*

In order to evaluate the effectiveness of the DCV in achieving this objective, it is necessary to track and monitor reoffending by DCV clients, both during their DTO and after program completion. Comparing this data to that of a matched cohort facilitates the comparison of the effectiveness of DCV in reducing the severity and frequency of offending as compared to traditional criminal justice interventions. As a key input to the evaluation, DoJ undertook a recidivism study which assessed reoffending data for 61 DCV participants who commenced and successfully completed a DTO between 1 July 2006 and 30 June 2012.

The DCV Cohort reoffending data was compared with a matched Control Cohort from the DoJ database. The Control Cohort used was not involved in therapeutic jurisprudence, and was matched according to the following variables (in prioritised order):

- Principal Proven Offence (PPO) associated with the index date;
- number of proven charges at index;
- date of birth;
- gender;



- Indigenous status (where available);
- 24 month prior offending history (excluding charges struck out); and
- sentence outcome equal to imprisonment.

Recidivism by each client in the DCV and Control Cohort was tracked for a period of 24 months:

- from the date of DTO completion (for the DCV Cohort); and
- from the date of sentence completion (for the Control Cohort).

Recidivism results for each client (both in the DCV Cohort and the Control Cohort) relating to offence date, time to fail in days (being the difference between the index date and first charge) over a 24 month period were produced by DoJ. In addition, offence descriptions and the severity of offences (as measured by the National Offence Index (NOI)) were also produced.

#### *Data limitations*

As noted in earlier sections, DoJ encountered a number of methodological issues during the development of the recidivism study related to the parameters of the analysed cohorts. Several of these issues stemmed from limitations in the data available via Courtlink and the Sentencing Advisory Councils (SAC) offender database. Notable limitations of the recidivism study include:

- **Variables relating to (potential) drug and alcohol use of the matched Control Cohort have not been considered** in the recidivism study. Accordingly, a key distinguishing feature of the DCV, being the fact that the cohort it services has a drug and/or alcohol dependency and has committed an offence under the influence of drugs or alcohol or to support a drug or alcohol habit, is not included in the analysis.
- The **small sample size** of the revised recidivist study, with just 61 clients included in each of the DCV and Control Cohort. The small size of the sample means the results of the recidivist study should be considered cautiously, and further observation and analysis of recidivism amongst these cohorts will be required in order to confirm findings.
- The **matched cohort assessed does not necessarily have a comparable offending history** to the DCV Cohort, as the study only considered offending history for 24 months prior. It has been noted by stakeholders that many DCV clients are deeply entrenched offenders, with a history of offending that can span decades.

As a result, a number of data limitations remain which mean the results of this section must be treated with caution and limit the potential to extrapolate the findings related to frequency and severity of reoffending. Further details on the recidivism study methodology are included in Appendix D.

#### **7.1.1. Frequency and severity of reoffending whilst on a DTO**

In considering the effectiveness of the DCV in reducing the frequency and severity of reoffending, it is important to first analyse reoffending by the DCV Cohort whilst on the DTO.

A key risk of the drug court model is the elevated potential for harm to the community presented by the fact that offenders serve their sentence (i.e. the DTO) in the community rather than in prison. Offenders on a DTO live in the community, and it is to be expected given the entrenched nature of their substance use and offending behaviours, that a portion of them will inevitably reoffend in some shape or form. DCV tracks the frequency and type of reoffending whilst on a DTO and KPMG has analysed this data for all DCV clients, including those who do not complete or progress in the DTO.

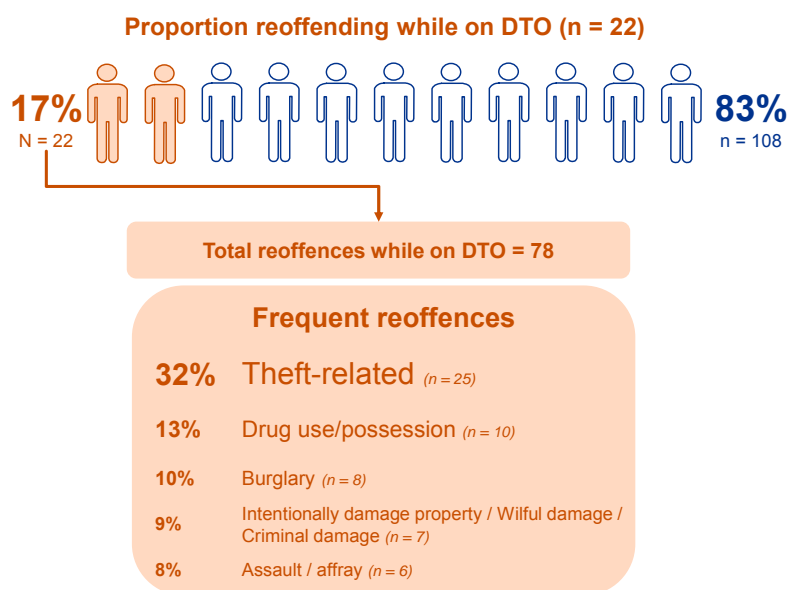
Analysis of reoffending whilst on a DTO over the evaluation period shows that the significant majority (83 per cent,  $n = 108$ ) of DCV clients do not reoffend while on their DTO.<sup>114</sup> This is a comparably low rate of reoffending given the nature of the DTO cohort, particularly given the fact that the DCV Cohort begins their DTO with all their criminogenic risk factors still in place. Only 22 clients (17 per cent)

<sup>114</sup> Drug Court of Victoria, *DRUIS Database Extracts (1 July 2010 – 30 June 2013)*.

reoffended while on the DTO during the evaluation period, committing a total of 78 offences. The number of reoffences committed ranged from one to eight additional offences, with an average of 3.55 reoffences per client.

The type of reoffences committed by clients whilst on the DTO are consistent with the type of offending committed at entry to the DTO. The most frequently committed offences were theft-related offences, which accounted for 25 of 78 (32 per cent) of all reoffences whilst on the DTO. Drug use and possession offences and burglary were the next most common offence categories. Reoffending whilst on the DTO for the DCV Cohort is summarised in Figure 7-2.

Figure 7-2: Reoffending whilst on the DTO (2010-11 through 2012-13)



Source: Drug Court of Victoria, *DRUIS Database Extracts (1 July 2010 – 30 June 2013)*.

For the 22 clients who reoffended whilst on the DTO, nine clients (41 per cent) subsequently received an immediate imprisonment sentence and had their DTO cancelled. The total number of immediate imprisonment days received by this group amounted to 1,821 days. Twelve clients did not receive an immediate imprisonment sentence, including six clients who had their sentence subsumed into their DTO. Table 7-1 summarises the sentences received by clients who reoffended whilst on a DTO during the evaluation period.

Table 7-1: Sentences received by clients reoffending whilst on DTO (2010-11 through 2012-13) (n = 21\*)

Sentence	Number of clients
Immediate imprisonment	9
Imprisonment subsumed into DTO	6
Suspended imprisonment sentence	4
Fined	1
Convicted and discharged	1
<b>Total immediate imprisonment days for offences committed whilst on DTO = 1,821</b>	

Source: Drug Court of Victoria, *DRUIS Database Extracts (1 July 2010 – 30 June 2013)*. \*One client was convicted but had no sentence information recorded in DRUIS

### 7.1.2. Frequency and severity of reoffending post-DTO

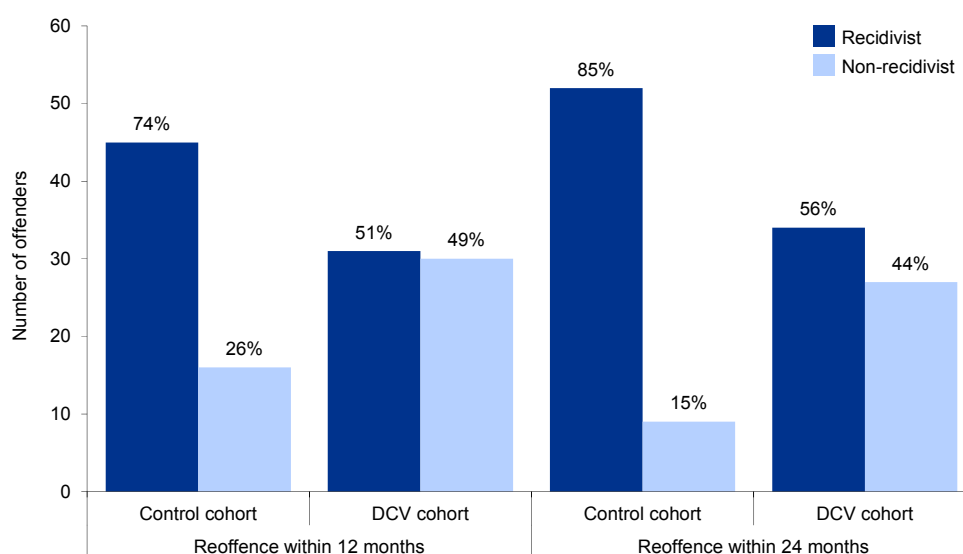
As described in 7, KPMG has relied on a recidivism study conducted by DoJ which tracked the frequency and severity of reoffending by a group of DCV clients who commenced and successfully completed a DTO between 1 July 2006 and 30 June 2012. The reoffending of these clients was tracked for a period of 24 months post-intervention and compared with a matched cohort who did not receive a therapeutic intervention. This sub-section examines the results of this analysis to compare the recidivism frequency and severity of these two cohorts (called the "DCV Cohort" and "Control Cohort"). It is important to restate the data limitations noted in 7 regarding the parameters of these cohorts and sample size. It is also worth noting that the DoJ recidivism study did not provide any information about the characteristics or DTO experience of the DCV Cohort who did reoffend. The provision of such information would have facilitated detailed analysis of how different variables (e.g. prior offending history, demographic characteristics) correlated with the likelihood of reoffending.

#### Proportion reoffending post-intervention

Analysis of reoffending data post-intervention collated by DoJ indicates that the DCV has a significant impact on the likelihood of reoffending in the medium (12-24 months) term. Available evidence indicates that after 24 months, the DCV Cohort analysed was 29 per cent less likely to have reoffended than the matched Control Cohort.<sup>115</sup>

Analysis of the DCV and matched Control Cohort indicates that after 12 months there is a significant difference in the incidence of reoffending between the two cohorts, with 51 per cent of the DCV Cohort reoffending compared to 74 per cent of the Control Cohort, a 23 per cent drop in reoffending. After 24 months the difference in the rate of recidivism grows further, with 56 per cent of the DCV Cohort reoffending compared to 85 per cent of the Control Cohort, a percentage drop of 29 per cent. This comparison is summarised in Figure 7-3.

Figure 7-3: Reoffending post-intervention for DCV and Control Cohort at 12 and 24 months (n = 61)



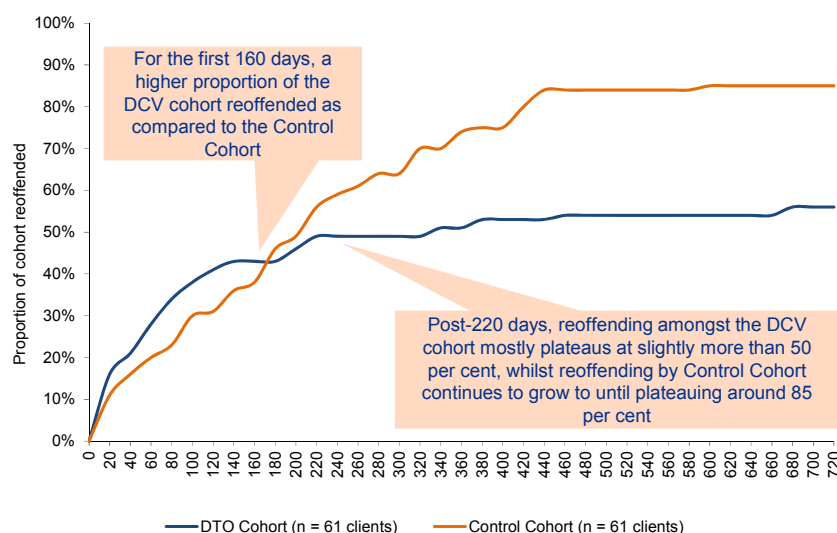
Source: Department of Justice, Dandenong Drug Court Recidivism Study 2014 (Department of Justice 2014).

A more detailed comparison of the time to reoffending amongst the DCV Cohort (post-DTO) and the Control Cohort (post-imprisonment) is displayed in Figure 7-4. This figure shows that the DTO intervention actually had little impact on reoffending in the immediate, post-intervention term (up to 180 days). Indeed, the DCV Cohort was actually faster to reoffend post-intervention, with 26 clients (43 per cent) having reoffended up to 160 days of completing their DTO compared to 23 clients (38 per cent) in the Control Cohort.

<sup>115</sup> Department of Justice, *Dandenong Drug Court Recidivism Study 2014* (Department of Justice 2014).

At 180 days, however, the proportion of Control Cohort clients reoffending surpasses that of the DCV Cohort and continues to rise until it reaches approximately 85 per cent (52 of 61) at 600 days. Conversely, the proportion of the DCV Cohort who reoffend mostly plateaus at around the 220 day mark and grows only marginally to 56 per cent (34 of 61) by 720 days. This finding is displayed in Figure 7-4.

Figure 7-4: Time to reoffending post-intervention for DCV and Control Cohort (0 - 720 days) (n = 61)



Source: Department of Justice, Dandenong Drug Court Recidivism Study 2014 (Department of Justice 2014).

#### Number of reoffences post-intervention

Consideration of the number of offences committed per offender over the two-year post-index period indicates that those DCV offenders who did reoffend, did so at a higher frequency rate than the Control Cohort. The DCV recidivist offenders committed an average of 1.01 offences per day, as compared to the Control Cohort which committed an average of 0.85 offences per day. The DoJ study notes that this analysis should be treated cautiously due to the sample size and the impact of a few offenders charged with a very high number of reoffences.<sup>116</sup> No further detail was provided in the study regarding the offending patterns or individual reoffenders which would enable analysis of the impact outliers have on total recidivism amongst the cohorts.

Figure 7-5: Total number of reoffences for DCV and Control Cohort (up to 24 months post intervention)

Control Cohort (recidivist offenders)			DCV Cohort (recidivist offenders)	
Total number of offences	number of	Offences per day	Total number of offences	Offences per day
623		0.85	738	1.01

Source: Department of Justice, Dandenong Drug Court Recidivism Study 2014 (Department of Justice 2014).

To summarise the available information from a limited sample size, reoffending data indicates that while the DCV has a significant impact on the rate of recidivism, it does not appear to have an impact on the frequency of reoffending for those that do reoffend vis-à-vis a matched Control Cohort.

#### Severity of reoffences post-intervention

To determine the severity of offences, the DoJ study utilised the ABS National Offence Index (NOI) scale, which assigns offences a severity index number in accordance with the perceived severity of

<sup>116</sup> Department of Justice, *Dandenong Drug Court Recidivism Study 2014* (Department of Justice 2014).

crime to facilitate comparison and sentencing. A lower NOI number indicates a higher perceived degree of offence severity.<sup>117</sup>

Analysis of the DCV Cohort and matched Control Cohort indicates that the reoffending within both groups was of relatively low average seriousness, however, the DCV Cohort reoffended with slightly higher average seriousness than the Control Cohort. The average NOI for the DCV Cohort was 84.25, compared to 92.34 NOI for the Control Cohort.<sup>118</sup> Detailed analysis of the major categories of reoffences is displayed in Table 7-2.

Table 7-2: Offending by notable offence type for DCV and Control Cohort (two years post-intervention)

NOI	Offence description	Control Cohort			DCV Cohort		
		Count of presenting offence	Count of reoffence	% change	Count of presenting offence	Count of reoffence	% change
21	Trafficking drugs (amphetamines, drug of dependence, ecstasy, heroin, etc.)	7	12	71%	30	3	-90%
23-28	Assault with weapon, recklessly/intentionally cause injury, robbery, assault of police officer, unlawful assault	15	8	-47%	13	6	-54%
47-51	Weapons possession offences	27	5	-81%	20	8	-60%
59-60	Burglary/obtain property by deception/financial advantage	84	30	-64%	72	17	-76%
68-71	Theft/attempted theft of or from motor vehicle	11	14	27%	10	7	-30%
70-75	Other theft/ other attempted theft	13	46	254%	12	58	383%
77	Dealing in property suspected proceeds of crime, dishonestly realise or receive stolen goods	7	7	-	6	14	133%
124 - 125	Possession/use of drugs (cannabis, prescription drugs, heroin, drug of dependence, etc.)	No data	9	n/a	No data	18	n/a
141+	Use of drugs (prescriptions drugs, heroin, etc.)	4	24	500%	No data	23	n/a

Source: Department of Justice, *Dandenong Drug Court Recidivism Study 2014* (Department of Justice 2014). Note: The above table focuses on the most numerous (re)offences and does not include all offences and reoffences committed by the cohorts.

While the average NOI was slightly higher for the DCV Cohort, the above table shows that the Control Cohort actually committed a higher number of more serious offences (defined here as offences with

<sup>117</sup> ABS, *National Offence Index 2009* (ABS 2009).

<sup>118</sup> Department of Justice, *Dandenong Drug Court Recidivism Study 2014* (Department of Justice 2014).

an NOI between 21-71). This range spans offences from trafficking drugs (NOI 21) to theft from a motor vehicle (NOI 71). In total, the DCV Cohort showed a 67 per cent reduction in more serious offences (NOI 23 – 71) as compared to their presenting offences. The call out box in the above table reflects this significant decrease. Looking at moderately severe offences, DCV recidivist offenders committed a higher number of theft-related offences, which carry an NOI in the 70-74 range.

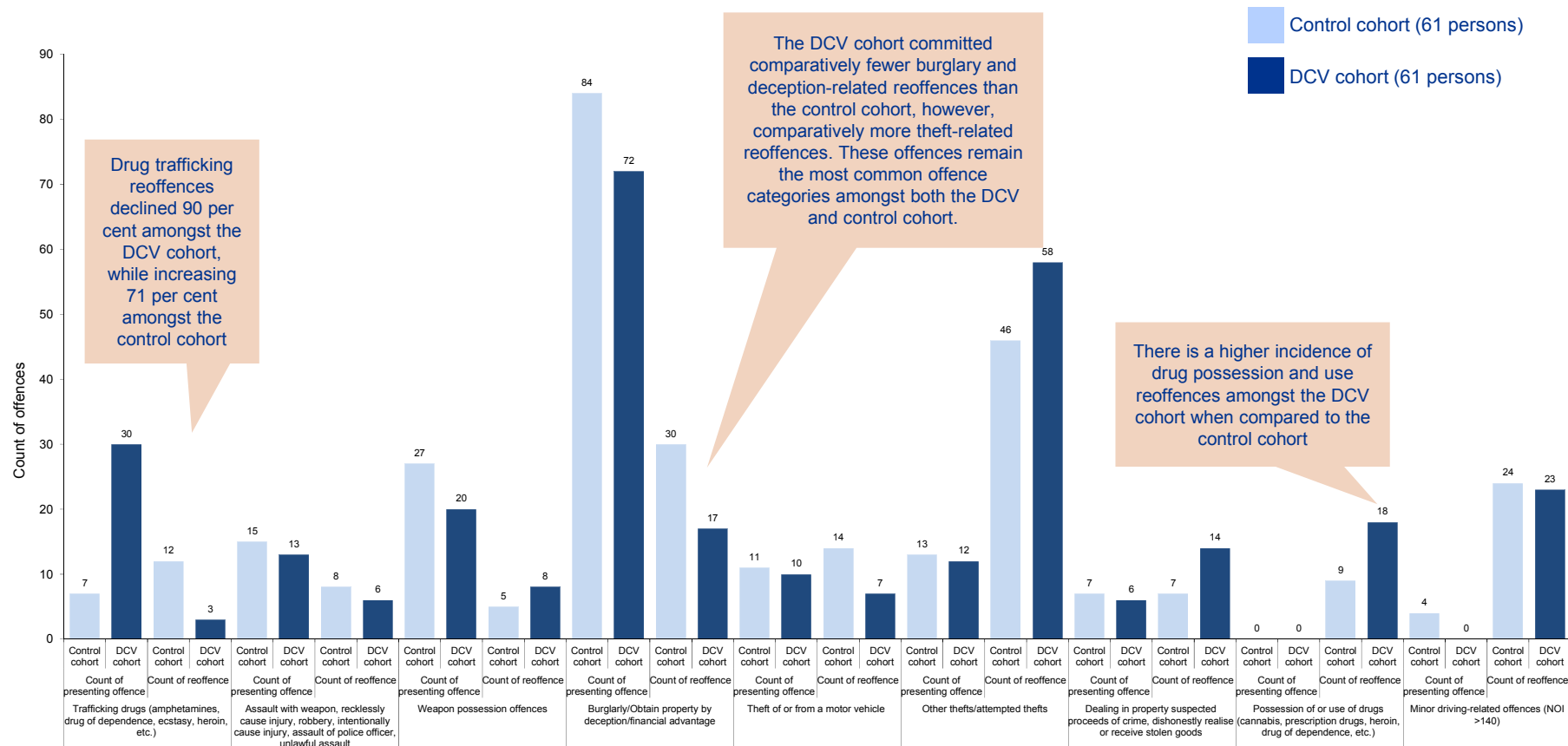
Reoffending by both the DCV and Control Cohort appears to be of a less serious nature than presenting, pre-intervention offences. Both cohorts commit comparatively fewer serious offences and comparatively more frequent minor offences as compared to their presenting offences baseline. The below Table 7-2 and Figure 7-6 display reoffending trends for both cohorts for some of the most frequently committed offence categories.

Consideration of the types of offences committed by the reoffenders in the DCV and Control Cohorts indicates there is a marked difference in the number of drug trafficking re-offences between the groups – with the DCV Cohort committing three drug trafficking-related offences (down from 30 presenting offences) compared to 12 by the Control Cohort (up from seven presenting offences).

These findings indicate that the DTO intervention is positively impacting the patterns of reoffending amongst the small DCV Cohort. Instead of committing more serious offences, the DCV reoffending cohort demonstrates a slightly higher incidence of theft-related re-offences (which are frequently committed to support a drug and/or alcohol habit) and drug possession and use-related re-offences. Figure 7-6 displays these findings in more detail.



Figure 7-6: Offending by notable offence type for DCV and Control Cohort (2 years post-intervention)



Source: Department of Justice, Dandenong Drug Court Recidivism Study 2014 (Department of Justice Victoria 2014). Note: The above figure focuses on the most numerous (re)offences and does not include all offences and reoffences committed by the cohorts.

### 7.1.3. Sentences received for clients not completing the DTO

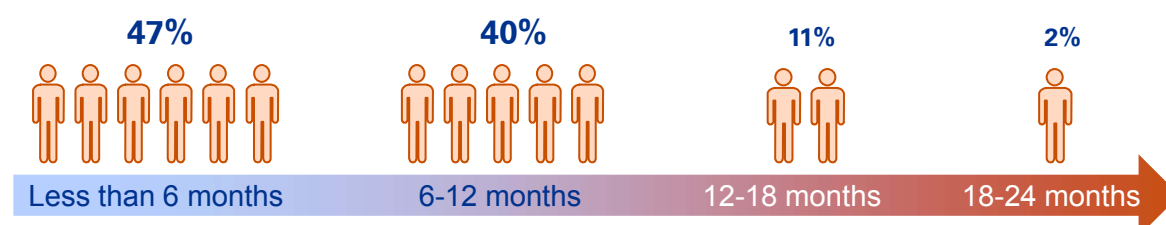
#### *Penalties and sanctions for clients not completing the DTO*

Sixty-five clients failed to complete their DTO during the evaluation period and subsequently had their DTO cancelled. As outlined in Section 3.4, cancellation of a DTO by the Magistrate results in either the activation of the custodial component of the DTO or the cancellation of the custodial component and re-sentencing of the offender.

The significant majority of clients (57 of 65, 88 per cent) who fail to complete the DTO are imprisoned for a period post-DTO.<sup>119</sup> Three clients who did not complete their DTO received a suspended sentence and a further three received non-custodial or not immediately servable gaol sentence. One client was deceased.

Post-DTO imprisonment sentences for clients who fail to complete their DTO tend to be relatively short in duration. Of the 57 clients who received an imprisonment sentence, nearly one in two of this group (27 clients, 47 per cent) received an imprisonment sentence of less than six months and the significant majority (50 clients, 87 per cent) received a sentence of 12 months or less. Only a small minority (two per cent) received a sentence longer than or equal to 18 months in duration. These proportions are displayed in Figure 7-7.

Figure 7-7: Duration of post-DTO imprisonment sentences for clients not completing (n = 57)



Source: Data provided by DCV.

The costs of these sentences are explored in 8.3.

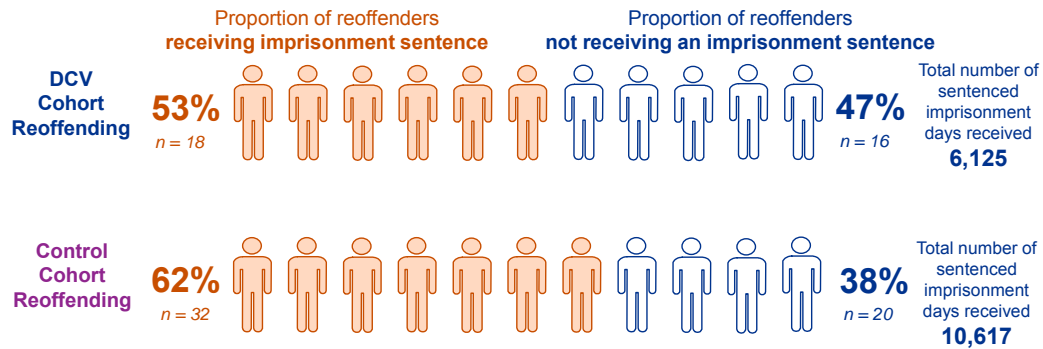
#### *Penalties and sanctions for clients reoffending after completing their DTO*

As outlined in Section 7.1.2, 34 clients (56 per cent) of DTO Cohort clients and 52 of 61 (85 per cent) of Control Cohort clients reoffended within 24 months of completing their intervention. To reiterate earlier findings, the DTO Cohort had an average NOI slightly higher than the Control Cohort, however, committed comparatively fewer serious offences. In analysing the sentences received in connection with these re-offences, DCV Cohort clients received fewer total imprisonment sentences in both total and proportionate terms, as displayed in Figure 7-8. In total, the DCV Cohort were also sentenced to 42 per cent less total imprisonment days (6,125 days) as compared to the Control Cohort (10,617 days).<sup>120</sup>

<sup>119</sup> Data provided by DCV.

<sup>120</sup> Data provided by MCV in e-mail dated 2 December 2014.

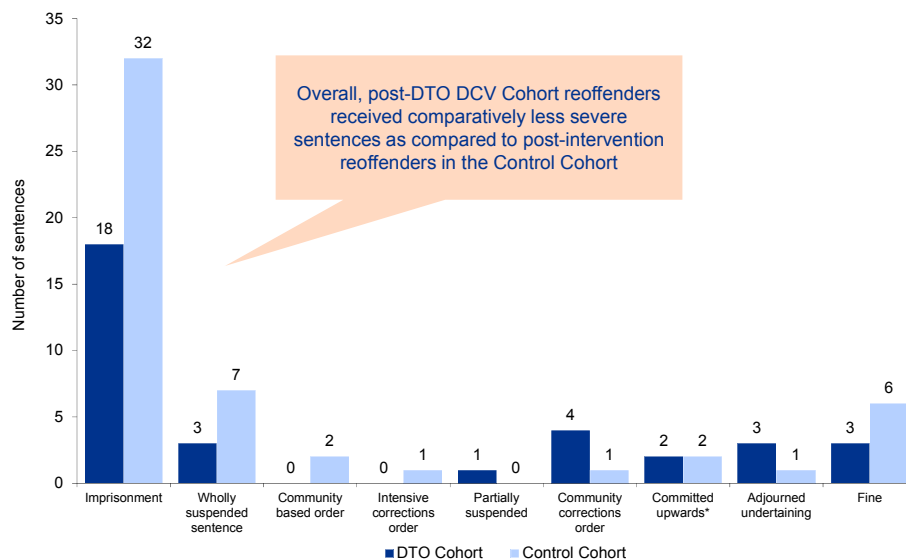
Figure 7-8: Proportion of post-DTO (DCV Cohort) and post intervention (Control Cohort) reoffenders receiving imprisonment sentence (up to 24 months)



Source: Data provided by MCV in e-mail dated 2 December 2014.

Slightly more than half (52 per cent, n = 18) the DCV Cohort reoffending within 24 months received a sentence of imprisonment, which is less than the 62 per cent (n = 32) of the Control Cohort who received imprisonment sentences. Overall, post-intervention DCV Cohort reoffenders received comparatively less severe sentences as compared to post-intervention reoffenders in the Control Cohort, as shown in Figure 7-9.

Figure 7-9: Sentences received by post-DTO (DCV Cohort) and post intervention (Control Cohort) reoffenders (up to 24 months)



Source: Data provided by MCV in e-mail dated 2 December 2014. \*Committed upwards refers to a sentence being committed to a higher court (i.e. up to County Court)

The costs of these sentences are explored in Section 8.3.

## 7.2. Unintended benefits

In general, stakeholders reported few unintended costs or benefits associated with the DCV. However, professional development opportunities were recognised in the Drug and Alcohol Counselling space. In recognising this, Drug and Alcohol Counsellors noted that:

- ordinarily, an agency is brokered for a single episode of care per client, which may involve approximately six to eight counselling sessions over a period of up to six months; however
- the two-year DTO period provides staff with an opportunity to apply counselling skills with clients on a longer-term basis, enabling them to 'delve deeper' into client issues such as childhood trauma and abuse.

In the view of these stakeholders, this provided the opportunity to exercise professional skills which were infrequently used, and enabled them to build greater trust and rapport with clients.

Further ancillary benefits were noted by Drug and Alcohol Counsellors, some of whom invited a DCV participant's partner and/or significant family member(s) to attend counselling sessions. Many of these individuals had issues relating to drug and alcohol use and anger/conflict management. The provision of 'vicarious counselling' was viewed positively by these stakeholders, who considered that any element of support and/or awareness of strategies to minimise drug and alcohol use was likely to deliver some benefit to these individuals.

## 7.3. External factors impacting on achievement of the Court's objectives

No external factors impacting on achievement of the DCV's objectives have been identified to date, however, it was noted that there was no permanent DCV magistrate between March and October 2013. During this six month period, approximately ten magistrates sat in the DCV on a rotating basis. Stakeholders reported that (anecdotally) there was a reduction in participant engagement and retention in the Court during this period, although data illustrating this is yet to be provided.

Stakeholders highlighted the importance of maintaining an active, supervisory relationship throughout the DTO as a key facet which increases the likelihood that a participant remains in treatment and demonstrate progress and improvement whilst on their DTO.

It is noted that the National Association of Drug Court Professionals (USA) highlights ongoing judicial interaction with each drug court participant as 'essential', and one of the ten key components of successful drug courts. In particular, it is recognised that 'ongoing judicial supervision communicates to participants – often for the first time – that someone in authority cares about them and is closely watching what they do'.<sup>121</sup> Loss of this dedicated authority figure impacts on the responsibility and accountability of participants in relation to their behaviour, alcohol and drug use.

Analysis of the DCV and matched Control Cohort indicates that after 12 months there is a significant difference in the incidence of reoffending between the two cohorts, with 51 per cent of the DCV Cohort reoffending compared to 74 per cent of the Control Cohort, a 23 per cent drop in reoffending. After 24 months, the difference in the rate of recidivism grows further, with 56 per cent of the DCV Cohort reoffending compared to 85 per cent of the Control Cohort, a percentage drop of 29 per cent. This comparison is summarised in Figure 7-3.

### Key Findings

- The recidivism study shows a lower level of re-offending for the DCV Cohort over the first 12 months (51 per cent compared to 74 per cent for the Control Cohort) and first 24 months (56 per cent compared to 85 per cent for the Control Cohort).
- After 220 days the DCV Cohort rate of reoffending plateaus, whereas the Control Cohort rate continues to increase until approximately 440 days.

<sup>121</sup> US Department of Justice (Office of Justice Programs – Bureau of Justice Assistance), *Defining Drug Courts: The Key Components* (US Department of Justice 1997) 31.

- The DCV Cohort showed a 90 per cent decrease in drug trafficking offences, and 67 per cent reduction in more serious offences (NOI 23 – 71) compared to a 71 per cent increase and 47 per cent decrease respectively for the Control Cohort. After a two year imprisonment the number of offences for trafficking drugs for the Control Cohort increased to the rate it was before the DTO intervention for the DCV Cohort.
- Both cohorts show significant increases in theft offences (not related to motor vehicles) from low bases (from 12 to 59 for DCV, an increase of 383 per cent, and from 13 to 46 for the Control Cohort, an increase of 254 per cent). The DCV Cohort also shows a 133 per cent increase in dealing in stolen goods (from six to 14). Notably, the Control Cohort offences related to the use of drugs increases from four to 24, a 500 per cent increase.

## 8. Funding/delivery and efficiency

### 8.1. Funding received and expenditure

The Drug Court operates within an allocation from the courts budget, designed to cover the additional costs incurred in its operation. Table 8-2 shows that the DCV has been underspent in total over the past three years.

Table 8-1: Revenue and expenditure for 2010-11 to 2012-13

	2010-11	2011-12	2012-13	Total
<b>Revenue Total</b>	<b>\$ 1,313,700</b>	<b>\$ 1,511,300</b>	<b>\$ 1,647,900</b>	<b>\$ 4,472,900</b>
<b>Expenses</b>				
Drug & alcohol rehabilitation	\$ 516,721	\$ 656,248	\$ 240,517	\$ 1,413,485
Professional Services (excluding VGS)	\$ 94,200	\$ 111,533	\$ 671,749	\$ 877,482
Medical / Vaccination costs	\$ 161,132	\$ 41,928	\$ 2,775	\$ 205,835
Med related contractors	\$ 9,555	\$ -	\$ 66,442	\$ 75,997
<b>Sub-total (Med exp)</b>	<b>\$ 781,608</b>	<b>\$ 809,709</b>	<b>\$ 981,483</b>	<b>\$ 2,572,799</b>
Salaries and related	\$ 446,451	\$ 441,536	\$ 464,552	\$ 1,352,539
Other contractors	\$ 50,201	\$ 21,518	\$ 66,442	\$ 138,161
Office administration	\$ 5,306	\$ 17,405	\$ 15,663	\$ 38,373
Other expenses	\$ 27,502	\$ 19,476	\$ 29,876	\$ 76,853
Property related	\$ 123,833	\$ 140,786	\$ 55,205	\$ 319,824
<b>Expenses Total</b>	<b>\$ 1,434,900</b>	<b>\$ 1,450,429</b>	<b>\$ 1,613,221</b>	<b>\$ 4,498,550</b>
<b>Revenue - Expenses</b>	<b>-\$ 121,200</b>	<b>\$ 60,871</b>	<b>\$ 34,679</b>	<b>-\$ 25,650</b>

Source: MCV data provided in e-mail dated 3 December 2013.

Well over half of all expenditure is on variable costs such as urine testing, medical and other drug related support, and this expenditure has increased year on year. The fluctuations in expenditure appear to be related to inconsistent categorisation of expenditure from year to year, rather than actual variations in expenditure. Salaries make up another 30 per cent of the cost. The magistrates' remuneration is not charged against the DCV funding (unlike the Neighbourhood Justice Centre or the Assessment and Referral Court List), and, along with court accommodation costs, is shown elsewhere in MCV financial reporting.

Given the very unpredictable nature of the cohort being dealt with by the DCV, it would appear prudent to ensure that some funds are available 'in reserve' each year, for emergencies, or to respond to the changing number of participants. Therefore, it would be unrealistic to expect the program to fully expend its funding annually. To this end, budgets appear to have been set each year at levels below the funding received, and in 2011-12 and 2012-13, there were further underspends against these budgets.

Table 8-2 shows the variations between budgets set for different items of expenditure, and the actual expenditure in each year.



Table 8-2: DCV budget and expenditure (2010-11 through 2012-13)

Expenses	2010-11			2011-12			2012-13			TOTAL 2010-11 to 2012-13		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
Drug & alcohol rehabilitation	\$ 417,400	\$ 516,721	-\$ 99,321	\$ 610,700	\$ 656,248	-\$ 45,548	\$ 566,300	\$ 240,517	\$ 325,783	\$1,594,400	\$1,413,485	\$ 180,915
Professional Services (excluding VGSO)	\$ 239,300	\$ 94,200	\$ 145,100	\$ -	\$ 111,533	-\$ 111,533	\$ 520,000	\$ 671,749	-\$ 151,749	\$ 759,300	\$ 877,482	-\$ 118,182
Medical related contractors	\$ -	\$ 9,555	-\$ 9,555	\$ 90,600	\$ -	\$ 90,600	\$ 20,000	\$ 66,442	-\$ 46,442	\$ 110,600	\$ 75,997	\$ 34,603
Medical / Vaccination costs	\$ 178,000	\$ 161,132	\$ 16,868	\$ 100,000	\$ 41,928	\$ 58,072	\$ -	\$ 2,775	-\$ 2,775	\$ 278,000	\$ 205,835	\$ 72,165
<b>Sub-total (Med costs)</b>	<b>\$ 834,700</b>	<b>\$ 781,608</b>	<b>\$ 53,092</b>	<b>\$ 801,300</b>	<b>\$ 809,709</b>	<b>-\$ 8,409</b>	<b>\$1,106,300</b>	<b>\$ 981,483</b>	<b>\$ 124,817</b>	<b>\$2,742,300</b>	<b>\$2,572,799</b>	<b>\$ 169,501</b>
Salaries and related	\$ 401,300	\$ 446,451	-\$ 45,151	\$ 478,200	\$ 441,536	\$ 36,664	\$ 457,600	\$ 464,552	-\$ 6,952	\$1,337,100	\$1,352,539	-\$ 15,439
Other contractors		\$ 50,201	-\$ 50,201	\$ 104,400	\$ 21,518	\$ 82,882	\$ 20,000	\$ 66,442	-\$ 46,442	\$ 124,400	\$ 138,161	-\$ 13,761
Office administration	\$ 27,700	\$ 5,306	\$ 22,394	\$ 35,800	\$ 17,405	\$ 18,395	\$ 22,000	\$ 15,663	\$ 6,337	\$ 85,500	\$ 38,373	\$ 47,127
Other expenses	\$ 62,200	\$ 27,502	\$ 34,698	\$ 47,900	\$ 19,476	\$ 28,424	\$ 27,000	\$ 29,876	-\$ 2,876	\$ 137,100	\$ 76,853	\$ 60,247
Property related	\$ 107,300	\$ 123,833	-\$ 16,533	\$ 134,300	\$ 140,786	-\$ 6,486	\$ 35,000	\$ 55,205	-\$ 20,205	\$ 276,600	\$ 319,824	-\$ 43,224
<b>Expenses Total</b>	<b>\$1,433,200</b>	<b>\$1,434,900</b>	<b>-\$ 1,700</b>	<b>\$1,601,900</b>	<b>\$1,450,429</b>	<b>\$ 151,471</b>	<b>\$1,667,900</b>	<b>\$1,613,221</b>	<b>\$ 54,679</b>	<b>\$4,703,000</b>	<b>\$4,498,550</b>	<b>\$ 204,450</b>

Sources: MCV data provided in e-mail dated 3 December 2013.

As the table illustrates, the budget each year was set against the expected income, which did not always eventuate. For instance, the overspend in 2010-11 is almost entirely (apart from the \$1,700 variance shown in Table 8-2 above) due to the fact that revenue received of \$1,313,700 was \$119,500 below the budget for expenditure set (which was \$1,433,200). Overall income for the period was anticipated to be \$4,703,000, which was revised down to \$4,498,550. Actual expenditure was \$204,450 underspent against the budgets set against this anticipated revenue, resulting in the small over spend shown in Table 8-1.

Over the evaluation period, there have been departmental changes to the chart of accounts structure, as well as amendments to classification of expenditure against different cost codes, which means that the way expenditure has been coded against categories, and the way in which budgets have been allocated appears to be inconsistent. For instance in 2010-11, the budget for professional services, medical contractors and other contractors has been combined, but the expenditure was categorised into the different cost codes. The following year a budget was set for medical contractors, but no costs allocated against it. This makes the identification of trends in these major expenditure areas difficult. Further analysis of the figures to better understand the relationship between the number of participants and costs incurred was not undertaken as part of this evaluation.

The varied under and over spends on different budget items year on year mean that it is not possible to assess whether the funds have been administered efficiently. Internal controls over DCV related expenditure have been reported, for example, the scrutiny of expenditure by the DCV project manager.

There does not appear to be an easily identifiable relationship between the data currently available on the number of participants each year and the variations in cost which might be driven by the changing numbers going through the DCV. This also makes a "unit cost" hard to calculate. However, based on 60 participants at any one time, the cost was around \$26,000 in 2012-13.

Stakeholders have not identified any potential efficiencies going forward. Further analysis of the relationship between costs and outcomes is needed to fully understand whether there are efficiencies either in process or expenditure that could be instituted.

#### Key findings

- DCV had an overall overspend for the evaluation period of just over \$25,650.
- Changes to the classification of costs and the cost codes available mean that it is not possible to identify the relationship between participant numbers and the various participant specific costs (such as urinalysis) incurred.
- Based on 60 participants being on the program at any given time, the unit cost per participant in 2012-13 was \$26,000.

## 8.2. Cost comparison to other problem-solving court initiatives

Three court-based programs operating in NSW, Victoria, and Western Australia have been selected as comparators for DCV. These programs are the:

- **Drug Court of NSW**, which provides non-violent defendants who are dependent on illicit drugs in eligible locations in Greater Sydney access to services and supports including residential rehabilitation and wrap-around case management services for up to 24 months.<sup>122</sup>
- **Court Integrated Services Program**, which provides defendants appearing before the Magistrates' Court of Victoria with access to services and supports such as drug and alcohol treatment, acquired brain injury services, accommodation, disability support and mental health care via a multidisciplinary case management model for up to four months.<sup>123</sup>
- **Supervised Treatment Intervention Regime**, a Western Australian Magistrates' Court program to assist defendants with drug use problems who are attending court for moderate-level crimes - defendants are required to attend treatment with a drug and alcohol counsellor, undergo drug testing and attend court at regular intervals for approximately three months whilst their case is remanded.<sup>124</sup>

Table 8-3 provides an over of the key features of each program, including objectives, services/supports offered, eligibility criteria and the program's target cohort.

<sup>122</sup> NSW Attorney General & Justice, *Drug Court of NSW*, available at [http://www.drugcourt.justice.nsw.gov.au/drgcrt/dc\\_program.html,c=y](http://www.drugcourt.justice.nsw.gov.au/drgcrt/dc_program.html,c=y), accessed 1 November 2014.

<sup>123</sup> Magistrates' Court of Victoria, *Court Integrated Services Program (CISP)*, available at <https://www.magistratescourt.vic.gov.au/jurisdictions/specialist-jurisdictions/court-support-services/court-integrated-services-program-cisp>, accessed 29 October 2014.

<sup>124</sup> Government of Western Australia (Drug and Alcohol Office), *Supervised Treatment Intervention Regime (STIR)*, available at <http://www.dao.health.wa.gov.au/Informationandresources/WADiversionProgram/SupervisedTreatmentInterventionRegimeSTIR.aspx>, accessed 29 October 2014.

Table 8-3: Court-based drug and alcohol diversionary initiatives

Program name, jurisdiction and duration	Objectives	Services/supports offered	Eligibility criteria	Target cohort
<b>Drug Court of NSW</b>  NSW Local and District Courts  At least 12 months, up to 24 months	<ul style="list-style-type: none"> <li>Assist non-violent offenders to overcome both their drug dependence and criminal offending</li> <li>Promote the reintegration of drug dependent persons into the community</li> <li>Reduce the need for such drug dependent persons to resort to criminal activity to support their drug dependencies</li> <li>Reduce drug-related crime in the community</li> </ul>	<ul style="list-style-type: none"> <li>Wrap-around case management, social and health services provided by a multidisciplinary team of providers</li> <li>Residential rehabilitation (if required)</li> <li>Social support and living skills training</li> </ul>	Eligible persons must: <ul style="list-style-type: none"> <li>Be likely to be sentenced to full-time imprisonment</li> <li>Be dependent on the use of illicit drugs</li> <li>Live within the catchment area and be referred from an eligible Local or District Court</li> <li>Be 18 years of age or over</li> <li>Be willing to participate</li> <li>Not be charged with an offence involving violent or sexual conduct, or certain types of drug offences</li> <li>Not have a serious psychiatric condition</li> </ul>	Non-violent offenders who are dependent on illicit drugs
<b>Court Integrated Services Program (CISP)</b>  Magistrates' Court of Victoria  Up to four months	<ul style="list-style-type: none"> <li>To provide short term assistance before sentencing for accused with health and social needs</li> <li>To work on the causes of offending through individualised case management</li> <li>To provide priority access to treatment and community support services</li> <li>To reduce the likelihood of re-offending</li> </ul>	<ul style="list-style-type: none"> <li>A multi-disciplinary team-based approach to the assessment and referral to treatment of clients</li> <li>Three levels of support based on the assessed needs of the client</li> <li>Case management for up to four months for medium and high risk clients</li> <li>Referrals and linkages to support services including drug and alcohol treatment, acquired brain injury services, accommodation services, disability support and mental health care</li> <li>Services for Koori clients such as the Koori Liaison Officer program</li> </ul>	<ul style="list-style-type: none"> <li>Any party to a court proceeding can access the CISP by way of referral, including applicants, respondents, and accused from all jurisdictions of the Magistrates' Court, such as the Family Violence division</li> <li>The accused is on summons, bail or remand pending a bail hearing</li> <li>The program is available to the accused regardless of whether a plea has been entered or whether they intend to plead guilty or not</li> <li>The accused must provide consent to be involved in the program.</li> </ul>	Medium to high risk defendants with identified health and social needs
<b>Supervised Treatment Intervention Regime (STIR)</b>	<ul style="list-style-type: none"> <li>To provide an incentive for offenders to attend and treat their drug use</li> <li>To engage the offender in suitable treatment to treat their drug use</li> </ul>	<ul style="list-style-type: none"> <li>Intake and assessment by a court-based Diversion Officer</li> <li>Appearance in the Drug Court of Western Australia to determine whether STIR is appropriate</li> </ul>	Any person pleading guilty to an offence who: <ul style="list-style-type: none"> <li>Has problems related to substance use and is prepared to access treatment</li> <li>Has fairly stable living circumstances;</li> </ul>	Defendants with more entrenched drug use problems and offending histories appearing before the Western Australian Magistrates'

Program name, jurisdiction and duration	Objectives	Services/supports offered	Eligibility criteria	Target cohort
Western Australian Magistrates' Court  Up to six months	<ul style="list-style-type: none"> <li>To provide ongoing supervision in order to support the offenders participation in the program</li> <li>To engage family members/significant others of offenders, if appropriate</li> <li>To refer offenders to other support service(s) as required</li> <li>To refer the offender to continuing treatment at the conclusion of the program</li> </ul>	<ul style="list-style-type: none"> <li>Assignment to a Court Assessment and Treatment Service (CATS) Office, who refers the defendant to an appropriate treatment agency and arranges urinalysis</li> <li>Provision of counselling (either individual or as part of a group, usually on a weekly basis), detoxification, residential rehabilitation or other services via a treatment agency</li> <li>Provision of urinalysis up to three times per week</li> <li>Attendance at court approximately every three to four weeks for Magistrate review and consideration</li> <li>Provision of reports to the sentencing Magistrate regarding the participant's engagement in the program for consideration in sentencing</li> </ul>	<ul style="list-style-type: none"> <li>Would normally expect to receive a fine or community based order on a plea of guilty;</li> <li>Has no serious offences, or offences in the District or Supreme Courts; and</li> <li>Is on bail, or is eligible for bail.</li> </ul>	Court in respect of moderate-level crimes which will often result in a Community Based Order or Intensive Supervision Order upon a plea of guilty

Sources: NSW Attorney General & Justice, Drug Court of NSW, available at [http://www.drugcourt.justice.nsw.gov.au/drgcrt/dc\\_program.html,c=y](http://www.drugcourt.justice.nsw.gov.au/drgcrt/dc_program.html,c=y), accessed 1 November 2014, NSW Attorney General & Justice Magistrates'; Government of Western Australia (Drug and Alcohol Office), Diversion Programs for Aboriginal People, available at, accessed 29 October 2014; Government of Western Australia (Drug and Alcohol Office), Supervised Treatment Intervention Regime (STIR), available at <http://www.dao.health.wa.gov.au/Informationandresources/WADiversionProgram/SupervisedTreatmentInterventionRegimeSTIR.aspx>, accessed 29 October 2014; University of Western Australia Crime Research Centre, WA Diversion Program (POP/STIR/IDP) - Final Report (University of Western Australia 2007) 128, 131 (note that unit costs have been indexed for inflation to June 2013).

These programs have been selected to enable a comparative analysis against DCV; attributes which have been considered are the targeting of a defendant cohort which has drug-related offending issues (and in some instances, mental health concerns), and where appropriate, a similar program duration to DCV.

The analysis of participant unit costs for each program, on a funding basis, is provided in Section 8.1. Where sufficient data is available, unit costs have been disaggregated into specific categories (i.e. participants who have been assessed, participants engaged in [but did not complete] the Program, and participants who completed the Program). All unit costs have been indexed to present costs in 2012-13 terms. It is noted that the DCV related unit costs have been developed with reference to funding allocated in 2012-13, but that the "total" cost of DCV (including the court costs for instance) has not been ascertained. The analysis of unit costs contained below should only be viewed as a "ball park" indicator, and not as the basis for further analysis.

*Table 8-4: Court-based early intervention and diversion services – unit costs of service delivery*

Program	Participant status	2012-13 unit cost on the basis of program funding (\$)	Comparison to DCV
Victoria			
Drug Court of Victoria	Average number of participants on program (includes partially completed)	26,000	Includes range of services including residential rehabilitation if required. Up to 24 months duration.
Court Services (CISP)	Integrated Program	Did not complete program	Lower unit costs per participant. No urinalysis or rehab. Four months duration
		Completed program	
Western Australia			
Supervised Treatment Intervention	Assessment only	7,069	Range of services, including urinalysis and rehabilitation where required. Up to six months duration.
	Did not complete program	8,580	
	Completed program	10,601	
New South Wales			
NSW Drug Court	Accepted on to program	24,000 <sup>125*</sup>	Mandatory week of residential secure rehabilitation for each participant. Up to 24 months duration.

Sources: PricewaterhouseCoopers, *Economic Evaluation of the Court Integrated Services Program (CISP)* (PwC 2009) 6-7 (note that unit costs have been indexed for inflation to June 2013) Victorian Government, *2009-10 State Budget: Budget Paper 3* (Victorian Government 2009) 286; University of Western Australia Crime Research Centre, *WA Diversion Program (POP/STIR/IDP) - Final Report* (University of Western Australia 2007) 128, 131 (note that unit costs have been indexed for inflation to June 2013); KPMG analysis.

The Drug Court of NSW is probably the closest comparator to the DCV, and has comparable costs. The NSW Drug Court provides additional services to the DCV (e.g. mandatory residential rehabilitation), however, the court also had an average client case load of approximately 143 clients per year during the evaluation period from which the above unit cost is drawn.<sup>126</sup> This case load is more than twice the size of the DCV case load and likely contributes to the slightly higher DCV unit cost. The STIR program appears to be less expensive, but given it is only six months long, a

<sup>125</sup> Haas et al. (2008) The Costs of NSW Drug Court. The NSW unit cost figure has been calculated to, as close as possible, reflect the operating costs included in the DCV unit cost shown above. Due to a lack of detail regarding NSW line items, however, an exact comparison cannot be made and this comparison should be considered indicative rather than exact. \*Excludes final sentencing costs

<sup>126</sup> Ibid.



comparison of outcomes would need to be included to ascertain whether this is a more cost effective delivery model than the NSW or Victorian drug courts.

CISP has been included as another Victorian court program, which, even though it is not a sentencing option, is a likely alternative for some defendants who are currently going through the DCV. Potentially some participants on this program will progress to be on a DTO at some point, or are individuals who may not be able to be awarded a DTO given its current geographic limitations.

Further analysis of the costs included in each calculation of unit cost would be required to make further findings, but these figures show that the DCV costs are in line with other alternatives available, including CISP which, if it was extended to cover a two year period, would be likely to cost even more than either of the existing drug courts in NSW or Victoria

### 8.3. Cost effectiveness of the Drug Court

The cost effectiveness of the DCV is a combination of the costs incurred and the outcomes delivered.

#### *Cost of the Drug Court*

As Section 8.1 describes, the DCV received \$4,872,900 over the three year period of this evaluation, and expended \$4,459,160 on the delivery of the program. As previously discussed there are other costs associated with DCV which are accounted for elsewhere in the MCV accounting records.

One such cost is sanction days, where some DTO participants receive a sanction in the form of imprisonment. For all 130 DCV clients during the evaluation period, a total of 2,965 sanction days were imposed while on the Order, or an average of 23 sanction days per client.<sup>127</sup> The additional cost of imprisonment can be estimated as 988 days per annum on average, based on the offences committed by the cohort under review, which at an estimated daily cost of imprisonment of \$270<sup>128</sup> equates to \$266,760 per annum.

Of course, the alternative to incurring the cost of the DCV for this cohort group is likely to be a period of imprisonment, particularly now that suspended sentences are no longer an option for magistrates.

#### *Reoffending whilst on a DTO*

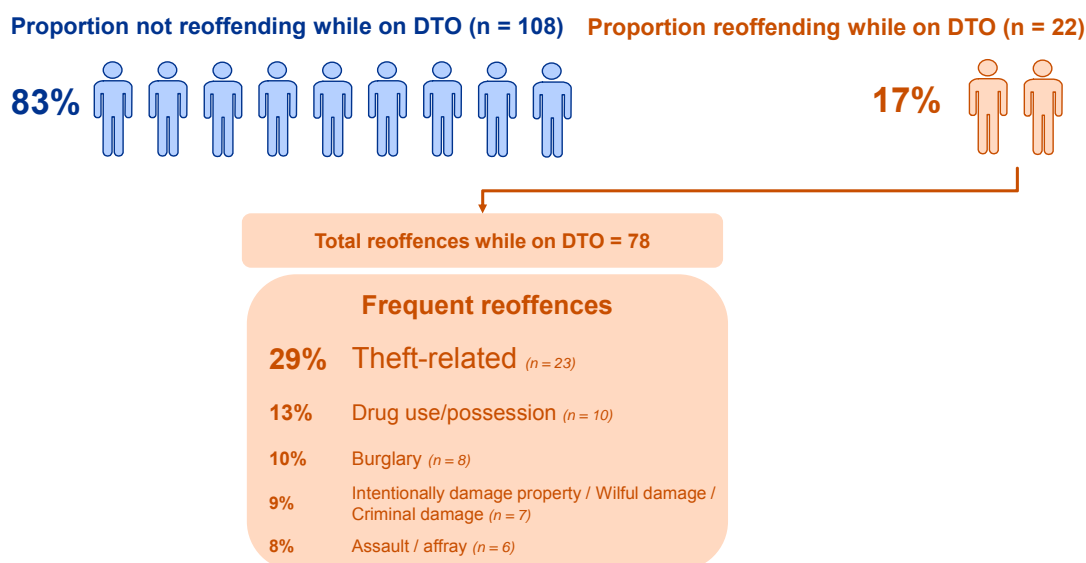
In addition to these costs to the justice system, the fact that offenders are receiving their sentences within the community, rather than being incarcerated, puts an additional cost on to the community, namely those offences which participants commit whilst on the order. Seventy-eight offences were committed during the period under review, by DCV participants.

---

<sup>127</sup> Drug Court of Victoria, DRUIS Database Extracts (1 July 2010 – 30 June 2013).

<sup>128</sup> Prison cost data from the Magistrates' Court of Victoria, e-mail dated 18 March 2014.

Figure 8-1: Reoffending whilst on the DTO (2010-11 through 2012-13)



Source: Drug Court of Victoria, *DRUIS Database Extracts* (1 July 2010 – 30 June 2013).

Table 8-5: Sentences received by clients reoffending whilst on DTO (2010-11 through 2012-13) (n = 21\*)

Sentence	Number of clients
Immediate imprisonment	9
Imprisonment subsumed into DTO	6
Suspended imprisonment sentence	4
Fined	1
Convicted and discharged	1
<b>Total immediate imprisonment days for offences committed whilst on DTO = 1,821</b>	

Source: Drug Court of Victoria, *DRUIS Database Extracts* (1 July 2010 – 30 June 2013). \*One client was convicted but had no sentence information recorded in DRUIS

The total direct cost of the immediate imprisonment days for offences committed whilst on the DTO during the evaluation period is approximately \$491,670, or \$163,890 per annum.<sup>129</sup>

Whilst it is not possible to quantify the impact on the community of offences committed, it is generally accepted that there are costs incurred, including reduced productivity (due to physical injury, or mental health issues related to being the victim of crime), reduced profitability for businesses (particularly retail businesses which suffer shop lifting), destruction of property and the increasing cost of addiction to illegal substances due to drug trafficking.

Communities are protected from these adverse outcomes in the short term when offenders are sentenced to imprisonment rather than a DTO. However, as the recidivism study illustrated, once an individual has completed the DTO they are less likely to re-offend, or will display a decrease in the severity of the offence.

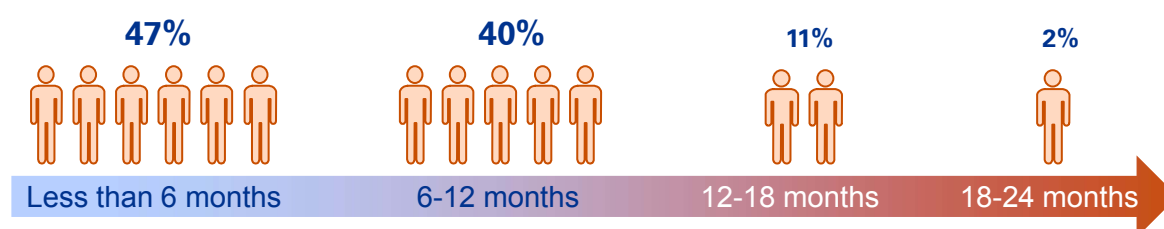
<sup>129</sup> Department of Justice, *Dandenong Drug Court Recidivism Study 2014* (Department of Justice 2014); prison cost data from the Magistrates' Court of Victoria, e-mail dated 18 March 2014.

### Post-DTO penalties and sanctions

Imprisonment sentences given to clients who fail to complete their DTO tend to be relatively short in duration. Of the 65 clients who did not complete the Order, 57 subsequently received an imprisonment sentence with nearly one in two of this group (27 clients, 47 per cent) receiving a term of imprisonment of less than six months. Three clients who did not complete their DTO received a suspended sentence and a further three received non-custodial or not immediately servable prison sentence. One client was deceased.

The significant majority (87 per cent, n = 50) received a sentence of 12 months or less. Only a small minority (two per cent) received a sentence longer than or equal to 18 months in duration. These proportions are displayed in Figure 7-7.

Figure 8-2: Duration of post-DTO imprisonment sentences for clients not completing (n = 57)



Source: Data provided by MCV in e-mail dated 17 May 2014.

### DTO outcomes

In addition to the above, the sentence outcomes of the recidivist offenders show that a greater proportion of Control Cohort reoffenders were sentenced to a term of imprisonment (n = 32) than the DCV Cohort (n = 18). Analysis of this term of imprisonment data by DoJ indicated that the Control Cohort was sentenced to a total of 10,617 days imprisonment (at a cost of \$2,866,590), compared with 6,125 days for the DCV Cohort (at a cost of \$1,653,750). This is a difference of \$1,212,840, or 42 per cent.<sup>130</sup> Given the entrenched offending nature of the DCV Cohort, and the likelihood that without intervention their offending trajectory into the future would be at least equal to, if not exceeding, the Control Cohort, this probably represents the lower band of potential savings in imprisonment costs alone. In addition to the reduced rates of re-offending shown by the DCV Cohort, the other improvements in health and well-being experienced by DCV graduates will have knock on positive impacts on demand for, and costs of, other front-line services, such as family support, homelessness services, unemployment benefits, health service (including emergency departments) and mental health services.

#### Key findings

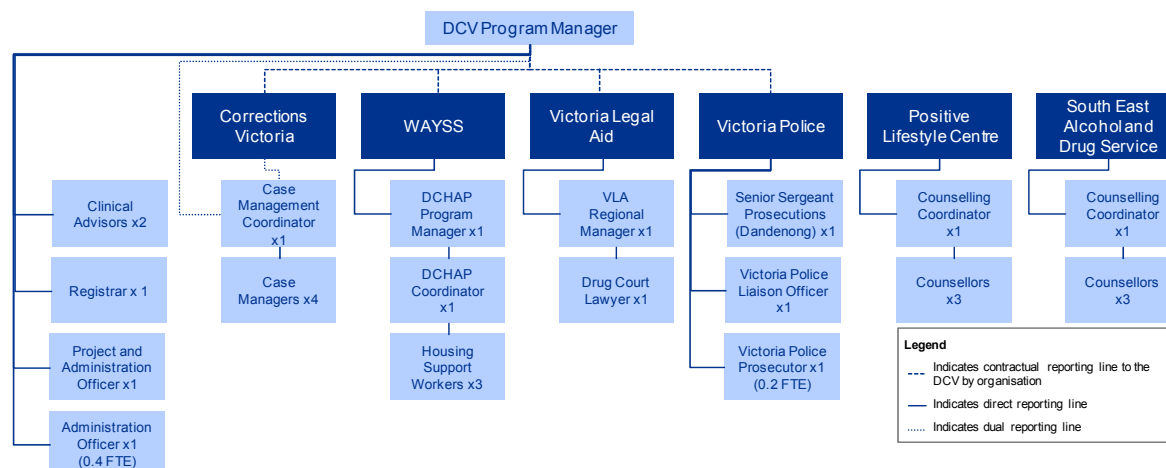
- The reduction in frequency and severity of offending by the DCV Cohort in the recidivism study has resulted in 4,492 fewer imprisonment days, at a reduced cost of \$1,212,840 over a two year period.
- The DCV offers a cost effective alternative to imprisonment for the target cohort, being more effective at reducing recidivism than imprisonment, and considerably cheaper.
- DCV compares favourably to the unit cost of alternative sentencing options (such as incarceration) and against comparable programs in other jurisdictions, and support programs run by the MCV.
- There are additional costs to the community of offences committed whilst participants are on the DTO which cannot be quantified, but evidence shows a reduction in severity and frequency of offending whilst participants are on the DTO compared to their offending record, resulting in total additional imprisonment costs of \$163,890 per annum.

<sup>130</sup> Department of Justice, *Dandenong Drug Court Recidivism Study 2014* (Department of Justice 2014); prison cost data from the Magistrates' Court of Victoria, e-mail dated 18 March 2014.

## 8.4. Governance arrangements

An overview of the current DCV organisational chart and key service providers is outlined in Figure 8-3.

Figure 8-3: DCV organisational chart



Sources: Drug Court of Victoria, *Drug Court Organisational Chart v 1.0* (Drug Court of Victoria 2012); Drug Court of Victoria, *Drug Court Key Service Providers* (Drug Court of Victoria, undated).

Stakeholders commented on the complexity of the current governance arrangements, and difficulties arising from the engagement of multiple service providers required to deliver the DCV.

Particular issues were noted in respect of performance management and accountability, such as who a particular DCV team member is required to report to, and the (limited) levers available to the DCV to influence and address issues of poor staff performance in instances where an employee is directly accountable to (and employed by) one of the DCV's service providers. This issue has been recognised by the DCV, and progress has been made to address key concerns. For example, a Memorandum of Understanding (MoU) is now in place between the DCV and Victoria Police and the DCV and Corrections Victoria, while the Corrections Victoria Officer in Charge of the Case Management Team now reports to both the Community Corrections Services Regional Manager and the DCV Program Manager.<sup>131</sup> Notwithstanding this, WAYSS, VLA, PLC and SEADS personnel still report to their organisation, rather than the DCV.

In addition to the organisational structure and reporting lines outlined earlier, the DCV has established a range of working groups and committees to monitor and improve service delivery mechanisms, contractual arrangements and financial management. A brief overview of these arrangements is provided below.

Table 8-6: Working groups and committees

Group	Purpose and membership	Meeting frequency
Participant Representative Committee	Comprised of active DCV participants who represent the views and interests of all DCV participants; designed to give participants a voice, promote leadership skills, problem solving and provide feedback.	Monthly
Tier One/Team Meetings	Attended by the DCV Magistrate, Program Manager, Registrar, Projects and Registry Officer, Corrections Victoria Staff, Clinical Advisors, DCHAP Staff and Management, VLA and Victoria Police Liaison Officer to discuss key operational issues concerning the DCV.	Monthly
Service Review Meetings	Held between the DCV Program Manager and:	Monthly

<sup>131</sup> Magistrates' Court of Victoria, *Drug Court – Monthly Report (October 2013)* (Magistrates' Court of Victoria 2013).

Group	Purpose and membership	Meeting frequency
	<ul style="list-style-type: none"> <li>DCHAP Management to monitor the use of transitional housing properties and review targets of DCHAP service delivery;</li> <li>Community Corrections Services General Manager to review service delivery and facilitate adherence to MoU requirements;</li> <li>Victoria Police Senior Sergeant to review service delivery in accordance with MoU requirements; and</li> <li>Healthscope Commercial Coordinator to review service delivery arrangements.</li> </ul>	
Inter-Agency Drug and Alcohol Services	Meetings with PLC, SEADS and DCV staff; purpose not specified.	Monthly
Court Service Users	Chaired by DCV Magistrate and open to Corrections Victoria Offender Behaviour Programs representative, WAYSS, Alcohol and Other Drug Services, Victoria Police, VLA, Corrections Victoria General Manager, DCV Program Manager, DCV Registrar, Healthscope, Monash University Clinical Psychology Services, Forensicare, key General Practitioners and the Sheriff's Office. Terms of Reference for this group are yet to be finalised.	Monthly

Source: Memo from Drug Court of Victoria to Magistrates' Court of Victoria (*Governance Structure – Drug Court of Victoria*), 12 February 2014.

Notwithstanding the complexities associated with the DCV's organisational structure, a range of committees and working groups have been established to facilitate ongoing monitoring of contractual arrangements between the DCV and its service providers, and to provide fora in which service design and delivery improvements may be canvassed. MCV is also in the process of planning the establishment of a Specialist Courts and Court Support Services (SCSS) Steering Committee, which will provide monitoring and oversight of a number of specialist courts and support services, including:

- the Drug Court of Victoria;
- Assessment and Referral (ARC) List;
- Court Integrated Services Program (CISP);
- Credit/Bail Support Program (CBSP);
- CISP Remand Outreach Pilot (CROP);
- Family Violence programs and initiatives; and
- Koori Court.<sup>132</sup>

These cross-agency collaboration opportunities assist in providing holistic, integrated service delivery as well as regular review and monitoring of performance standards.

## 8.5. Risk management practices

A range of risks were identified by stakeholders in delivery of the DCV relating to:

- risks presenting to DCV participants of self-harm, overdose and harm to others;
- risks presenting to DCV staff exposed to significant levels of stress and/or trauma associated with the DCV Cohort; and

<sup>132</sup> E-mail received from MCV dated 12 December 2014.

- risks impacting upon successful delivery of the DCV (such as staffing, capacity, budget concerns and infrastructure requirements).

Risk management practices in the DCV are well defined, and are cognisant of risks arising to participants, the community, staff and general service delivery.

It is noted that the DCV participant cohort presents a number of risks due to their volatile behaviour, engagement in criminal activity and drug and alcohol use. As such, developing and implementing a risk management framework which appropriately accounts for this cohort is challenging and needs to be able to respond to the quickly changing circumstances of participants.

#### 8.5.1. Risks to DCV participants

The DCV target cohort is particularly volatile with multiple and complex needs. Instability in participants' lives due to issues of violence, homelessness and drug and alcohol dependency (frequently abuse), coupled with engagement in criminal activity means that the client cohort is susceptible to rash decision-making and present risks of self-harm, and harm to others in the community which need to be actively monitored and mitigated.

The provision of regular engagement with DCV participants through counselling sessions, appointments with Case Managers and Clinical Advisors, presentation at Drug Court House for urinalysis, attendance at pharmacists for medication collection and hearings with the DCV Magistrate enable relevant DCV staff to monitor participants and identify and manage risks proactively. The provision of weekly case management meetings enables all DCV staff to raise identified risks with other DCV team members and identify appropriate mitigation strategies in a collaborative, cross-disciplinary manner.

In January 2014, a High Risk Panel was established to identify particular DCV clients which present with higher levels of risk and/or need due to issues of fatality through withdrawal, overdose, financial concerns, unsafe injecting techniques, psychosis, disinhibited behaviour, risks to others, suicide, severe emotional crisis, etc. The High Risk Panel facilitates a greater level of collaboration and organisational support for individual staff when managing high-risk and high-needs participants.<sup>133</sup>

#### 8.5.2. Risks to DCV staff

Stakeholders consulted noted that issues of staff stress and 'burn out' were of concern, given the difficulties associated with assisting and working with the DCV Cohort. These risks are managed through the provision of clinical supervision and debriefing for DCV staff. In particular:

- the Clinical Advisors and Officer in Charge are provided with external clinical supervision via Caraniche Services;
- monthly group supervision is held for Corrections Victoria Staff, along with team meetings which include training modules based on emerging clinical themes; and
- the VLA Lawyer is provided with regular debriefing through the VLA Regional Manager.<sup>134</sup>

Such approaches suggest that concerns relating to staff wellbeing are being appropriately managed.

#### 8.5.3. Service delivery risks

A range of risks arise in the successful facilitation of the DCV. Such risks relate to staffing concerns, capacity of the DCV, adequate budgeting and building and infrastructure concerns.

The DCV adheres to the *Courts Risk Management Protocol* (CRiMP) which identifies, assesses and manages political, program, human resources, infrastructure and local community risks. Each month the DCV Program Manager updates the DCV CRiMP outlining the risks pertaining to its jurisdiction. Any pertinent risks may be brought to the attention of the Executive Group. This creates a

<sup>133</sup> Magistrates' Court of Victoria, *Drug Court Monthly Report – October 2013* (Magistrates' Court of Victoria 2013).

<sup>134</sup> Memo from Acting Manager, Drug Court of Victoria to Magistrates' Court of Victoria (*Governance Structure – Drug Court of Victoria*), 12 February 2014.



transparent risk management process, and facilitates escalation of major risks to senior executives within the MCV.<sup>135</sup>

In addition, the DCV Program Manager provides monthly reports to the Manager of Specialist Courts and Court Support Services highlighting areas of performance measurement, issues, alerts, budgets, complaints, feedback, business improvements, community engagement activities and workforce planning issues.<sup>136</sup> This process enables the MCV to maintain broader operational oversight of the DCV.

#### Key Finding

- The Program is delivered with an appropriate level of risk management and governance, with mechanisms in place to keep processes up to date and running smoothly

<sup>135</sup> Magistrates' Court of Victoria, *Courts Risk Management Protocol (CRiMP) – Purpose, Policy and Definitions* (Magistrates' Court of Victoria, undated); Magistrates' Court of Victoria, *Courts Risk Management Protocol (CRiMP) – Procedures* (Magistrates' Court of Victoria, undated); Drug Court of Victoria, *Risk Management Framework* (Drug Court of Victoria, undated); Magistrates' Court of Victoria, *Drug Court Monthly Report – October 2013* (Magistrates' Court of Victoria 2013).

<sup>136</sup> See, for example, Magistrates' Court of Victoria, *Drug Court Monthly Report – October 2013* (Magistrates' Court of Victoria 2013).

## 9. Future

### 9.1. Service delivery improvements

A range of service delivery improvements were identified by stakeholders. These service delivery improvements displayed in Table 9-1 are focused on enhancing participant, service provider and criminal justice system outcomes without significant change to the DCV model.

Table 9-1: Potential service delivery improvements

Improvement	Expected benefit(s)
<p>Enable and undertake regular data collection activities which relate to:</p> <ul style="list-style-type: none"> <li>the number and source of referrals received (including all data recorded as not collected in Figure 3-3);</li> <li>points throughout the DTO where there are noted trends in a lack of compliance or breaching of DTO conditions; and</li> <li>to the extent possible, longitudinal data on the health, wellbeing and reoffending patterns of former participants.</li> </ul>	<ul style="list-style-type: none"> <li>Improved understanding of demand for the DCV, along with referral sources and the types of referrals received (e.g. offender demographics, offences, etc.).</li> <li>Enables identification of 'indicators' which can assist in monitoring trends in compliance and particular points at which offenders are more vulnerable and susceptible to breaching DTO conditions, meaning that service delivery options can be tailored to address these issues, provide appropriate, targeted interventions and improve compliance and completion rates.</li> <li>Greater understanding of medium-long term outcomes for DCV participants and an evidence base to compare these outcomes against other intervention programs/services.</li> </ul>
Facilitate staggered Court Hearings (similar to staggering of urinalysis/breath testing times)	<ul style="list-style-type: none"> <li>Reduces DCV participants' engagement with other known associates and affiliated temptation to use drugs or engage in criminal activity.</li> </ul>
Facilitate longer opening hours (e.g. opening at 8:30AM) at Drug Court House which enable urinalysis/breath testing to be undertaken earlier in the day	<ul style="list-style-type: none"> <li>Enables DCV participants in full- or part-time employment to attend necessary testing appointments without impacting on employment commitments.</li> </ul>
<p>Facilitate an improved interface between health and medical professionals and the DCV, potentially through:</p> <ul style="list-style-type: none"> <li>formalising relationships with key treatment providers (e.g. General Practitioners, Mental Health Nurses, Psychiatrists, Pharmacists); and/or</li> <li>greater use of the eHealth database amongst service providers.</li> </ul>	<ul style="list-style-type: none"> <li>Enables health and medical professionals to understand the purpose of a participant's referral, key objectives the participant seeks to achieve whilst on the DTO and appropriate interventions/treatment options which will give effect to this.</li> <li>Reduces chances of DCV participants duplicating access to medicines/drugs from various treatment providers.</li> <li>Enables improved access to treatment options (particularly pharmacotherapy and psychiatrist assistance), for which there are often long waiting lists.</li> </ul>
Consider opportunities to include principles of restorative justice in administration of DTOs	<ul style="list-style-type: none"> <li>Affords community members who may have been affected by a DCV participant's criminal behaviour an apology and improved understanding as to why a DTO was used as a sentencing alternative to imprisonment.</li> </ul>

Improvement	Expected benefit(s)
Enhance resourcing for the DCV to include a Receptionist and Community Liaison Officer position	<ul style="list-style-type: none"> <li>Provision of a receptionist alleviates currently workload placed on Clinical Advisors and Case Managers (which are responsible for undertaking reception duties).</li> <li>Provision of a Community Liaison Officer would assist in facilitating improve community engagement activities for participants, and assist in linking the DCV to other community service agencies and groups (e.g. churches, local clubs).</li> </ul>

## 9.2. Expansion and reform opportunities

In addition to the service design improvements discussed earlier, stakeholders also identified a range of broader reform and expansion opportunities. These opportunities are of a larger scale, requiring potential legislative change, additional funding/resourcing and more substantive changes to the existing DCV model and operations. The opportunities and expected benefits are summarised in Section 9.2.

Table 9-2: Expansion and reform opportunities and expected benefits

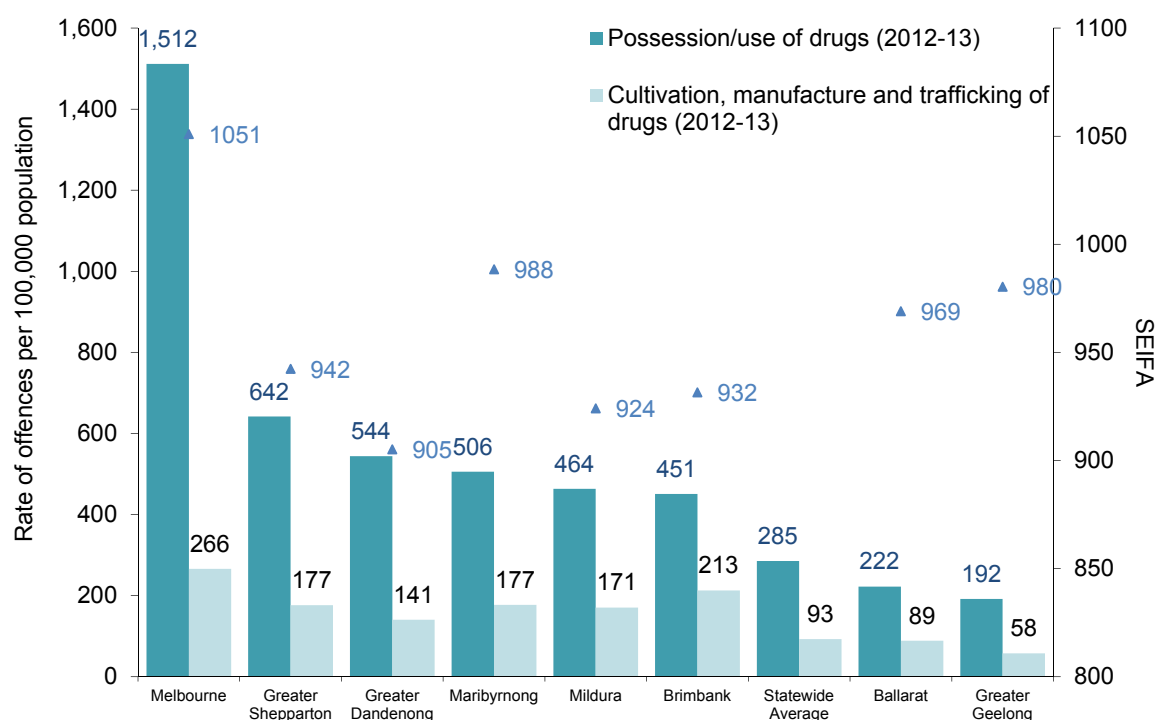
Expansion and reform opportunities	Expected benefit(s)
Broaden offence categories to which a DTO may be a suitable sanction to include offences which carry up to five years imprisonment	<ul style="list-style-type: none"> <li>Facilitates consistency with the broader MCV jurisdiction which encompasses offences which carry a penalty of up to five years' imprisonment</li> </ul>
Establish a secure detoxification facility for DCV participants	<ul style="list-style-type: none"> <li>Alleviates capacity constraints on police holding cells which are currently used to accommodate participants who reach a specified number of sanctions and receive a period of incarceration as a result</li> <li>Enables sanctions to be administered in a therapeutic environment</li> </ul>

Sources: KPMG analysis

Stakeholders also considered the principal expansion and reform opportunity to be the expansion of the use of drug courts in selected Victorian locations to facilitate access to the DTO as a sentencing option in geographic areas which experience high case volumes concerning drug and alcohol-related offences (and offenders). This would facilitate improved access to DTO as a sentencing option, particularly locations where high demand is evident.

Stakeholders considered that potential locations may include the Neighbourhood Justice Centre [given existing infrastructure and problem-solving court focus] and other locations with high levels of drug-related crime and low SES, including Footscray (Maribyrnong LGA), Sunshine (Brimbank LGA), the Melbourne CBD, Shepparton, Geelong, Ballarat and Mildura. High-level analysis of levels of drug-related crime and SEIFA index for each of these LGAs is provided in Figure 9-1.

Figure 9-1: Comparison of selected LGAs



Sources: Victoria Police, Victoria Police 2010-11 Crime Statistics (Victoria Police 2010); Victoria Police, Victoria Police 2012-13 Crime Statistics (Victoria Police 2013); Australian Bureau of Statistics, Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia 2011 (Cat. No. 2033.0.55.001) (Australian Bureau of Statistics 2013).

Of the LGAs identified by stakeholders, Greater Dandenong has the lowest SEIFA index and a higher rate of drug-related offences than the statewide average.

Melbourne has the highest rate of drug-related offences, but a considerably higher SEIFA index (which is reflective of the high level of socio economic diversity in the LGA), while Greater Shepparton has a high rate of drug-related offences (particularly possession/use offences), and a relatively low SEIFA index of 942.

Stakeholders were cognisant of the need for sufficient infrastructure and resourcing requirements to be met in order to facilitate effective service delivery in any proposed drug court location.

## Appendix A: Evaluation framework

The key evaluation questions used to structure this engagement have been drawn from DTF Guidelines, and tailored to the specific requirements of the DCV and MCV, acknowledging that funding for the DCV is ongoing,

Key evaluation question	Sub-questions	Evidence	Data source(s)
<b>Justification/problem</b>			
What is the evidence of a continued need for the Drug Court of Victoria (DCV) and the role of the Victorian Government in delivering it?	To what extent does the DCV continue to address a demonstrable need and is responsive to the needs of Victorians?	<p>Desktop review of documentation relating to rationale for DCV (e.g. strategy documents, business cases, briefing documents)</p> <p>Findings from previous evaluations</p> <p>Analysis of statistics relating to past and current:</p> <ul style="list-style-type: none"> <li>prevalence of drug and alcohol use in Victoria (2010-11 to 2012-13)</li> <li>prevalence of drug alcohol-related crime in Victoria (2010-11 to 2012-13)</li> </ul> <p><i>Projections of alcohol and drug use in Victoria and prevalence of drug and alcohol-related crime (if available)</i></p> <p>Analysis of DCV participant data</p> <p>Literature review findings</p> <p>Number of referrals to the DCV over time (2010-11 to present), including number and profile of participants</p> <p>Stakeholder feedback (<i>NB stakeholders to be</i></p>	<p>DCV, <i>Strategic Plan 2013-2015</i> (DCV 2013)</p> <p>Magistrates' Court of Victoria (MCV), <i>Drug Court</i>, available at <a href="http://www.magistratescourt.vic.gov.au/jurisdictions/specialist-jurisdictions/drug-court">http://www.magistratescourt.vic.gov.au/jurisdictions/specialist-jurisdictions/drug-court</a> (MCV 2013)</p> <p>DCV, <i>Victorian Drug Court – Magistrates' Training Manual</i> (DCV undated)</p> <p>Acumen Alliance, <i>Benefit and Cost Analysis of the Drug Court Program – Final Report</i> (Acumen Alliance 2005)</p> <p>Health Outcomes International &amp; Turning Point Alcohol and Drug Centre, <i>Process Evaluation and Policy &amp; Legislation Review – Final Report</i> (Health Outcomes International &amp; Turning Point Alcohol and Drug Centre 2004)</p> <p>DoJ, <i>Final Report – Re-Evaluation of the Dandenong Drug Court</i> (DoJ 2010; incomplete)</p> <p>DCV, <i>International Best Practice in Drug Courts</i> (DCV undated)</p> <p>Turning Point Alcohol &amp; Drug Centre, <i>Trends in Alcohol and Drug Related Ambulance Attendances in Victoria: 2011-12</i> (Turning Point Alcohol &amp; Drug Centre 2013)</p> <p>National Association of Drug Court Professionals, <i>Adult Drug Court Best Practice Standards: Volume 1</i> (NADCP 2013)</p> <p>US Department of Justice, <i>Defining Drug Courts: The Key Components</i> (Bureau of Justice Assistance 2004)</p> <p>Victorian Alcohol &amp; Drug Association, <i>Submission to Senate Legal and Constitutional Affairs Committee: Value of a justice reinvestment approach to criminal justice in Australia</i> (VAADA 2013)</p> <p>Victorian Alcohol &amp; Drug Association, <i>Drug Courts in Victoria: Evidence &amp; Options</i> (VAADA 2013)</p> <p>Australian Institute of Health and Welfare, <i>National Drug Strategy Household Survey</i> (Australian Government 2010)</p> <p>Victoria Police, <i>Crime Statistics 2010-11</i> (Victoria Police 2011)</p> <p>Victoria Police, <i>Crime Statistics 2011-12</i> (Victoria Police 2012)</p> <p>Victoria Police, <i>Crime Statistics 2012-13</i> (Victoria Police 2013)</p> <p>Department of Health, <i>Victorian Drug Statistics Handbook 2009-10</i> (Victorian Government 2010)</p> <p>Analysis of DCV participant information as recorded on Platypus database between 1 July 2010 and 30 June 2013, including:</p> <ul style="list-style-type: none"> <li>Problem substance use (at intake)</li> <li>Drug and alcohol program involvement (at intake)</li> </ul>

Key evaluation question	Sub-questions	Evidence	Data source(s)
		<i>consulted to be agreed with MCV)</i>	<ul style="list-style-type: none"> <li>Offending history (at intake)</li> <li>Community-Based Order (CBO)/disposition within three years of referral to DCV (at intake)</li> <li>Number and nature of offences at time DTO imposed (at intake)</li> <li>Imprisonment sentences (history of imprisonment) (at intake)</li> <li>Referrals received (by referral source) (at intake)</li> <li>Referrals rejected (at intake)</li> </ul> <p>Stakeholder consultations with:</p> <ul style="list-style-type: none"> <li>DCV Magistrate</li> <li>Other Victorian Magistrates</li> <li>DCV team members (including DCV Registrar, Case Managers, Clinical Advisors, Victoria Legal Aid [VLA], WAYSS, South East Alcohol and Drug Service [SEADS] and Victoria Police representatives)</li> <li>Courts and Tribunals Service (CTS) and MCV Courts Policy representatives regarding the need for the DCV</li> </ul>
	Is the DCV the best way to respond to the problem and deliver the intended outcomes? To what extent did MCV investigate other options to address the identified problem?	<p>Literature review findings</p> <p>Findings from previous evaluations</p> <p>Any options analysis undertaken as part of funding bid or implementation planning</p> <p>Desktop research into similar programs/problem-solving court approaches in 3-4 other jurisdictions (e.g. Canada, United States of America, New Zealand, United Kingdom and other Australian states and territories; <i>selected jurisdictions to be agreed with MCV</i>)</p> <p>Stakeholder feedback (<i>NB stakeholders to be</i></p>	<p>DCV, <i>Victorian Drug Court – Magistrates' Training Manual</i> (DCV undated)</p> <p>Acumen Alliance, <i>Benefit and Cost Analysis of the Drug Court Program – Final Report</i> (Acumen Alliance 2005)</p> <p>Health Outcomes International &amp; Turning Point Alcohol and Drug Centre, <i>Process Evaluation and Policy &amp; Legislation Review – Final Report</i> (Health Outcomes International &amp; Turning Point Alcohol and Drug Centre 2004)</p> <p>DoJ, <i>Final Report – Re-Evaluation of the Dandenong Drug Court</i> (DoJ 2010; incomplete)</p> <p>DCV, <i>International Best Practice in Drug Courts</i> (DCV undated)</p> <p>National Association of Drug Court Professionals, <i>Adult Drug Court Best Practice Standards: Volume 1</i> (NADCP 2013)</p> <p>US Department of Justice, <i>Defining Drug Courts: The Key Components</i> (Bureau of Justice Assistance 2004)</p> <p>Victorian Alcohol &amp; Drug Association, <i>Submission to Senate Legal and Constitutional Affairs Committee: Value of a justice reinvestment approach to criminal justice in Australia</i> (VAADA 2013)</p> <p>Victorian Alcohol &amp; Drug Association, <i>Drug Courts in Victoria: Evidence &amp; Options</i> (VAADA 2013)</p> <p>Publicly available information relating to drug courts in 3-4 selected jurisdictions</p> <p>Consultations with:</p> <ul style="list-style-type: none"> <li>DCV Magistrate</li> <li>Other Victorian Magistrates</li> </ul>



Key evaluation question	Sub-questions	Evidence	Data source(s)
		<i>consulted to be agreed with MCV)</i>	<ul style="list-style-type: none"> <li>DCV case team members (including DCV Registrar, Case Managers, Clinical Advisors, VLA, WAYSS, SEADS and Victoria Police representatives)</li> <li>CTS and MCV Courts Policy representatives to inform assessment of better-practice approaches to the management of offenders with drug and alcohol issues</li> </ul> <p>Consultation with MCV policy representatives to outlined the options assessment process undertaken in developing the DCV</p>
	What changes have there been to the economic, environmental and social conditions since the DCV was funded and how will it meet these conditions?	<p>Desktop review and analysis of changing conditions, including relevant government policies and programs</p> <p>Analysis of statistics relating to past and current:</p> <ul style="list-style-type: none"> <li>prevalence of drug and alcohol use in Victoria (2010-11 to 2012-13)</li> <li>prevalence of drug alcohol-related crime in Victoria (2010-11 to 2012-13)</li> </ul> <p>Analysis of DCV participant data</p> <p>Stakeholder feedback (<i>NB stakeholders to be consulted to be agreed with MCV)</i></p>	<p>Acumen Alliance, <i>Benefit and Cost Analysis of the Drug Court Program – Final Report</i> (Acumen Alliance 2005)</p> <p>Health Outcomes International &amp; Turning Point Alcohol and Drug Centre, <i>Process Evaluation and Policy &amp; Legislation Review – Final Report</i> (Health Outcomes International &amp; Turning Point Alcohol and Drug Centre 2004)</p> <p>DoJ, <i>Final Report – Re-Evaluation of the Dandenong Drug Court</i> (DoJ 2010; incomplete)</p> <p>DCV, <i>International Best Practice in Drug Courts</i> (DCV undated)</p> <p>Victorian Alcohol &amp; Drug Association, <i>Submission to Senate Legal and Constitutional Affairs Committee: Value of a justice reinvestment approach to criminal justice in Australia</i> (VAADA 2013)</p> <p>Victorian Alcohol &amp; Drug Association, <i>Drug Courts in Victoria: Evidence &amp; Options</i> (VAADA 2013)</p> <p>Platypus database reports relating to DCV participant demographics</p> <p>Stakeholder consultations with:</p> <ul style="list-style-type: none"> <li>DCV Magistrate</li> <li>Other Victorian Magistrates</li> <li>DCV team members (including DCV Registrar, Case Managers, Clinical Advisors, VLA, WAYSS, SEADS and Victoria Police representatives)</li> <li>CTS and MCV Courts Policy representatives to determine views on shifting conditions</li> </ul>

Key evaluation question	Sub-questions	Evidence	Data source(s)
	Is there evidence that the marketplace cannot deliver the DCV?	Desktop review and analysis of similar programs and interventions for accused persons with drug and alcohol problems Stakeholder feedback (NB stakeholders to be consulted to be agreed with MCV)	DCV, <i>Strategic Plan 2013-2015</i> (DCV 2013) Acumen Alliance, <i>Benefit and Cost Analysis of the Drug Court Program – Final Report</i> (Acumen Alliance 2005) Health Outcomes International & Turning Point Alcohol and Drug Centre, <i>Process Evaluation and Policy &amp; Legislation Review – Final Report</i> (Health Outcomes International & Turning Point Alcohol and Drug Centre 2004) DoJ, <i>Final Report – Re-Evaluation of the Dandenong Drug Court</i> (DoJ 2010; incomplete) Victorian Alcohol & Drug Association, <i>Submission to Senate Legal and Constitutional Affairs Committee: Value of a justice reinvestment approach to criminal justice in Australia</i> (VAADA 2013) Victorian Alcohol & Drug Association, <i>Drug Courts in Victoria: Evidence &amp; Options</i> (VAADA 2013) Stakeholder consultations with: <ul style="list-style-type: none"> <li>• DCV Magistrate</li> <li>• Other Victorian Magistrates</li> <li>• DCV team members (including DCV Registrar, Case Managers, Clinical Advisors, VLA, WAYSS, SEADS and Victoria Police representatives)</li> <li>• CTS and MCV Courts Policy representatives</li> </ul> to identify whether other market-based initiatives or programs are available
	Are there any other similar services being provided by the Victorian Government, the Commonwealth or Non-Government Organisation sector that have commenced since the DCV's inception?	Desktop review and analysis of similar programs and interventions available in Victoria for accused persons with drug and alcohol concerns Stakeholder feedback (NB stakeholders to be consulted to be agreed with MCV)	Acumen Alliance, <i>Benefit and Cost Analysis of the Drug Court Program – Final Report</i> (Acumen Alliance 2005) Health Outcomes International & Turning Point Alcohol and Drug Centre, <i>Process Evaluation and Policy &amp; Legislation Review – Final Report</i> (Health Outcomes International & Turning Point Alcohol and Drug Centre 2004) DoJ, <i>Final Report – Re-Evaluation of the Dandenong Drug Court</i> (DoJ 2010; incomplete) Victorian Alcohol & Drug Association, <i>Submission to Senate Legal and Constitutional Affairs Committee: Value of a justice reinvestment approach to criminal justice in Australia</i> (VAADA 2013) Victorian Alcohol & Drug Association, <i>Drug Courts in Victoria: Evidence &amp; Options</i> (VAADA 2013) Stakeholder consultations with: <ul style="list-style-type: none"> <li>• DCV Magistrate</li> <li>• other Victorian Magistrates</li> <li>• DCV team members (including DCV Registrar, Case Managers, Clinical Advisors, VLA, WAYSS, SEADS and Victoria Police representatives)</li> <li>• CTS and MCV Courts Policy representatives</li> </ul> regarding similar programs/initiatives/services

Key evaluation question	Sub-questions	Evidence	Data source(s)
	Do the MCV, the MCV and the DCV have the capacity and capability to continue the DCV while responding to any changes found as a result of the evaluation?	Stakeholder feedback ( <i>NB stakeholders to be consulted to be agreed with MCV</i> )	Consultation with MCV and DCV representatives to determine the ongoing capacity and capability to deliver the DCV
<b>Effectiveness</b>			
<b>What evidence is available of the program's progress towards their stated objectives</b>	What are the objectives of the DCV and the outcomes it is seeking to achieve?	DCV objectives and outcomes, as articulated in program logic, budget announcements and government communications	DCV, <i>Strategic Plan 2013-2015</i> (DCV 2013) DCV, <i>Program Logic</i> (DCV undated)

Key evaluation question	Sub-questions	Evidence	Data source(s)
and expected outcomes, including alignment between the program's outputs, departmental objectives and stated government priorities?	Why was the DCV considered the best way to achieve the outcomes sought?	Evaluations of similar programs and problem-solving courts in other Australian and international jurisdictions Literature review findings Previous DCV evaluations Stakeholder feedback (NB stakeholders to be consulted to be agreed with MCV)	DCV, <i>Victorian Drug Court – Magistrates' Training Manual</i> (DCV undated) Acumen Alliance, <i>Benefit and Cost Analysis of the Drug Court Program – Final Report</i> (Acumen Alliance 2005) Health Outcomes International & Turning Point Alcohol and Drug Centre, <i>Process Evaluation and Policy &amp; Legislation Review – Final Report</i> (Health Outcomes International & Turning Point Alcohol and Drug Centre 2004) DoJ, <i>Final Report – Re-Evaluation of the Dandenong Drug Court</i> (DoJ 2010; incomplete) DCV, <i>International Best Practice in Drug Courts</i> (DCV undated) National Association of Drug Court Professionals, <i>Adult Drug Court Best Practice Standards: Volume 1</i> (NADCP 2013) US Department of Justice, <i>Defining Drug Courts: The Key Components</i> (Bureau of Justice Assistance 2004) Victorian Alcohol & Drug Association, <i>Submission to Senate Legal and Constitutional Affairs Committee: Value of a justice reinvestment approach to criminal justice in Australia</i> (VAADA 2013) Victorian Alcohol & Drug Association, <i>Drug Courts in Victoria: Evidence &amp; Options</i> (VAADA 2013) Stakeholder consultations with: <ul style="list-style-type: none"> <li>• DCV Magistrate</li> <li>• other Victorian Magistrates</li> <li>• DCV team members (including DCV Registrar, Case Managers, Clinical Advisors, VLA, WAYSS, SEADS and Victoria Police representatives)</li> <li>• CTS and MCV Courts Policy representatives</li> </ul> to inform assessment of better-practice approaches to the management of offenders with drug and alcohol issues

Key evaluation question	Sub-questions	Evidence	Data source(s)
	Do the stated objectives, outputs, and intended outcomes/impacts for the DCV align with stated government priorities?	Assessment of DCV outcomes against each objective outlined in the program logic (short-, medium- and long-term outcomes identified in the program logic) Desktop review and assessment of DCV alignment with Victorian Government objectives Review of DCV activities and outputs	DCV, <i>Strategic Plan 2013-2015</i> (DCV 2013) Department of Health, <i>Reducing the alcohol and drug toll: Victoria's Plan 2013-2017</i> (Department of Health 2012) DCV, <i>Program Logic</i> (DCV undated) DoJ, <i>Annual Report 2012-13</i> (Victorian Government 2013) Review of recent media releases and ministerial statements DCV, <i>Drug Court Participant Manual</i> (DCV, undated) DCV, <i>Drug Court Policy No. 1 – Key Components and Principles</i> (DCV undated) DCV, <i>Drug Court Policy No. 2 – Program Eligibility &amp; Selection</i> (DCV 2012) DCV, <i>Drug Court Policy No. 3 – Program Catchment Area</i> (DCV 2012) DCV, <i>Drug Court Policy No. 4 – Screening and Assessment</i> (DCV undated) DCV, <i>Drug Court Policy No. 5 – Participant Requirements</i> (DCV 2012) DCV, <i>Drug Court Policy No. 6 – Program Structure</i> (DCV 2012) DCV, <i>Drug Court Policy No. 7 – Sanctions and Rewards</i> (DCV 2013) DCV, <i>Drug Court Policy No. 8 – Urinalysis &amp; Breath Testing</i> (DCV 2012) DCV, <i>Drug Court Policy No. 17 – Material Aid</i> (DCV 2013) DCV, <i>Drug Court Process</i> (DCV 2011)
	What has been the impact of the DCV on participants and the criminal justice system?	Assessment of outcomes against each objective DCV participant interviews Case studies from DCV Analysis of DCV participant data, including number and profile of participants and services accessed Analysis of DCV participant outcome data Changes in DCV participant demographic and longitudinal data Findings of DCV recidivism study Analysis of legal outcomes for DCV participants, as recorded on CourtLink	DCV, <i>Strategic Plan 2013-2015</i> (DCV 2013) DCV, <i>Program Logic</i> (DCV undated) DCV, <i>Drug Court Policy No. 2 – Program Eligibility &amp; Selection</i> (DCV 2012) DCV, <i>Drug Court Policy No. 3 – Program Catchment Area</i> (DCV 2012) DCV, <i>Drug Court Policy No. 4 – Screening and Assessment</i> (DCV undated) DCV, <i>Drug Court Policy No. 5 – Participant Requirements</i> (DCV 2012) DCV, <i>Drug Court Policy No. 6 – Program Structure</i> (DCV 2012) DCV, <i>Drug Court Policy No. 7 – Sanctions and Rewards</i> (DCV 2013) DCV, <i>Drug Court Policy No. 8 – Urinalysis &amp; Breath Testing</i> (DCV 2012) DCV, <i>Drug Court Policy No. 17 – Material Aid</i> (DCV 2013) Analysis of DCV participant information as recorded on Platypus database between 1 July 2010 and 30 June 2013, including: <ul style="list-style-type: none"> <li>• Education levels (at intake, discharge and follow-up)</li> <li>• Employment (at intake, discharge and follow up)</li> <li>• Accommodation (at intake, discharge and follow-up)</li> <li>• Problem substance use (at intake, discharge and follow-up)</li> <li>• Maintenance/substitution of pharmacotherapy for addiction (at intake, discharge and follow-up)</li> </ul>

Key evaluation question	Sub-questions	Evidence	Data source(s)
		<p>Analysis of evidence of benefits (qualitative as well as quantitative)</p> <p>Stakeholder feedback <i>(NB stakeholders to be consulted to be agreed with MCV)</i></p>	<ul style="list-style-type: none"> <li>• Level of risk of criminogenic risk factors by category (at intake and discharge)</li> <li>• Motivation to change substance use (at intake, discharge and follow-up)</li> <li>• Services involved with drug and alcohol program involvement (past and present) (at intake, discharge and follow-up)</li> <li>• Services referred to during program (at intake and discharge)</li> <li>• Offending history (at intake, discharge and follow-up)</li> <li>• Subsequent offending while on Drug Treatment Order (DTO) (and after, where data available) (at discharge and follow-up)</li> <li>• Days spent in custody while on DTO (at discharge and follow-up)</li> <li>• Days spent in custody while on DTO (at discharge and follow-up)</li> <li>• DTO sentence details and amendments made throughout (at intake and discharge)</li> <li>• Date DTO closed and reason finalised (at discharge)</li> <li>• Diagnosis – mental health (DSM)</li> <li>• Mental health symptoms and changes to symptoms (at intake, discharge and follow-up)</li> <li>• Number of inpatient hospitalisations and length (at intake and discharge)</li> <li>• Physical and psychiatric health (and related to offending) (at intake, discharge and follow-up)</li> <li>• Cognitive functioning (Acquired Brain Injury etc) (at intake and discharge)</li> <li>• Suicide risk factors and history of suicide attempts (at intake and discharge)</li> <li>• Reasons for exit (at discharge)</li> <li>• Completers (at discharge)</li> <li>• Length of time on DTO (at discharge)</li> <li>• Number of warrants issued (at discharge)</li> <li>• Number of court reviews attended (at discharge)</li> <li>• Level of satisfaction with DTO (at discharge and follow-up)</li> <li>• Level of satisfaction with service from DCV (at discharge and follow-up)</li> <li>• Level of attendance at appointments (at discharge)</li> <li>• Living arrangements (at intake and discharge)</li> <li>• Main income source (at intake, discharge and follow-up)</li> </ul> <p>DoJ, <i>Recidivism Study</i> (DoJ 2013) (to be made available in February 2014)</p>



Key evaluation question	Sub-questions	Evidence	Data source(s)
			<p>DCV participant case narratives collated by the DCV case team</p> <p>Victoria Police, <i>Crime Statistics 2010-11</i> (Victoria Police 2011)</p> <p>Victoria Police, <i>Crime Statistics 2011-12</i> (Victoria Police 2012)</p> <p>Victoria Police, <i>Crime Statistics 2012-13</i> (Victoria Police 2013)</p> <p>VicHealth, <i>Community Indicators – Personal and Community Safety</i> (VicHealth 2011)</p> <p>Stakeholder consultations with:</p> <ul style="list-style-type: none"> <li>• DCV Magistrate</li> <li>• other Victorian Magistrates</li> <li>• DCV team members (including DCV Registrar, Case Managers, Clinical Advisors, VLA, WAYSS, SEADS and Victoria Police representatives)</li> <li>• health and medical service providers (General Practitioner, therapeutic communities)</li> <li>• CTS and MCV Courts Policy representatives</li> </ul> <p>to inform assessment of impact of DCV on participants</p> <p>Interviews with DCV participants to inform assessment of impact of DCV</p>
	Are there any external factors outside MCV's control which provide context for evaluation results regarding the achievement of outcomes?	<p>Analysis of barriers to MCV participation and engagement, and strategies to overcome these</p> <p>DCV participant interviews</p> <p>Stakeholder feedback</p>	<p>Stakeholder consultations with:</p> <ul style="list-style-type: none"> <li>• DCV Magistrate</li> <li>• other Victorian Magistrates</li> <li>• DCV team members (including DCV Registrar, Case Managers, Clinical Advisors, VLA, WAYSS, SEADS and Victoria Police representatives)</li> <li>• CTS and MCV Courts Policy representatives</li> </ul> <p>to inform assessment of any factors inhibiting achievement of objectives</p> <p>Interviews with DCV participants to inform assessment of any factors inhibiting achievement of objectives</p>
	Were there any unintended benefits and/or costs arising from the DCV?	<p>Stakeholder feedback</p> <p>Analysis of Sheriff's Office data</p>	<p>Stakeholder consultations with:</p> <ul style="list-style-type: none"> <li>• DCV Magistrate</li> <li>• other Victorian Magistrates</li> <li>• DCV case team members (including Case Managers, Clinical Advisors, VLA, WAYSS, SEADS and Victoria Police representatives)</li> <li>• CTS and MCV Courts Policy representatives</li> </ul> <p>to identify any unplanned benefits or costs of the DCV</p> <p>Data from Sheriff's Office regarding time saved and/or benefits associated with Sheriff's attendance at Drug Court House to assist in fine and/or infringement payments</p>

Key evaluation question	Sub-questions	Evidence	Data source(s)
<b>Funding/delivery and efficiency</b>			
<b>Has the DCV been delivered within scope, budget and expected timeframes, and in line with appropriate governance and risk management practices?</b>	What was the original scope and were there any scope changes agreed by Government (including associated funding, objective/performance adjustments)?	<p>DCV objectives DCV activities Review of DCV funding data, including:</p> <ul style="list-style-type: none"> <li>• Total funding as per original Expenditure Review Committee decision</li> <li>• Total budget for each year of operation</li> </ul> <p>Review of DCV timeframes Documentation of any reforms Stakeholder feedback (<i>NB stakeholders to be consulted to be agreed with MCV</i>)</p>	<p>Victorian Government Budget Paper information DoJ/MCV/DCV financial data related to the Court Documentation of any changes to funding arrangements</p>
	What was the total approved budget, including court costs and major cost drivers?	<p>Review of DCV funding data, including:</p> <ul style="list-style-type: none"> <li>• Total funding as per original Expenditure Review Committee decision</li> <li>• Total budget for each year of operation</li> </ul> <p>Stakeholder feedback (<i>NB stakeholders to be consulted to be agreed with MCV</i>)</p>	<p>Victorian Government Budget Paper information DoJ/MCV/DCV financial data related to the Court DoJ, MCV and DCV feedback to provide context for any gaps between estimated and actual costs</p>
	What was the price paid by Government and all additional funding provided	<p>Review of DCV funding data, including:</p> <ul style="list-style-type: none"> <li>• Total funding as per original Expenditure Review Committee</li> </ul>	<p>Victorian Government Budget Paper information DoJ/MCV/DCV financial data related to the Court</p>

Key evaluation question	Sub-questions	Evidence	Data source(s)
	to the DCV (as applicable)?	<p>decision</p> <ul style="list-style-type: none"> <li>Total budget for each year of operation</li> </ul>	
	<p>What were the total costs incurred for delivery of the DCV, (including a breakdown of expense categories, cost drivers, gaps between estimated and actual costs and all entities that charge expenses to the DCV)? Were there any variations between the estimated costs budgeted for delivery of the DCV and the actual costs? If yes, what were the cost drivers and gaps between estimated and actual costs?</p>	<p>Review of DCV funding and expenditure data, including:</p> <ul style="list-style-type: none"> <li>Total funding as per original Expenditure Review Committee decision</li> <li>Total budget for each year of operation</li> <li>Breakdown of budget into major expenditure categories (e.g. staff costs, brokerage, drug and alcohol testing, etc.)</li> <li>Actual expenditure against budget categories</li> </ul> <p>Documentation to support any decisions for redirecting funding, changes in objectives or changes in periods of funding</p> <p>Stakeholder feedback (<i>NB stakeholders to be consulted to be agreed with MCV</i>)</p>	<p>Victorian Government Budget Paper information</p> <p>DoJ/MCV/DCV financial data related to the Court</p> <p>DoJ, MCV and DCV feedback to provide context for any gaps between estimated and actual costs</p> <p>Documentation of any changes to funding arrangements</p>
	How do DCV costs compare to those of similar programs	<p>Review of DCV funding and expenditure data, including:</p> <ul style="list-style-type: none"> <li>Total funding as per original Expenditure</li> </ul>	<p>DoJ/MCV/DCV financial data related to the Court</p> <p>MCV backlog/waiting times (broken down by court location)</p> <p>Analysis of DCV input and output data as recorded on Platypus database between 1 July 2010 and 30 June 2013, including:</p> <ul style="list-style-type: none"> <li>Number of referrals received</li> </ul>

Key evaluation question	Sub-questions	Evidence	Data source(s)
	and/or courts elsewhere?	<p>Review Committee decision</p> <ul style="list-style-type: none"> <li>• Total budget for each year of operation</li> <li>• Breakdown of budget into major expenditure categories (e.g. staff costs, brokerage, drug and alcohol testing, etc.)</li> <li>• Actual expenditure against budget categories</li> </ul> <p>Comparison with costs of other MCV/DoJ problem-solving court initiatives, the Court Integrated Services Program [CISP]</p> <p>Desktop research into similar programs/problem-solving courts services in other Australian and international jurisdictions</p> <p>Current prison cost data</p> <p>Current therapeutic support cost data</p> <p>Offending, prison and remand histories</p>	<ul style="list-style-type: none"> <li>• Number of referrals accepted</li> <li>• Number of referrals rejected</li> <li>• Reasons for exit</li> <li>• Number of completers</li> <li>• Average length of time on DTO</li> <li>• Length of time between key decision points</li> <li>• Offending history (at intake, discharge and follow-up)</li> <li>• CBO/disposition within three years of referral to the DCV (at intake)</li> <li>• Mental Health Assessment within three years of referral to the DCV (at intake)</li> <li>• Number and nature of offences at time DTO imposed (at intake)</li> <li>• Days spent in custody while on DTO (at discharge and follow-up)</li> <li>• Subsequent offending while on DTO (and after, where data available (at discharge and follow-up)</li> <li>• Imprisonment sentences (at intake)</li> </ul> <p>University of Melbourne, <i>Evaluation of the Court Integrated Services Program – Final Report</i> (University of Melbourne 2009)</p> <p>Desktop research findings</p> <p>Productivity Commission, <i>Report on Government Services 2013</i> (Australian Government 2013)</p>

Key evaluation question	Sub-questions	Evidence	Data source(s)
	Did DCV implementation, delivery processes and timelines conform to original objectives, specifications and plans?	Consideration of DCV objectives Review of DCV implementation planning records Documentation of any reforms Stakeholder feedback ( <i>NB stakeholders to be consulted to be agreed with MCV</i> )	Tracking against DCV objectives and actions Documentation of any court reforms Implementation planning and reporting records Stakeholder consultations with: <ul style="list-style-type: none"> <li>DCV Magistrate</li> <li>DCV team members (including DCV Registrar, Case Managers, Clinical Advisors, Victoria Legal Aid [VLA] representatives and Victoria Police representatives)</li> <li>CTS and DoJ Courts Policy representatives</li> </ul> to inform assessment of implementation and planning processes
	Are the current governance arrangements and risk management practices between DCV, MCV, DoJ and other agencies appropriate?	Assessment of governance and risk management practices proposed and implemented Review of financial/risk management processes Review of documentation relating to relationships/partnerships with other service providers (e.g. Memoranda of Understanding, Service Level Agreements, etc.) Stakeholder feedback ( <i>NB stakeholders to be consulted to be agreed with MCV</i> )	DCV, <i>Drug Court Organisational Chart – Delinated by Direct Reports to the Program Manager</i> (DCV 2012) DCV, <i>Drug Court Key Service Providers</i> (DCV 2012) Risk registers DCV, <i>Risk Management Framework</i> (DCV 2013) Terms of Reference for earlier DCV Steering Committee Information relating to development of the Process and Policy Working Group Memorandum of Understanding between DCV and WAYSS Memorandum of Understanding between DCV and Victoria Legal Aid Memorandum of Understanding between DCV and Victoria Police Memorandum of Understanding between DCV and ACSO COATS DCV, <i>Drug Court Policy No. 2 – Program Eligibility &amp; Selection</i> (DCV 2012) DCV, <i>Drug Court Policy No. 3 – Program Catchment Area</i> (DCV 2012) DCV, <i>Drug Court Policy No. 4 – Screening and Assessment</i> (DCV undated) DCV, <i>Drug Court Policy No. 5 – Participant Requirements</i> (DCV 2012) DCV, <i>Drug Court Policy No. 6 – Program Structure</i> (DCV 2012) DCV, <i>Drug Court Policy No. 7 – Sanctions and Rewards</i> (DCV 2013) DCV, <i>Drug Court Policy No. 8 – Urinalysis &amp; Breath Testing</i> (DCV 2012) DCV, <i>Drug Court Policy No. 12 – Communications &amp; Media Policy</i> (DCV 2013) DCV, <i>Drug Court Policy No. 18 – Medical Certificates</i> (DCV 2013) DCV, <i>Victorian Drug Court – Magistrates' Training Manual</i> (DCV undated) DCV, <i>International Best Practice in Drug Courts</i> (DCV undated) Stakeholder consultations with: <ul style="list-style-type: none"> <li>DCV Magistrate</li> </ul>

Key evaluation question	Sub-questions	Evidence	Data source(s)
			<ul style="list-style-type: none"> <li>Other Victorian Magistrates</li> <li>DCV team members (including DCV Registrar, Case Managers, Clinical Advisors, VLA, WAYSS, SEADS and Victoria Police representatives)</li> <li>CTS and MCV Courts Policy representatives</li> </ul> to inform assessment of governance structure(s) and risk management practices
<b>Has MCV demonstrated efficiency and economy in relation to delivery of the DCV?</b>	Was the DCV delivered at the lowest possible cost without compromising quality?	<p>Analysis of DCV funding and expenditure data</p> <p>Comparison of the DCV with other problem-solving court initiatives</p> <p>Detail on approaches taken to minimise costs without compromising quality</p> <p>Assessment of appropriateness of cost of administration and management of the DCV</p> <p>Analysis of any improvements that have led to downstream efficiencies</p> <p>Results benchmarking using performance indicators to measure efficiency and economy</p> <p>Process benchmarking to provide information on the reasons for differing levels of performance</p> <p>Stakeholder feedback (<i>NB stakeholders to be consulted to be agreed with MCV</i>)</p>	<p>DoJ/MCV/DCV financial data related to the Court</p> <p>MCV backlog/waiting times (broken down by court location)</p> <p>DCV input and output data as recorded on the Platypus database between 1 July 2010 and 30 June 2013, including:</p> <ul style="list-style-type: none"> <li>Number of referrals received</li> <li>Number of referrals accepted</li> <li>Number of referrals rejected</li> <li>Reasons for exit</li> <li>Number of completers</li> <li>Average length of time on DTO</li> <li>Length of time between key decision points</li> <li>Offending history (at intake, discharge and follow-up)</li> <li>CBO/disposition within three years of referral to the DCV (at intake)</li> <li>Mental Health Assessment within three years of referral to the DCV (at intake)</li> <li>Number and nature of offences at time DTO imposed (at intake)</li> <li>Days spent in custody while on DTO (at discharge and follow-up)</li> <li>Subsequent offending while on DTO (and after, where data available (at discharge and follow-up)</li> <li>Imprisonment sentences (at intake)</li> </ul> <p>University of Melbourne, <i>Evaluation of the Court Integrated Services Program – Final Report</i> (University of Melbourne 2009)</p> <p>Desktop research findings</p> <p>Productivity Commission, <i>Report on Government Services 2013</i> (Australian Government 2013)</p> <p>Stakeholder consultations with:</p> <ul style="list-style-type: none"> <li>DCV team members (including DCV Registrar, Case Managers, Clinical Advisors, VLA, WAYSS, SEADS and Victoria Police representatives)</li> <li>CTS and MCV Courts Policy representatives</li> </ul>



Key evaluation question	Sub-questions	Evidence	Data source(s)
			to inform assessment of administrative effort involved, any efficiency improvement activities and general views of DCV efficiency

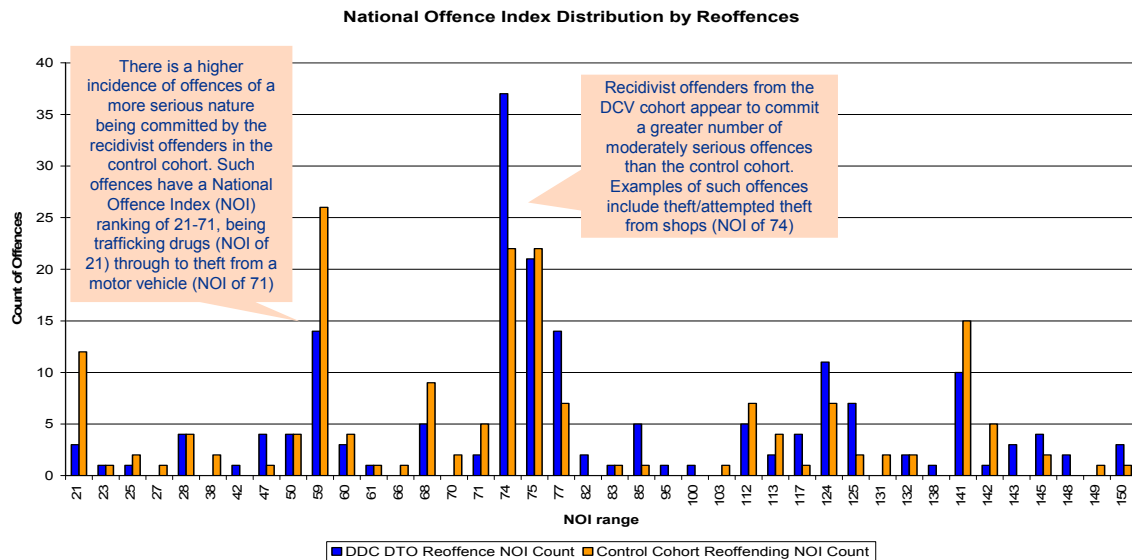
## Appendix B: Stakeholders consulted

An overview of stakeholders consulted for the purposes of this evaluation is provided below.

Stakeholder Group	Stakeholders
Drug Court Magistrate	<i>Drug Court Magistrate, Magistrates' Court of Victoria</i>
Other Victorian Magistrates	<i>Magistrate (and former Drug Court Magistrate), Magistrates' Court of Victoria</i> <i>Magistrate, Magistrates' Court of Victoria</i>
Drug Court Case Managers and Clinical Advisors	<i>Officer in Charge, Drug Court of Victoria</i> <i>Clinical Advisor, Drug Court of Victoria</i>
	<i>Case Manager, Corrections Victoria</i> <i>DCHAP Program Manager, WAYSS Housing &amp; Support Services</i>
Drug Court Service Providers	<i>Counsellor, Positive Lifestyle Centre</i>
Legal Representatives	<i>Drug Court Lawyer, Victoria Legal Aid</i> <i>Community Liaison Officer, Victoria Police</i>
	<i>Police Prosecutor, Victoria Police</i> <i>Registrar, Drug Court of Victoria</i>
Departmental Representatives	<i>Director (Courts Policy), Department of Justice</i> <i>Program Manager (Summary Crime) Victoria Legal Aid</i>
	<i>Managing Lawyer (Dandenong Office), Victoria Legal Aid</i>
Health and Medical Service Providers	<i>General Practitioner, South East Alcohol and Drug Service</i> <i>General Practitioner, Frankston Health Care</i>
Current Drug Court Participants	Thirteen current DCV participants were interviewed. Names of these participants remain confidential.

## Appendix C: Additional analysis

### Severity of reoffences according to National Offence Index (DCV and Control Cohorts)



## Appendix D: Recidivism study methodology

---

The following text is an excerpt from the Dandenong Drug Court Recidivism Study conducted by DoJ in October 2014.

The aim of the DoJ recidivism study was to measure reoffending rates from a cohort from the Dandenong Drug Court (DDC) with Drug Treatment Order (DTO) clients, against a matched control cohort from mainstream Magistrates' courts throughout Victoria.

### Methodology

Selection of the initial DDC cohort included clients who completed a DTO in lieu of an imprisonment sentence. The clients were selected from the Drug Court's internal database DRUIS, which is a client management database used to track and monitor clients. The extract consisted of 215 clients from DRUIS that commenced a DTO from 1 July 2006 to 30 June 2012.

The cohort was further narrowed to only include clients who had successfully completed their DTO by 30 June 2012 in the study. In total, 61 clients were included in the DDC cohort (a total of 77 clients had successfully completed their DTO, however 16 of the clients completed the DTOs post 30 June 2012).

A successful completion included the following: a) progression through the phases of a traditional graduation; b) completion of the two years and a final sentence of non-imprisonment; or c) cancelation of the DTO, as a reward for outstanding achievement at any time during the two years.

The monitoring period for the offending behaviour of the 61 clients commenced from the date of their successful DTO completion for a period of two years. The successful DTO completion date became the 'index date' for monitoring the offending behaviour of a DTO client.

The Magistrates Court of Victoria's database Courtlink and the Sentencing Advisory Councils (SAC) offender database were used to monitor the offending. The SAC database uses essentially the same data set as Courtlink, but enables a search to be performed by person (using one of the unique JAID or MNI identifiers) unlike Courtlink, which can only be interrogated case by case. A successful completion date of 30 June 2012 was selected for the DTO cohort because the SAC database is only current until 30 June 2014, DTO completions post 30 June 2012 could not be monitored for the required two year follow up period.

The results produced a list of first reoffences for each DDC cohort client, and contained the following fields:

- offence date,
- time to fail in days (difference between index date and first charge),
- offence description,
- national offence index (NOI),
- sentence disposition,
- sentence length,
- Courtlink case number,
- MNI,
- hearing date and
- court where hearing occurred.

This list was used to inform the recidivist status of each DDC cohort client.

A multivariate matching methodology as described by Rosenbaum and Rubin (1985), was then used to obtain a Control Cohort from mainstream Magistrate's courts throughout Victoria that are not involved in therapeutic jurisprudence. The variables used to produce a control group include,

in order of: the principal proven offence (PPO) associated with the index date, the number of proven charges at index, date of birth, gender, indigenous status where available, 24 months prior offending history (excluding charges struck out) and sentence outcome equal to imprisonment.

**Recidivism:** A person in this study is considered a recidivist from the date of their first offence resulting in a court conviction (a proven offence) during the follow up period.

## Appendix E: Participant interview responses

KPMG conducted voluntary interviews at Drug Court House in Dandenong with 13 DCV participants between 17-19 March, 2014. Participants were invited to participate by DCV staff. The participants were all active DCV clients and currently engaged in various phase of a DTO. De-identified answers to the questions participants chose to answer are summarised below.

Question	Response
<b>Introduction/Process</b>	
<b>Why did you agree to be involved in the Drug Court?</b>	<ul style="list-style-type: none"> <li>I promised my family members not to return to prison and when I was arrested and in the remand centre again I decided I'd lived the criminal lifestyle for too long and now was the time for a change.</li> <li>I heard of DCV from others who were on it and they recommended it to me.</li> <li>I lived in a circle of users where nobody wanted to change. In jail, I heard that the DCV gives help. I knew I had a drug problem. It's time to do something proper with my life.</li> <li>I heard out DCV from others when I was in custody. I've got kids and am over the jail thing. I've lost count of the number of times I've been in and out of jail – most times because of heroin use.</li> <li>I chose to enter drug court because I don't want to be remembered by my kids as a junkie. I had learned a lot of good things about from people who had been involved with it, even people who had been kicked off it.</li> <li>Someone in the cells told me about the different ways DCV does things. I'm getting older and I want to address my problems. I have a child now and I'm the primary carer.</li> <li>I'd committed a few crimes while on drugs and DCV was an opportunity to avoid incarceration and stay out of jail. I have several children and if I went to jail I would lose my kids.</li> <li>I was on a DTO before but didn't succeed. This time I was in a better place. I had a violent partner before and was heavily into heroin. Now I'm in a safer environment with my children.</li> <li>I had to try something different. I can't keep returning to jail. My barrister suggested DCV.</li> <li>I do believe I can change my life around with support and help from someone who understands my difficulties. I had to begin somewhere and do something.</li> <li>I agreed to join pretty selfishly [assume he wanted to stay out of jail]. I heard five years ago about DCV. I've been on the DTO before and this is my second time. The first DTO was more about harm minimisation for me. It made me more aware and I learned how to pull myself up.</li> <li>I've been to DTO previously and this time it was my only way not to go to prison. Last time I didn't graduate and this time I wanted to finish.</li> <li>I entered DCV to avoid a jail sentence and losing custody of my child. I've been on a DTO once before.</li> <li>I needed a change from my life of crime. I wanted to make a change.</li> </ul>



Question	Response
How often do you get to meetings, urine/breath tests and sessions with the Drug Court support staff?	<ul style="list-style-type: none"> <li>In phase 1 the urine tests are three times per week but they have backed off since I entered higher stages.</li> <li>I have about four appointments a week.</li> </ul>
Is there anything that stops you from attending your meetings and sessions at the Drug Court? Could this be fixed? How?	<ul style="list-style-type: none"> <li>I have no issues attending my appointments.</li> <li>I don't miss any appointments or have trouble getting to them.</li> <li>I am now able to get to DCV regularly. I used to live far away from DCV which made getting to Dandenong difficult. It was difficult, but manageable. I get here by bike and it takes 30-45 minutes. Sometimes I've been late but I call ahead and they tell me it's OK because they know I'm coming.</li> <li>I pretty much get to all my appointments. My Case Manager helps me get a schedule and a routine.</li> <li>I am able to make most appointments but I have missed some because I was sick.</li> <li>Phase 1 was a struggle to attend but during Phase 2 it became easier and easier.</li> <li>Unless I'm ill I attend all appointments.</li> <li>I've never missed a test or appointment. I actually come an hour early to my tests to be sure I'll be on time. The testing and weekly/fortnightly meetings are good.</li> <li>Appointments are busy there are lots but it's not too bad. Not overwhelming. I have missed three appointments because I relapsed. I take painkillers and that can confuse you and make you lose track of time.</li> <li>At the beginning, the first month is intense and it's very hard to find your way around. I made all my appointments though. I struggled though because I had a child at school and fitting appointments around that was hard.</li> <li>I get to meetings OK the numbers of appointments are OK.</li> <li>I make pretty much all my appointments. When I miss them, it's because I don't have money for transport.</li> </ul>

Question	Response
Do you find being involved in the Drug Court a good use of your time?	<ul style="list-style-type: none"> <li>• Yeah, it's definitely a good use of my time.</li> <li>• Yes. I had an injury which prevented me from working and DCV helped me fill my time.</li> <li>• think the DCV is a good use of my time. I learn all different things.</li> <li>• At the beginning the scheduling was intense but now I realise it was a good use of my time.</li> <li>• Yes. DCV is a good choice and use of time.</li> <li>• Yes.</li> <li>• Yes. I enjoy the sessions. If I didn't enjoy it I'd probably breach the order.</li> <li>• Appointments are a good use of my time. It makes you accountable. Before, you'd just go home and forget about life.</li> <li>• Yes.</li> <li>• It's maybe not a good use of my time but it keeps you busy, which is a good thing when you're on drugs.</li> <li>• Sometimes it's a good use of time. It stops me from working though.</li> </ul>
<p>Are you ever stressed, anxious or concerned about going to the Drug Court?</p> <p>If yes, how much so?</p> <p>How do you cope?</p>	<ul style="list-style-type: none"> <li>• I get stressed only if I've been doing the wrong things!</li> <li>• I don't get stressed or anxious about coming to drug court.</li> <li>• I don't get stressed about coming to drug court. They are all really good people who know how to help people who help themselves.</li> <li>• DCV doesn't stress me or make me anxious.</li> <li>• I have less stress and anxiety about going to Drug Court than other courts. There is more certainty. You know what you've done and not done.</li> <li>• At first there was some stress because there were so many appointments.</li> <li>• No.</li> <li>• No. I've never breached my order and seen the bad end of DCV.</li> <li>• Before I had anxiety about coming to Drug Court because I knew I'd been doing the wrong things. Now I've been good so I'm not stressed. [2<sup>nd</sup> time participant has been on a DTO]</li> <li>• It's stressful if I've done something wrong. If I have I either skip, or I use before I come, or I just face the music.</li> <li>• I get a little stressed and anxious before coming here. You see people from the past who can influence you. I come and go as quickly as I can so I don't have to be around them.</li> <li>• Sometimes I get stressed coming to DCV. When that happens I just deal with it I guess.</li> </ul>

Question	Response
<b>Background</b>	
<b>How is Drug Court different to other times you have been in court?</b>	<ul style="list-style-type: none"> <li>• When you're in DCV you're trying to deal with your problem, you get a lot of support.</li> <li>• Mainstream courts are all about punishment, DCV is about rehabilitation.</li> <li>• Coming to DCV is different. You get to interact with the judge more.</li> <li>• DCV is different. I have relapsed a few times but the Magistrate is flexible. He understands that it's hard to stop. Parole officers wouldn't understand.</li> <li>• It is court, but it's not like [regular] court. It's friendlier and you're not only attending for crimes.</li> <li>• DCV has a different atmosphere to regular court. They talk to you, not at you. They explain everything where in regular court they ignore you.</li> <li>• Yes there is a big difference. In regular court I feel like a proper criminal. Here I don't feel like that.</li> <li>• Regular court is a kangaroo court. The judge already knows before you show up what he's going to sentence you to. They know what sentence they're going to give you.</li> <li>• In mainstream court it's more harsh. There is no room for reason. They don't care about your history or that you're trying to change. It's cut and dry to them. The DCV sees that you're trying to change.</li> <li>• DCV is friendlier. They understand you a bit better.</li> </ul>
<b>Has being involved in the Drug Court changed the way you view coming to court? How?</b>	<ul style="list-style-type: none"> <li>• Yes, it's changed my views on a lot of things. I used to hate the coppers and the judge, now I have more respect for them and what they do.</li> <li>• I feel more comfortable in court.</li> <li>• DCV has changed my view of court. In DCV, you know you'll get a chance. I would often lie in regular court but I'm able to be honest about my using at DCV</li> <li>• I'm more trusting now of the judge and the people helping me.</li> <li>• Yes. Before DCV, judges looked at me as a criminal. A criminal is a criminal. They can't change. In DCV, I feel like I have a chance. They are willing to help.</li> <li>• I've changed my view of the police and the Magistrate. The regular Magistrate just want to know if your guilty or not guilty. I used to hate the police too but now I got more respect for them. I certainly wouldn't want to live in a world without them.</li> <li>• Coming to DCV has changed my views on the whole justice system. I was on parole before and I did no good at that. It was too black and white.</li> <li>• Sometimes I like the DC.</li> </ul>

Question	Response
<p><b>Do you find the way you deal with the Drug Court magistrate different to regular court magistrates? How?</b></p>	<ul style="list-style-type: none"> <li>• Yes the Magistrate respects me more</li> <li>• I feel real comfortable around [Magistrate], we talk like normal people. He gets involved a lot.</li> <li>• You get to interact with the judge more. I've done well and moved through the phases. When I moved to the next phase [Magistrate] said congratulations and shook my hand! This was the highlight of my life. I was thinking "I got to shake a very important man's hand." That means a lot to me. I can't say enough good things about the program.</li> <li>• When I have issues, I can discuss them with the Magistrate.</li> <li>• The Magistrate is more understanding.</li> <li>• The Magistrate is fair and abides by right and wrong. You have a chance to get to know him which is different from other courts.</li> <li>• I know what's going to happen here. I know if I've been good or bad and know what to expect.</li> <li>• The Magistrate looks at me as an individual not as a number. He's very stern but understands the world around you.</li> <li>• I feel like I'm back to school again. I have a teacher [Magistrate] that cares. In regular court, the teacher don't care. [Magistrate] sees that if you are willing to change he will support you all the way.</li> <li>• When I was promoted, the judge shook my hand and I was so happy. I was thinking, "is this court?"</li> <li>• At DCV you can have a conversation with the Magistrate like he is an average Joe person. He gets to know you and shows compassion.</li> <li>• This Magistrate listens more.</li> <li>• The Magistrate and I can talk more freely</li> <li>• I get scared of regular Magistrates. The DCV Magistrate is more understanding. I can talk to him.</li> </ul>
<p><b>What does the Drug Court do that other courts don't?</b></p>	<ul style="list-style-type: none"> <li>• Everyone is pretty easily accessible; you get a lot of support. If you like using, you just ring your case manager and have a talk with him.</li> <li>• Programs in jail are nothing like DCV. They give you biscuits and tea and talk crap. I've had other counsellors before and tried to trick them. I'm more honest with the DCV counsellors. I want to help myself and the DCV counsellors here are good.</li> <li>• The hearings are different. You have your support workers there and you get a chance to sit down.</li> <li>• You're not treated poorly here. You have a good experience in court which makes you want to do well.</li> <li>• DCV has changed the way I see being a bad person. I've seen the value of myself. This is the most important thing. Back then I saw no value in myself. DCV doesn't treat me like a criminal. For the first time in 26 years, I feel respected in court.</li> </ul>

Question	Response
	<ul style="list-style-type: none"> <li>• We had a BBQ and got a chance to interact with the Magistrate. He's a normal person. He's the first judge I've ever talked to.</li> <li>• I like being able to speak and give my side to the Magistrate.</li> <li>• They get involved. Regular court doesn't get involved.</li> </ul>
<p><b>What do you like most about the Drug Court? Is there anything you don't like?</b></p>	<ul style="list-style-type: none"> <li>• The level of support is what I like most. I don't like the urines but know it's something I got to do.</li> <li>• I like that there is a lot of help here. There is a lot of support. I don't like coming in three times per week but I know I need it.</li> <li>• I like the counselling sessions and being able to say things you can't talk to your family about. They give you chances and enough intense support at the beginning when you're trying to change. I don't like coming in three times a week for urines (laughs)</li> <li>• I like that if you want to be here and do well that the support is here. The staff will go out of their way. I wouldn't change anything.</li> <li>• DCV is great because you get to go home at the end of the day. I like that.</li> <li>• It doesn't need any changes.</li> <li>• What I most like is the fishbowl reward. I first received a clap. Then I got to skip a review which made me so happy. The third reward I got a Coles voucher and I couldn't believe it. I was like, "is this real?" Then everyone clapped and I blushed.</li> <li>• I like the gardening program which is packed. They should organise more programs for us. Drug users like learning new things. I think Narcotics Anonymous should play a bigger role in DCV. I know it's not for everyone but it's really helped me. I want to get off methadone and get away from going to the chemist every day. It's a bad meeting place.</li> <li>• I don't like how they make us wait around together before going to court. You meet the wrong people and sometimes someone has something and will try and get you to go and use or get up to something. I think the DTO needs to be longer than 2 years. When I was on the DTO last time I didn't graduate. Two years wasn't long enough. By the end I was just coming to terms with the changes. When I finished the order I relapsed. People should be allowed to stay on until they graduate or have their order cancelled. I felt lost when it was cancelled. I like the support they provide.</li> <li>• I like the support most and having someone to talk to. I don't like DCV because sometimes I want to play up but it makes you accountable.</li> <li>• Drug Court gives me something to do. I don't like not being able to work.</li> </ul>
<b>Health and Wellbeing</b>	

Question	Response
<p><b>Has the Drug Court helped you find or talk to:</b></p> <ul style="list-style-type: none"> <li>• <b>Drug and Alcohol counsellor?</b></li> <li>• <b>GP/doctor?</b></li> <li>• <b>food or clothing?</b></li> <li>• <b>medication?</b></li> <li>• <b>housing (i.e. accommodation, housing services)?</b></li> <li>• <b>lawyer?</b></li> <li>• <b>employment assistance?</b></li> <li>• <b>income support?</b></li> <li>• <b>mental health services?</b></li> </ul>	<ul style="list-style-type: none"> <li>• DCV has helped me find a drug and alcohol counsellor, GP, get medications. When I first started my DTO, I was living with my partner and child in emergency shelters. For the first four months I saw it as an opportunity for selling drugs but the environment there wasn't any good. People would fight and kick down doors at night. I used to stay out all night just to get away from it. The DCV helped me get into transitional housing through the Department of Housing. The participant now knows their neighbours who they have a really good relationship with. They are moving and for the first time the neighbours have said they are very sad and upset the family is leaving. This is surprising for the participant as he never thought anyone would consider them good neighbours. DCV has opened so many doors for me. They organised a 3 month photography course for me and my photos were displayed at Drug Court House. I was amazed to see my photos on the wall. I've done some speeches at secondary schools speaking in front of 200 people. I've become a volunteer at x as well. I've started a lot of stuff I never thought I'd be doing. I'm also considering starting a Certificate in x for x company.</li> <li>• DCV have given me help with counselling and help with housing. They have linked me with WAYSS and through them I have found housing. They have also helped me with employment by teaching me how to look for work, how to do up a CV. I haven't had this help before.</li> <li>• DCV connected me with WAYSS. When I first started my DTO I had no idea what was going on. I had a pile of things I was supposed to be doing on this order. The WAYSS worker explained how DCV worked to me, what my clinician does, what my case manager does. WAYSS helped me get a house which was so empowering. I have bills in my name! I've achieved something. I'm attending an amphetamine course three times per week. It's a matrix course where you bring a family member in. I've done it voluntarily but I think everyone should do it at DCV. They have good strategies to help with urges. [Magistrate] has also offered to help me stay away from [someone] who is a user. He's offered to get an intervention order to make them stay away from me.</li> <li>• I've got housing through WAYSS. Before DCV I always had to rehabilitate myself. Having DCV staff to talk to was really supportive. I'm seeing a Drug and Alcohol Counsellor and a psychologist for my anxiety and depression. I have a mental health plan through my GP and DCV is arranging some heavy sessions with psychologists to assess whether I have a serious brain injury.</li> <li>• DCV has helped him get a doctor who prescribes him his medication.</li> <li>• Since I started the order I've got housing and medical support. I'm on anti-depressants now and am seeing a psychologist regularly. DCV has helped me get a larger house away from my ex-partner who is abusive. My Case Manager helps discuss life with me, where I'm at and how I feel.</li> </ul>



Question	Response
	<ul style="list-style-type: none"> <li>I have a counsellor now and housing support through WAYSS. I'm receiving dental health support.</li> <li>I have a counsellor through the DCV. [Case Manager] is my big brother. He is very supportive of me. I have this problem of going blank and confused. When I first started the program [Case Manager] taught me to think clearer. [Case Managers] are more like psychiatrists. Instead of saying "you have to do this and you have to do that" they help me to think for myself. I had a house before and still do. Participant has legal aid through DCV.</li> <li>Participant found a full time job with help of DCV.</li> <li>DCV has got me a counsellor who puts things right for me. She's great and so is my Case Manager. Getting off methadone really scares me. My Clinical Advisor has helped me make a plan for that. I'm seeing a worker over at REES who is looking into getting me work once I'm in Phase 2. That's what I'm aiming for.</li> <li>DCV set me up the first time with medication and housing through WAYSS. Before DCV housing was my biggest problem. DCV helps me structure my days for me which stops me from getting bored. Getting bored is really bad for drug users. They run courses and help me out with general living things.</li> <li>The first time I was in DCV they helped me with accommodation and getting a GP. [participant still has both of these] My teeth are being fixed too.</li> <li>DCV got me a house through WAYSS and got me on rehab.</li> </ul>
<p><b>Did someone from the Drug Court help you get into these services?</b></p> <p><b>How? (i.e. referral, contact information, other?)</b></p> <p><b>What did your Case Manager and/or Clinical Advisor do to assist you get access to these services?</b></p>	<ul style="list-style-type: none"> <li>My Case Manager and Clinical Advisor helped me get these services. They have given me a lot of support. My Case Manager is hard enough on me and when I have problems he asks me what the issue is and tries to solve it with me.</li> <li>My Case Manager helped me and set up the courses at DCV.</li> <li>DCV has helped me get involved with the community vegetable garden at DCV. It's a small patch, I know, but I want to help get the veggies grown.</li> <li>My Clinical Advisor helps me get a doctor and my Case Manager helps with housing and food when I need it.</li> <li>I was referred to these services by my case manager and clinical advisor.</li> <li>Case Manager</li> <li>Case Manager</li> <li>Case Manager &amp; Clinical Advisor referred</li> <li>Case Worker referred me to WAYSS and gets me involved in courses.</li> <li>My Case Manager and Clinical Advisor helped me with these things.</li> <li>Case Manager referred participant to WAYSS.</li> </ul>

Question	Response
	Case Manager and Clinical Advisor help me by referring me and making calls for me.
<p><b>Before the Drug Court, had you recently (say, in the last two months) had any of the following supports?</b></p> <ul style="list-style-type: none"> <li>• <b>Drug and Alcohol counsellor?</b></li> <li>• <b>GP/doctor?</b></li> <li>• <b>food or clothing?</b></li> <li>• <b>medication?</b></li> <li>• <b>housing (i.e. accommodation, housing services)?</b></li> <li>• <b>lawyer?</b></li> <li>• <b>employment assistance?</b></li> <li>• <b>income support?</b></li> <li>• <b>mental health services?</b></li> </ul>	<ul style="list-style-type: none"> <li>• I was living in emergency accommodation before DCV. I was employed before as well, I've always worked, even when dealing.</li> <li>• Before DCV, I had a GP but no counsellor or lawyer</li> <li>• I had housing but it was in a very bad environment living with my relatives. I lived in a drug house in a circle of users.</li> <li>• A had a doctor when I was in remand who prescribed me my methadone. He was really good.</li> <li>• I was homeless before my DTO and in and out of transitional housing. Before the DCV I've always had to rehabilitate myself.</li> <li>• Before DCV I had no counsellor. I live with my parents, partner and child.</li> <li>• Before DCV I lived in three-bedroom house which was small for my family.</li> <li>• I had a counsellor before but I had a relapse and ended up reoffending.</li> <li>• I had my own GP before who I still see. I had housing before which I still have.</li> <li>• I had an existing house which I still have.</li> <li>• I had housing before living with a family member and still do.</li> <li>• I used to live in a boarding house [prior to first DTO] and living there is the same as jail.</li> </ul>
<p><b>Is there any help that you think you need from the Drug Court, but haven't been able to get?</b></p>	<ul style="list-style-type: none"> <li>• No</li> <li>• I get all the help I need here.</li> <li>• No</li> <li>• No</li> <li>• No, DCV has helped me with everything I need.</li> <li>• No</li> <li>• No</li> <li>• DCV has helped me reach all my goals and filled all my needs.</li> <li>• Money can be an issue but DCV doesn't provide this anymore. I think people took advantage of it.</li> <li>• No</li> </ul>
<p><b>Has your behaviour or the</b></p>	<ul style="list-style-type: none"> <li>• Yes. I don't associate with my former friends. I tell them I'm not doing any of that stuff anymore. I now think before I do something and weigh</li> </ul>

Question	Response
<p><b>way you live your life changed since you have been with the Drug Court?</b></p> <p><b>Yes/no?</b></p> <p><b>If so, how?</b></p> <ul style="list-style-type: none"> <li><i>Consider any of the following:</i></li> <li><i>Daily routine and activities</i></li> <li><i>Social interactions (who the participant socialises with and how)</i></li> <li><i>Sleep patterns</i></li> <li><i>Diet</i></li> <li><i>Physical activity</i></li> <li><i>Relationships</i></li> <li><i>How the participant feels about life generally</i></li> <li><i>How the participant behaves towards/gets along with others</i></li> </ul>	<p>the pros and cons. I've restarted relations with my child. I want to be a good role model for them and be a good influence for the family.</p> <ul style="list-style-type: none"> <li>I am much more positive now. I wake up feeling I have a purpose. I feel wanted and needed. I sleep and eat better now.</li> </ul> <p>My relations with my partner are better now as well. Before, when I was using, I put them through hell.</p> <ul style="list-style-type: none"> <li>I juggle my days between organising my house and my life, my appointments at DCV and the veggie garden at DCV. I have to help get the soil right.</li> </ul> <p>My life has been changed now I keep my blinkers on. I don't steal anything and don't have a criminal mind anymore.</p> <p>Before I was suicidal but I decided I'm a good person and I'm going to break this cycle. But I have to be on guard to make sure I don't slip. I have to break years of patterns and the structure of DCV helps me.</p> <p>Before the DTO, my attitude was "I don't want to change."</p> <ul style="list-style-type: none"> <li>Before, I was in a cycle, I would be in jail for 2/3 weeks and then get out, start using, and end up in prison again. I was having to take part in crime to get the money I needed for drugs. It consumed my life.</li> </ul> <p>I see my kids nearly every day now, before I didn't see them at all and barely saw my parents. When I was using, my family kept my kids away from me.</p> <p>My parents are getting old, me being clean has helped my relations with them. I'm aware now that using was making my parents suffer.</p> <p>Before, when I tried to get clean I would just give up and go and use but now I know it all comes down to me, I know myself a bit better.</p> <ul style="list-style-type: none"> <li>My behaviour has changed. When I've used on the DTO, my Case manager has helped me get clean again. Life in general is good at the moment, my newborn child has changed my life. Now, I wouldn't even consider dealing drugs.</li> </ul> <p>I used to drive without a license without a care. Now I don't even consider it. I'm not going to jeopardise going back to jail.</p> <p>My relationship with my parents is now much better. We do out together for lunches. Before I wouldn't do that because I was afraid my mum would find out I was using.</p> <ul style="list-style-type: none"> <li>When I got the DTO, I didn't realise I had a drug problem. I was a weekly user and didn't realise the knock on effects it had on my life.</li> </ul> <p>My whole life has changed, my kids are happier and I see my brother and mum more often. I cope with day to day life much better and have the motivation to keep going.</p> <p>I have a feeling of confidence. I now have enough confidence to go back to school and study at university. I hope to study Law at university.</p> <ul style="list-style-type: none"> <li>Yes. I'm more relaxed than before and I think before I do things. My counsellor helps me get things out and I've learnt I can trust the people helping me. I've had depression in the past but I'm now quite happy.</li> <li>My behaviour has changed. I've never been given a chance like this before and don't want to blow it. I got two years jail hanging over my head [which motivates the participant to change].</li> <li>Before I entered this program I had no hope. I actually wanted to become worse than I already was. Nothing mattered back then. My</li> </ul>

Question	Response
	<p>work didn't matter. Time didn't matter. Appointments didn't matter. I had no time management.</p> <p>Drug court is helping me see real life and that there's more to life than using. It's taught me to think before I talk and act, respect others and be a part of the community. I've done it all by myself.</p> <p>(Case Manager) encouraged me. He gets in my head and makes me realise I'm not worthless. I'm not useless. I can speak multiple languages.</p> <p>I had been unemployed before for a long time. Since starting the DTO I got a job at x where I've been working ever since. I work on commission and am very competitive. I'm not useless.</p> <p>My old crowd is still trying to lure me in. Now I send them away and talk to [Case Manager] about this.</p> <p>I now see the importance of time. My partner is seeing more of that. I see the value of working and earning commission is much more rewarding than any hit of speed or ice.</p> <p>I sleep better.</p> <p>Since I came into DCV there is hope for me. Before there was no hope. My life was using, life on the street being a mule. Each time I went to jail I came out worse.</p> <p>I'm closer with my family but I still have a way to go before things will be back to normal. DCV helped me to be OK around normal people.</p> <p>I have saved money and within two months I have bought a car! I now enjoy the things I do. I'd like to go on holiday and see other countries.</p> <p>If I didn't get into DCV I think I would be dead on the street or in jail.</p> <p>I do normal things now like gardening. I built my own Japanese garden which was difficult. I work 9-5 and then spend my commission which is very rewarding. I take my partner out for dinner once a week. Spending my own money instead of shortcut money is very rewarding.</p> <ul style="list-style-type: none"> <li>• My relationships with my friends have deteriorated since I stopped using. I've pulled away from people.</li> </ul> <p>My family relationships have changed. My daughter says I always have more energy and am happy to play.</p> <p>Since I got off drugs I can feel the energy that I've never had. I'm a lot more positive about life. Before life was bleak.</p> <ul style="list-style-type: none"> <li>• No drastic changes. I don't socialise with anyone anymore. My family relationships aren't so good but they weren't good before either. I don't get along with my mum or dad. They think I'm just a junkie.</li> </ul> <p>I used to shoplift and thief. I was a kleptomaniac. Now I don't do that anymore.</p> <p>I'm working as well.</p> <ul style="list-style-type: none"> <li>• Yes. I usually sleep better but I haven't slept in four days right now. I relapsed on the weekend.</li> </ul> <p>My diet is better.</p> <p>Some relationships with friends and family are better.</p> <p>My outlook on life is just OK. But that's OK. It's OK to be OK.</p> <p>I went to rehab which helped.</p> <p>I don't commit any crimes. I don't want to get locked up.</p>

Question	Response
<p><b>Have you made changes to your drug and/or alcohol use since being on a Drug Treatment Order?</b></p> <p><b>If yes, can you describe the change?</b></p> <p><b>What made you make these changes?</b></p> <p><b>If no, is there anything that has prevented you from making these changes?</b></p>	<ul style="list-style-type: none"> <li>I'm now eight months clean. I've had trouble sacking the marijuana and haven't completely kicked it but my use is minimal compared to what it was. When I first started the DTO I wasn't taking it seriously. I was clocking up sanction after sanction and ended up being locked up over Christmas. I was doing stupid things, not thinking before doing stuff.</li> <li>I have made huge changes. I have stopped taking all drugs for six months now. Before, I was taking cannabis every day, heroin as much as I could. Now I am on methadone and have stopped taking heroin and marijuana. I've used benzos but have stopped drinking alcohol altogether as well.</li> </ul> <p>I've made these changes because of Drug Court. The rewards and sanctions have especially influenced me and helped me make the changes.</p> <ul style="list-style-type: none"> <li>I still struggle a bit with drinking. When I first got my own place I was drinking a slab of beer a fortnight but after a couple of months I thought "I don't need this." I worried I was replacing the drugs with alcohol so I stopped the drinking altogether.</li> </ul> <p>I relapsed for a couple of weeks while on the DTO when I was moving house with x who is a user.</p> <p>I'm on methadone and that really shits me.</p> <p>I feel good within myself, I've made lots of changes.</p> <ul style="list-style-type: none"> <li>I would use before because of the people I was associated with. I was up all day and all night chasing and using heroin. I was using all day every day, 365. I was using about 7 grams of heroin a day.</li> </ul> <p>I haven't been 100% drug free. I've used methamphetamine probably twice and used heroin maybe five times since being on the DTO. Compared to using 5 times a day it's alright. Now though I've been months clean and am doing pretty good.</p> <ul style="list-style-type: none"> <li>I have relapsed a few times since starting the DTO, but I've been mostly clean.</li> <li>I had smoked marijuana for 20 years but now I don't anymore. I also used to use ice occasionally but not anymore.</li> <li>Before I was heavily into heroin but now my drug and alcohol use has stopped completely.</li> <li>I've dramatically changed my drug and alcohol use. I don't do needles or powders anymore. I still occasionally smoke marijuana.</li> <li>I was a heavy drug user with heroin and ice. I saw no value in myself. Just using ice and heroin all day long.</li> </ul> <p>Now I am totally off it. I have no cravings and am not tempted by my old crowd.</p> <ul style="list-style-type: none"> <li>I was on heroin and painkillers for years.</li> </ul> <p>I've stopped using marijuana and have been taking way less pills but I still struggle to get past 10 days clean.</p> <p>I'm on an alcohol ban which I asked for. In the last five months I've only had four or five drinks. I know alcohol is one of my triggers.</p> <ul style="list-style-type: none"> <li>I've made big changes. Before I used pills nearly every day. Now I only use about once a month. I'm using the same drugs but not as much.</li> </ul>

Question	Response
	<p>Participant attributes changes to the frequent testing and sanctions.</p> <ul style="list-style-type: none"> <li>I've stopped smoking marijuana and taking drugs. I don't drink or take pills anymore. I don't use heroin as much anymore – only every six months or so. I made these changes because someone is making me take responsibility. My case manager will ask me why I did it. I used last week and the Magistrate made me write answers to four questions instead of giving me sanctions. This really helped.</li> <li>I used to take drugs every day but now I take them much less – only occasionally.</li> </ul> <p>I take them less because I understand my problems and the drugs better. It's usually because of who I'm with and where I'm at</p>
<p><b>Has your overall health changed? Is it better or worse now?</b></p>	<ul style="list-style-type: none"> <li>My health is better. I don't think about using drugs anymore.</li> <li>My health has improved. I get around on my bike and riding my bike is good for my hips. If I had to walk here I'd be stuffed and need a weekend in bed.</li> <li>Overall my health has improved, when I don't use my Hep C doesn't come up. [Since starting the DTO] my liver test have been OK.</li> <li>My overall health is much better.</li> <li>My overall health is improving and I have more energy.</li> <li>I was in poor health at the start of my order but that's now improved.</li> <li>Sometimes I get anxiety and depression.</li> <li>My overall health has improved. I have a lot more energy which makes me happy. I am smiling more. I like smiling. Food gives me the energy to be happy.</li> <li>When you get housing your stress goes way down and so does your using.</li> <li>My health is good although I'm sick at the moment. I have less dental pain.</li> <li>My health is better overall.</li> </ul>
<p><b>Do you do anything different to avoid getting into trouble now?</b></p> <p><b>Is this because of the assistance you received?</b></p> <p><b>If so, was there anything in particular?</b></p>	<ul style="list-style-type: none"> <li>I avoid people I used to associate with. I think before I act and weigh the pros and cons.</li> <li>I stay at home more instead of going out. I meditate as well.</li> <li>I've severed my ties with my negative brother who is a user and a bad influence. I've come good and I feel better. Now I tell him not to use in front of me and try and stay away from him. We're not mates anymore. Sometimes when he tries and come over I play possum and turn off the lights and lock the doors.</li> <li>I don't involve myself with addicts anymore which helps me stay clean. I try and tell my using friends to get clean.</li> <li>I stay away from people who are bad influences.</li> <li>I don't associate with people who are negative influences and I only associate with my family who are very supportive</li> </ul>



Question	Response
	<ul style="list-style-type: none"> <li>I don't put myself in positions where I get into trouble anymore.</li> <li>I've asked dealers not to contact me but if they need money they still call.</li> <li>I think before I act now. Before I didn't do this I was just stoned all the time. I used to be scared to open the door when someone knocked because I'd be using. It's nice to be able to open the door without being scared.</li> <li>No.</li> </ul>
<b>Improvement</b>	
<p><b>If you knew someone else who was eligible for the Drug Court, would you encourage them to participate in it instead of a normal court?</b></p> <p><b>Why or why not?</b></p>	<ul style="list-style-type: none"> <li>I would encourage people to participate in Drug Court only if they were serious about change. People need to be ready.</li> <li>I definitely would encourage others to participate in DCV and tell them that DCV has been a very positive thing in my life.</li> <li>I would encourage others to come to the DCV.</li> <li>I would encourage someone to participate if they were doing it for the right reasons (i.e. they wanted to make a change rather than solely avoid jail).</li> <li>I would definitely recommend those who are motivated to use the Drug Court.</li> <li>I would most definitely encourage others to participate in DCV.</li> <li>I have already recommended DCV to others.</li> <li>I have already recommended others to join DCV.</li> <li>DCV really works for me so I would recommend it. I referred a lot of people here. They didn't believe something like this exists. Do you know how happy people from the Westside would be if they knew something like this exists?</li> <li>It depends on the person and where you're at in life but I would recommend it. Before [on first DTO] I just wanted to stay out of jail.</li> <li>I would recommend the DCV depending on the person. You have to want to change. DCV is only for people who really want to change. Last time I stuffed up toward the end of the DTO.</li> <li>I try and encourage people to participate in DCV and come here.</li> </ul>
<p><b>What are the best things and the worst things about the Drug Court for you?</b></p>	<ul style="list-style-type: none"> <li>The best things for me have been the photography course and the level of support and encouragement. If you have problems they try and solve them for you. Before when I tried to change by myself I would end up falling in a heap. The worst thing is the urines.</li> <li>The best thing is the help and resources at DCV. The worst was the beginning stage. I had difficulty getting used to the DTO and stopping using drugs.</li> <li>I don't think there are any bad things about the DCV. This is the right way to help people, they can't take people out of their life and put them in jail.</li> </ul>

Question	Response
	<p>I would recommend they make participants attend the amphetamine course as it has been helpful. Another suggestion is having a mentor program which would help for the young people. Hearing someone say I've been 5 years clean, 10 years clean is really inspiring. I've helped some young people out who don't know nothing.</p> <ul style="list-style-type: none"> <li>• When I first started DTO it was really hard. You can't work due to all the appointments three/four times per week. Not working makes it hard because paying boarding house rates uses all your new start allowance. More financial resources from DCV for things like transport and food would help. Sometimes I have had to borrow money to get to appointments and go to WAYSS to get food vouchers.</li> <li>• Best thing about DCV is the supports available and having someone to talk to always. The worst thing is the three times per week urine tests [laughs].</li> <li>• The best things are the changes you can make to your life. There are no worst things, I'm all for drug court. It's better than jail (laughs). My ex-partner is in and out of jail and doesn't get the support he needs.</li> <li>• The best thing is knowing your being set up to live on your own, clean and without needing the people behind you. The worst thing is all the appointments at the beginning.</li> <li>• I've been going to jail for over 30 years and believe this [the DCV] is a better solution.</li> <li>• There are quite a bit of best things. Sharon [legal aid lawyer] is very supportive. More supportive than my old private lawyer. The best thing is the staff are really helpful. They don't look down on you. They are honest and direct. All staff are very supportive. Their words are very profound. Like you see in a movie. I think all the staff should get a raise! Worst thing is the timing of the tests. I show up one hour early for tests but I have to wait around until 930 to do my test. Sometimes, if the nurse is here and not doing anything she will let me take my test early but sometimes they say it is policy to wait until 930. I am managing work and DCV so time is important.</li> <li>• Me myself. That's the biggest change. Best part about DCV is the way they treat you. When case workers applaud you, you walk away on a high. You know you've achieved something and that helps you get through the next day. Worst part about DCV is bumping into people you knew in the past. Sometimes you know people from the past who you don't agree with.</li> <li>• The worst is waiting in court as I see people I don't have anything in common with anymore. The best thing is the support. Having someone to call and help organise things for you. When I call, my Case Worker answers 90% of the time.</li> <li>• The best thing is being made accountable for my actions. The worst thing is all the appointments. I hate counselling. I've been doing it since I was very young. The urines are OK.</li> <li>• The best thing is DCV is giving me a second chance at life. The worst is all the appointments stop me from working. I want to go out and work but all these appointments means I can't.</li> </ul>