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Department of Justice

office of crime statistics and research

ADULT CARDS

FINAL EVALUATION REPORT

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Kevin Harkin, Bevan Fletcher and Bev O'Brien

Office of Crime Statistics and Research
South Australian Department of Justice
G.P.O. Box 464
ADELAIDE SA 5001

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Executive Summary

This report is the final evaluation report of the South Australian Court Assessment and Referral Drug Scheme pilot (hereafter CARDS).

Description of the Scheme

CARDS is designed to refer individuals whose offending is believed to be drug-related to drug assessment and treatment. It targets defendants appearing before a Magistrates Court who are deemed suitable for release on bond or bail, and who have been assessed as being likely to benefit from some form of drug treatment. The Scheme targets offenders that may fall between the gaps of prior established diversionary and court-based programs, such as the Police Drug Diversion Initiative (which targets simple possession drug offences) and the Drug Court (which targets serious drug-related offending).

The Scheme operated as a pilot from June 2004 to June 2006 and it is this period which the evaluation covers. The pilot sites, which commenced at staggered intervals, were the Magistrates Courts at Port Adelaide (including the Nunga Court), Adelaide and Murray Bridge. Later in this period further Magistrates Courts commenced involvement in the Scheme. A range of staff including a coordinator, assessors and administrative support were appointed and together formed the CARDS Team.

Designated criteria determine whether a defendant is eligible to participate. These include that the defendant's involvement in the Scheme is voluntary, that the offence is drug-related in some manner, and that the offence(s) for which they are before the court are summary or minor indictable in nature. Individuals with a history of violent offending are generally ineligible, as are those for whom alcohol is the principal drug related to their offending.

Referral of a defendant to CARDS is most commonly provided by a magistrate when the offender is attending court on new charges. Solicitors and police prosecutors also provide an avenue of referral, whilst self-referral is also possible. When a referral to CARDS is received, the matter is adjourned for an assessment to be undertaken by a CARDS assessor regarding the defendant's suitability for the Scheme. The magistrate receives this assessment and the assessor's recommendation as a report. If the magistrate chooses to accept the defendant to CARDS, they may do this at either the stage of pre-sentence, via an adjournment or bail, or post sentence, via a bond condition.

Once referred and accepted onto the Scheme, participants must attend four sessions of drug counselling within a three-month to satisfy the requirements of the Scheme. Drug and Alcohol Services South Australia (DASSA) is the primary agency contracted to provide drug treatment. Under the model, failure to comply is in breach of the bond or bail conditions and could result in a defendant's arrest and having the matter brought back to court. Compliance may also be considered in the sentencing of a defendant.

Evaluation Scope

An evaluation of the pilot Scheme was undertaken by the Office of Crime Statistics and Research (OCSAR) during the period of the pilot from June 2004 to June 2006. The evaluation focuses on both CARDS processes and outcomes and was based on a mixed-method approach incorporating quantitative and qualitative techniques. The main data collection methods utilised were:

- Stakeholder interviews with the range of professionals involved in aspects of the Scheme's implementation and operation;
- Pre and post-treatment survey of participants;
- Interviews with participants upon completion of CARDS;

- Analysis of participant data and other data sources; and
- Liaison and evaluator observation of aspects of the Scheme.

Throughput of Participants

In the two years from June 2004 to June 27th 2006, 332 referrals were made to CARDS. Thirty-two of these involved individuals referred to CARDS on two or three separate occasions. The most common Magistrates Courts from which referrals were derived were the first two pilot areas of Port Adelaide and Adelaide. As the Scheme expanded to further courts during the Pilot period, the number of referrals increased from 118 referrals in the first full year to 215 in the second year.

Of the 300 discreet individuals referred to June 27th 2006, 207 ultimately were accepted onto the CARD Scheme and agreed to participate. Of these 207 participants, 25 were Indigenous. At June 27th 2006, 52 participants were still involved in the CARD Scheme, 93 had successfully completed the Scheme's requirements, whilst 62 failed to complete. This represented a successful completion rate of 60%. Of the 93 participants who successfully completed, 48 were said to have voluntarily continued with further treatment as is possible under the Scheme. The progression of participants from referral to their first CARDS episode through to acceptance and completion (or otherwise) of CARDS is presented below:

Profile of Participants Accepted onto CARDS

Of the 207 participants accepted onto CARDS, 156 (75.4%) were male and 51 female (24.6%). The majority (86.0%) were under 40 years of age. The mean age of the sample was 30.7, whilst the median age was 30. Overall, females (mean 29.6, median 28) were slightly younger than males (mean 31.0, median 30.5). Of the 25 Indigenous participants on the Scheme, 18 were male and seven female, and all were under 40 years of age.

Of those individuals accepted onto CARDS, by far the two most common drugs used were amphetamines and cannabis. This was true regardless of gender, Indigenous status or age. Between two-thirds and three-quarters of participants reported using these drugs at their assessment interview.

Generally, participants were educated to Year 10 or below, with only around one-third studying beyond Year 10. Approximately four-fifths of CARDS participants were unemployed, with a similar proportion indicating that their main source of income was a government pension or benefit. More than half of the participants indicated having some level of personal debt, although information was not available on the extent to which assets offset any debt. Nearly 90% of participants lived in a private residence rather than forms of supported accommodation or homelessness.

The Scheme in Operation

Stakeholders raised a range of issues and points worth noting regarding the Scheme in operation as part of the interview process. These are discussed below under the titles, 'Management and Coordination', 'Referral and Assessment', 'Treatment' and 'Court Processes'.

The Scheme in Operation - Management and Coordination

The extent to which key stakeholders were informed of or trained in the CARD Scheme was mixed. Considerable effort was made to promote the Scheme and a series of forums and communication activities were undertaken both prior to commencement at each court location and during the operation of the Scheme. Despite this some treatment workers (in particular those more recently appointed to the role) and lawyers reported not being sufficiently informed about the Scheme. This highlights the need for continued promotion of CARDS.

Generally there was positive communication and collaboration between stakeholders with a role to play in the operation of the Scheme. This was primarily instigated by the CARDS Team, which included the Coordinator of the Scheme, assessors and an administrative officer. An exception to this view came from some treatment providers (clinicians), who considered that they were not regarded as equal partners in the Scheme and not adequately consulted regarding the Scheme. Some of these issues may have arisen from intra-agency communication issues within DASSA, which were said to leave operational level staff 'out of the loop' regarding CARDS information. A range of responses, particularly information forums, have been implemented to resolve some of these communication issues.

During the rollout of the pilot Scheme, and due to limited referrals, it became apparent that CARDS was not effectively utilising staff appointed. Changes were made to the structure of the CARDS Team to increase staff workloads and to provide challenges to the staff. These changes ensured a full-time assessor at each metropolitan Court site (except Holden Hill where the Scheme is yet to be officially rolled out), as well as services being offered at Murray Bridge and Mount Barker. At these outer metropolitan locations, appointments are pre-booked and the Country Liaison Officer or another CARDS assessor travels to the site to conduct assessments when necessary.

Managing lower than anticipated referrals was a particular challenge for CAA management of the Scheme. Several strategies were put in place in order to deal with the lower than anticipated referrals. The primary change involved assessors visiting courts and later being based in court locations (as described above), which allowed 'on the spot' assessments, thus ensuring that delays in 'processing' participants were kept to a minimum. Also adopted was the opportunity for participants to self-refer to the Scheme. This was promoted via printed materials positioned in prominent places in court buildings where individuals who may be eligible for CARDS may see them. In addition, and due in part to the 'unused capacity' from low referrals, the Scheme was also made available to the Mount Barker Magistrates Court in July 2005, extended to Elizabeth in February 2006 and Christie's Beach in November 2006.

The Scheme in Operation - Referral and Assessment

Referrals to CARDS were originally possible from a range of sources including magistrates, police, lawyers and Department of Corrections staff. Self-referral was later added. The vast majority of referrals came from magistrates, whilst most referrals came from the Adelaide and Port Adelaide Magistrates Courts during the pilot term. As stated, referrals were well below that anticipated at the outset of the Scheme. Several reasons were provided by stakeholders to explain this, including the preparedness or knowledge to refer by certain stakeholders and aspects of the eligibility criteria.

It was evident that most potential referrers had reasonable knowledge of the Scheme, particularly where formal training had been received. However, some potential referrers only received information regarding the Scheme in passing. This led to some stakeholders being less familiar with the process and possibly more reluctant to suggest a referral. There was a perception amongst some stakeholders that lawyers and police prosecutors and even some magistrates were not contributing to the referral process. Identifying possible CARDS participants was reported to be difficult by magistrates, prosecutors and lawyers because it was not always clear that drug use was a factor in their criminal activity. Strategies may be required to assist these professionals in identifying individuals that may benefit from involvement on the Scheme.

Eligibility criteria for CARDS prohibiting individuals with a history of violence were seen by some stakeholders as preventing participation by individuals who may potentially benefit from involvement in CARDS. This was particularly considered so for otherwise eligible Indigenous individuals. Moves have been made to consider such individuals on a case-by-case basis whilst still taking into account staff safety. Indigenous referrals were also thought to be low because the Scheme was not seen by some to have the ability to meet the complex needs of Indigenous participants.

Following referral the participant is assessed by a CARDS assessor to determine whether the participant is to be recommended for inclusion onto the Scheme. Whilst a move to on the

spot assessments in court was a challenge to assessors in terms of time pressures and achieving rapport with participants, this new process of assessment was reported to have streamlined court processes as it eliminated the need for a lengthy adjournment. The assessment tool utilised was supported by assessors and other stakeholders were satisfied with the assessment process, so much so that no assessor recommendation was questioned by either a lawyer or magistrate in the Scheme to date.

The Scheme in Operation - Treatment

The process of making treatment appointments along with more general communication between CARDS assessors, the Cards Appointment Line and DASSA administration personnel generally operated smoothly. Some issues existed regarding the extent to which some clinicians had been informed or trained in relation to the Scheme. This was particularly so for clinicians new to CARDS who may not have received formal training sessions but at times were simply assumed to know of the Scheme.

A range of service and treatment limitations were identified by stakeholders including:

- a lack of after hours treatment services (except the Northern Drug Service), which limits access to those who work or do not live nearby;
- certain clinicians picking which participants they will and will not see and only working with motivated participants, despite clinicians being appropriately trained and expected to deal with and motivate participants;
- failure by some clinicians to offer a voluntary continuation of treatment once four sessions have been undertaken by the participant;
- difficulty for participants voluntarily continuing treatment after four sessions to obtain further appointments as all 'voluntary' appointments were booked at some clinics;
- a lack of Indigenous clinicians. There was also some suggestion that existing treatment services did not meet the complex needs of many Indigenous participants;
- clinicians being pressured by assisting the participant to complete four appointments in the three-month deadline, particularly where appointments missed by the participant required rescheduling. This may impact on clinician morale and also on treatment provided to participants due to the need to rush later appointments within the designated timeframe;
- certain clinicians being uncomfortable working with participants that they perceive to be mandated or involuntary participants, resulting in a reluctance to report non-compliance back to court and the potential to treat CARDS participants differently to other participants that are perceived to participate more voluntarily; and
- related to the above, a disparity was reported between the extent to which different clinicians treat participant issues beyond drug use. For some participants there may only be a focus on their drug use, whilst for others the focus may extend to issues such as housing, mental health and debt. This latter approach was said to be more consistent with the clinicians' approach to general participants. However, some CARDS participants were reported to not receive this level of service from their clinician, primarily due to the requirement that clinicians 'deal' with CARDS participants in four appointments.

Overall, despite some of the limitations outlined, the level of demand for treatment is reportedly being comfortably met by DASSA. This is particularly so due to the lower than anticipated number of referrals. Notwithstanding the funding provided to DASSA, it was suggested by treatment workers that an increase in referrals could place extra pressure on their service, particularly in regional areas where limited appointments are available.

Stakeholders' views of the effectiveness of CARDS were influenced by how they interpreted and defined effectiveness. With respect to providing access to treatment services, the Scheme was considered effective as demand for services was generally met. It was also considered effective where a participant merely completes the requirements of CARDS. When referring to individual outcomes, comment was mainly received from clinicians who had mixed views of the Scheme's effectiveness. They considered that for some participants,

completion of CARDS may not necessarily lead to positive outcomes, whilst for others it may. In some participants who failed to complete CARDS, positive outcomes were also thought to have resulted from their exposure to treatment services, which may be of use to them at a later date. A Scheme like CARDS was also thought to result in some participants pretending to have motivation to be accepted onto the Scheme, when in reality some will have little motivation to address their drug use. Hence, this will affect the outcomes for these participants.

The Scheme in Operation - Court Processes

There was some suggestion from stakeholders involved in court that CARDS places time pressures on court processes, particularly in terms of increasing the number of court appearances, arranging appointments for assessment and widening the range of options to be considered for a defendant. The introduction of assessors on-site part way through the pilot period alleviated some of these challenges.

Most stakeholders working in the court had an appropriate level of understanding of the Scheme. However, for some lawyers and police prosecutors, their understanding of CARDS was limited due to their workload and working across numerous courts, some which do not offer the Scheme. Knowledge was also impacted by changeover in staff and some individuals not receiving any training or information sessions. Whilst magistrates tended to have a strong grasp of CARDS, their belief in how the Scheme should operate influenced when some of them chose to refer or how they interpreted completion or failure to complete. There was also differing support for the Scheme from some magistrates based on their support for therapeutic jurisprudence and their preparedness to 'share' their court with other agencies.

Magistrates mostly preferred the bail option to the bond option because it gave the defendant an opportunity to participate and demonstrate that they had made changes which could be taken into account during sentencing. Magistrates are tending to adopt an approach where the court grants an adjournment in the sentencing process to give the defendant an opportunity to demonstrate their prospects of rehabilitation by attending CARDS. The voluntary nature of CARDS is maintained with no requirement of sanction if not completed. However, this raised concerns for the relevance of or need for Department of Correctional Services involvement in supervision of conditions, which has been involved for some participants.

Some assessment reports were described by magistrates and lawyers as containing limited information. However, having assessors present at final hearings as now commonly occurs usually served to fill in any gaps. The assessor possesses hard copies of the treatment report, which can be provided to magistrates and defence lawyers if required.

Treatment Received and Compliance with Treatment by Participants

DASSA data was used to analyse the range of treatment types utilised. Most common was counselling followed by rehabilitation and then assessment only. Limited instances of pharmacotherapy and withdrawal management were provided. Over nine-tenths of sessions were face-to-face sessions within a DASSA clinic, with most of the remainder of sessions conducted via telephone. Fifteen different DASSA Units provided treatment services to CARDS participants. Most commonly attended were the Elura, Northern Drug Service and Adelaide clinics. Information regarding particular DASSA Units ability to accommodate appointments required for CARDS defendants, or their ability to reschedule missed appointments was not available. Upon ending a treatment episode, only around one-eighth of participants were referred to some other form of treatment or service, mainly other non-residential DASSA services or programs. However it is possible that participants were referred to other services during the treatment episode.

As at June 27th 2006, of 196 individuals referred to DASSA under the Scheme, 35 (17.9%) did not attend within four to six weeks of the initial appointment. Of 161 participants that attended a session at some point, 92 (57.1%) did not attend at least one session, with nearly

half of these missing two to four scheduled appointments. Across these 161 participants, approximately two-thirds of 814 scheduled sessions were attended. An episode of treatment was recorded as 'completed' for 118 participants. Reasons for the episode being completed included the treatment having been completed, the individual ceasing to participate without notice or against the advice of the treatment worker, a change in service provider, or non-compliance.

A series of chi-square analyses were undertaken to compare the likelihood of CARDS completion between participants on a range of demographic and other variables. On the basis of categorised differences in age, gender, CARDS referral site, education levels, self-reported literacy and participant's primary drug used, participants did not significantly differ in their likelihood to complete CARDS. Indigenous status was found to be a basis for significant differences in the likelihood to complete, with Indigenous participants significantly less likely to complete CARDS than non-Indigenous participants. Significant differences were also found in the likelihood of completing CARDS based on the assessor's perception of the level of motivation of their participant to address their drug use. Those who were perceived to be more motivated were more likely to complete CARDS, highlighting a good degree of accuracy in the professional judgement of the assessors.

Participants Experiences and Perceptions of the CARD Scheme

Approximately one third of individuals who completed the Scheme were able to be interviewed regarding their experience. The majority of these were not aware of the CARD Scheme at the point of their first court hearing. Most reported that CARDS was first mentioned by the magistrate or their lawyer during the court hearing. Almost two-thirds reported that they had received enough information to make a decision to accept a referral to CARDS and the vast majority were satisfied with the referral process.

Three-quarters of those interviewed rated the assessment process as 'good' or 'very good'. For some individuals the assessment also provided an opportunity to ask questions and to clarify what CARDS involved. Almost all were comfortable with the assessment process and few had any difficulties in attending. Some individuals were clear that they were already motivated to address their drug use prior to the CARDS assessment. However the discussion during the assessment may have increased their motivation or given them a sense of direction. For others, some sense of motivation to address their drug use came about during the assessment.

The majority of those interviewed experienced few difficulties in getting to CARDS treatment sessions or in completing the required number of sessions within a three month period. This said, over half of those interviewed missed and/or rescheduled appointments on one or more occasions. A desire to change their drug use was the most frequently reported motivating factor in treatment. However, concerns about the loss of family or friends, or that their current offence would lead to them going to jail, also motivated individuals to complete the treatment.

More than half of those interviewed were satisfied with the treatment received and the majority had felt comfortable with the clinician. The most significant benefits gained from the treatment were reported as 'having someone to talk to', learning specific techniques to control the urge to use drugs, or gaining support and information at specific points in reducing or ceasing their drug use. Just over a third of individuals explicitly reported being dissatisfied with one or more particular aspects of the treatment phase of CARDS. Reasons for this included that in their view they had not really received 'counselling', the sessions being too short or too few, or the sessions not addressing the real issues for them.

Only one third of individuals reported that the health treatment received was what they expected. For individuals who reported that the treatment was not what was expected responses were varied, with many suggesting that the experience was better than they had expected. When asked if they had felt comfortable with the clinician, over three quarters of individuals responded positively, with many referring to the way that the clinician interacted with them as being helpful or non-judgemental. None of those interviewed reported any difficulties in the treatment process which were related to their cultural background and needs or their level of literacy, and only one individual interviewed reported any issues specifically

related to their mental health needs. Over half of those interviewed were satisfied with the treatment aspect of CARDS and just over three quarters of the group reported that completing CARDS treatment assisted with addressing their drug use and criminal behaviour in some way. A high proportion of these reported having reduced their drug use and related criminal activity.

Just over half reported that the court outcome was better than they had expected. Most of these reported that the penalty received was less than they had expected.

Overall, more than eight in ten interviewees rated the CARD Scheme as 'good' or 'very good'. When asked whether there was anything they would change about the CARD Scheme, one third reported that no changes were necessary. The most frequently suggested change, made by approximately one third of those interviewed, was to increase the number, frequency and/or duration of treatment sessions, or to add a follow up session. Several individuals also noted the lack of information either about the CARD Scheme, or about other services available to individuals with drug issues.

Pre and Post-Treatment Questionnaire Analysis

A selection of CARDS participants agreed to complete either or both a pre and post-treatment questionnaire. The information requested was similar in both questionnaires, including 12 questions that form the SF-12 Physical and Mental Health Summary Scales (PCS and MCS) and a range of other questions regarding the individual's personal and social life, criminal activity and involvement with CARDS. Low response rates to the questionnaires were achieved, particularly at post-treatment, which limited the level of analysis of this data.

Interesting demographic and social information gleaned from the questionnaire included that half the respondents had lived in only one place over the six months prior to treatment, one-fifth lived with a heroin user in this period, nearly two-thirds reported 'hanging around' with people who use drugs in this period and nearly half were unemployed at all times in the six months prior to treatment. A minority of around one-sixth admitted to offending in the one month prior to CARDS involvement. These results were compared to post-treatment responses. Whilst improvements in a desired direction were found at post-treatment in the proportion of participants living in one place only, living with a heroin user, hanging around with drug users and offending in the previous month, the latter sample utilised only participants who successfully completed CARDS. Therefore, they may be different in some way from participants who did not complete CARDS. The most common reason provided by responding participants for taking part in CARDS was that they may benefit from talking to someone about their drug problem. Following CARDS involvement, more than half the responding participants indicated that they continued to use drugs, however, most of these claimed to have reduced their use since receiving treatment.

With respect to their health, questions asked of participants formed the SF12. On both the physical (PCS) and mental health (MCS) scales, the sample of participants reported significantly lower levels of health than the best known population norms for South Australians. Mental health appeared particularly poorer with nearly nine-tenths of CARDS participants scoring below the population norm on this scale. Unlike the general population where males display better health than females, in this CARDS sample there were no significant differences in PCS and MCS scores between males and females. No statistically significant changes in SF12 scores from pre to post-treatment were found, but the small sample limited the ability to detect changes.

Contact with the Criminal Justice System

An analysis of the major charge and overall charges laid against a sample of participants for which they were referred to CARDS revealed that:

- participants were most likely to enter CARDS on a major charge related to property crime (excluding property damage) that is acquisitory in nature, particularly larceny and receiving and serious criminal trespass;

- given the eligibility criteria of CARDS which generally will not accept violent offenders, offences against the person amongst the sample are rare;
- approximately only 5% of the sample had a drug offence as the major charge; and
- the major charge for the 74 participants in this sample were mainly of minor or moderate seriousness according to the seriousness index utilised (based on the National Offence Index - NOI).

An overview of the offending history of a sample of CARDS participants in the five years prior to their entry to the Scheme revealed that:

- they had an average of 16.2 criminal events each (median 12), equating to approximately three events per year;
- the number of prior offences in this period was highest in those aged 18 to 24 (mean 20.5, median 17), which may reflect the prevalence of offending in juvenile years;
- a relatively even split had either less than or more than 10 events in the period; and
- the most common offence category these offenders were charged with was acquisitory crimes, mostly larceny and receiving.

In the six months prior to involvement in the Scheme, participants averaged 2.55 criminal events each. Again a very high proportion of events were acquisitory in nature. During their involvement in the Scheme, approximately 60% of participants were not charged with a criminal event. Those participants who successfully completed the Scheme averaged just .05 events per week whilst on the Scheme, or one event for every 20 weeks spent on the Scheme. This was significantly different to those who did not complete the Scheme who averaged 0.14 events per week, or one event for every seven weeks whilst on the Scheme.

In the six months following involvement in CARDS, the same sample of participants averaged 1.7 criminal events each in the six months following their involvement in CARDS. This compares favourably with the average 2.5 offences that participants had in the six months prior to CARDS involvement, and this difference was statistically significant. Along with this significant reduction for the overall group, significant reductions in criminal events were also found for males, non-Indigenous participants, those aged 30 or under, participants who completed and did not successfully complete CARDS, and participants that had not received previous treatment for their drug and alcohol usage. Also encouraging was a reduction in the seriousness of criminal events committed by participants post-CARDS using a seriousness index based on the NOI. The proportion of serious and moderately serious events reduced, with a higher proportion of events being classified at a minor level.

Chi-Square analyses were undertaken on the offending data comparing the likelihood of CARDS completion between participants based on their extent of prior offending and the seriousness of the major offence at entry to CARDS. Results indicated that participants with higher levels of offending in the five years prior to CARDS involvement were significantly less likely to successfully complete CARDS than participants with lower levels of offending in the same period. This pattern was not found in relation to offending levels in the six months prior to CARDS involvement. The seriousness of offence at entry to the Scheme was not found to influence the likelihood of successful completion in this sample.

Progress Toward Objectives

The objectives of CARDS are to:

- Ensure there is an option for court referral into drug assessment and treatment services available
- Encourage drug users to seek treatment by capitalising on the reality that the drug using defendant has entered the criminal justice system as a result of being charged for a drug related crime
- Reduce the risk of further offending to support drug use and associated criminal activity and harm to themselves or others

The first objective - to provide an option for court referral into drug assessment and treatment - was achieved at each of the pilot court sites and a number of others. This said, the numbers referred during the pilot was lower than anticipated, but appears to be increasing over time. The likelihood of individual defendants being referred to CARDS rests heavily on the ability of magistrates, prosecutors and lawyers to identify suitable defendants and the willingness of magistrates to then refer. On this basis there seems merit in continuing a dialogue with magistrates about CARDS in order to promote and reinforce the place of the Scheme within the criminal justice system.

The CARD Scheme appears to be achieving its objective of capitalising on the opportunity to encourage drug users to seek treatment as a result of having entered the criminal justice system. There is scope to enhance this opportunity by resolving issues with respect to treatment and the lower than desirable completion rates amongst Indigenous participants. There is also merit in (a) ensuring that CARDS assessors use the opportunity of assessment to further motivate defendants to comply with treatment, (b) exploring other ways individuals might be supported to successfully comply with treatment, and (c) continuing the dialogue with magistrates about whether CARDS should be a condition of bail or bond or whether there are alternative ways that the court can encourage defendants to seek drug treatment.

The relatively short period of time in which to track offending amongst CARDS completers (i.e. minimum of six months), combined with the low response rate to the post-treatment questionnaire, make it difficult at this point in time to definitively say that CARDS has reduced the risk of further offending to support drug use. This said, the available data show encouraging signs in regard to a reduction in contact with the criminal justice system amongst CARDS participants during and after their participation on the Scheme, along with some evidence of improved health and social functioning. Notably, there appears to be a reduction in offending amongst both individuals who completed CARDS as well as those who did not. This suggests that the CARD Scheme may have benefits for individuals even if they do not complete all of the required treatment sessions.

Conclusion

Overall, the evidence available indicates that the objectives of CARDS are being achieved. There have been some variations in the Scheme from the original model and some of these potentially have implications for the level of resources which may be required for a state-wide rollout of CARDS. The level of support for the Adult CARD Scheme amongst stakeholders and the outcomes for participants (to the extent that they are available) suggest that there is merit in continuing the Scheme and considering how it may be offered more broadly across the State, taking account of the recommendations contained within the report and comments made below regarding its future. The main issues to be addressed are the level of take up of CARDS, its appropriateness for Indigenous defendants (given the low completion rates amongst this group) and a subset of issues regarding the treatment regime. Each of these will need to be addressed in the context of the Scheme's continuation and any expansion.

A number of recommendations have been made with respect to the Scheme. These are tabled overleaf.

Recommendation 1

It is recommended that consideration be given to ways of increasing the retention and successful completion of CARDS by Indigenous defendants.

Recommendation 2

It is recommended that CARDS management consider ways to ensure the provision of training and written information is received by all relevant agency staff and that this take account of the needs of existing and newly appointed staff.

Recommendation 3

It is recommended that CARDS and DASSA management consider creating additional opportunities for staff from both agencies to discuss their respective concerns in relation to the implementation, rollout and procedures associated with CARDS. Included in this should be consideration of the respective roles and workload allocation for both CARDS assessors and DASSA clinicians.

Recommendation 4

It is recommended that the CARDS Steering Group and management continue to monitor the number of referrals to CARDS and to develop further strategies to identify suitable defendants and ensure their referral to CARDS. Consideration of such strategies may well require the involvement of magistrates and lawyers in their development and implementation.

Recommendation 5

It is recommended that discussions be held between the CARDS Steering Group, CARDS management and DCS management with respect to the ongoing role and resourcing of the Department for Correctional Services in relation to CARDS.

Recommendation 6

It is recommended that CARDS management give consideration to arrangements for ongoing database technical support and for the monitoring of CARDS data quality.

Recommendation 7

It is recommended that all appointments for CARDS continue to be booked through the CARDS Appointment Line.

Recommendation 8

Should CARDS expand its use of treatment providers beyond DASSA, it is recommended that steps be taken to ensure the standardisation of data collection across agencies and that consideration be given to ensuring these data are sufficient for ongoing monitoring and evaluation purposes.

Recommendation 9

It is recommended that consideration be given to ways to address the reluctance of some clinicians to working with CARDS clients and the appropriate distribution of this type of work.

Recommendation 10

It is recommended that an agreed position be reached to whether CARDS clients who elect to continue treatment beyond the four required sessions continue to use CARDS priority appointments or be treated as voluntary clients for DASSA purposes, and that all CARDS clients (with ongoing drug related issues) be proactively encouraged to continue treatment.

Recommendation 11

It is recommended that CARDS staff and management give consideration to ways of further increasing support for the Scheme amongst magistrates.

Recommendation 12

It is recommended that consideration be given to whether the option of 'inviting' a defendant to participate on CARDS should formally be included in the model, the implications of this change considered and monitored, and any changes in outcomes of the Scheme reported on.

Recommendation 13

It is recommended that consideration be given to the existing treatment regime offered to CARDS participants, taking account of the feedback provided by former participants.

INTRODUCTION

An evaluation of the pilot Adult Magistrates Court Assessment and Referral Drug Scheme (hereafter CARDS) was undertaken by the Office of Crime Statistics and Research (OCSAR). The evaluation aimed to assess the extent to which the CARD Scheme achieved its specified objectives (as listed in the Program Description), as well as monitoring and observing project implementation, coordination and operational procedures. The main evaluation period was of two years duration, from June 2004 to June 2006.

The present report is the final evaluation report. However, during the evaluation period a number of briefing papers were prepared for the CARDS Steering Committee and management. These were a combination of statistical analyses of participant characteristics and the Scheme's throughput. They also addressed process issues as they arose, and attempted to capture the perceptions of the Scheme from key stakeholder groups.

What is CARDS?

The Magistrates Court Assessment and Referral Drug Scheme (hereafter CARDS) is one of a number of specialist schemes established in South Australia under the National Illicit Drug Strategy. The Scheme was developed at a policy level by the South Australian Attorney General's Department and is similar to schemes operating in several other states. The lead agency in managing the administrative operation of the Scheme is the Courts Administration Authority (CAA). The Scheme provides an increased opportunity for individuals with a drug dependency who have charges being heard in the Magistrates Court, to receive health treatment.

CARDS complements existing strategies such as the Drug Court and the Police Drug Diversion Initiative (PDDI), established in 2000 and 2001 respectively. Each is designed to disrupt links between drug use and crime through health intervention strategies targeting different drug using or offending populations. The Drug Court provides judicial supervision and health treatment to individuals with a drug dependence involved in serious offending and likely to receive a prison sentence. In contrast, the PDDI enables police to divert adults and juveniles with a simple possession offence into health treatment. The CARD Scheme was designed to address perceived gaps created by existing 'diversion' strategies, in order to maximise opportunities for drug using offenders to engage with the health system. Accordingly, it targets less serious levels of offending not currently addressed by the Drug Court. Further, it may also provide health treatment for individuals involved in drug related offences not diverted by police.

The intended target group for CARDS is adults apprehended for minor indictable offences with a demonstrable drug problem, who are eligible and suitable for release on bail or bond, and assessed as motivated to receive health treatment for their drug dependency. Suitable candidates are required to attend four treatment sessions within a three-month period at a specified health service. The intention was for CARDS to be offered as either a pre-sentencing bail or post sentence bond option.

Three sites were selected for the piloting of the Adult CARD Scheme; Port Adelaide, Adelaide and Murray Bridge. Start dates were staggered with Port Adelaide commencing in June 2004, Adelaide in October 2004 and Murray Bridge in February 2005.

Report Structure

This report is divided into ten sections. Sections 1 and 2 describe the CARD Scheme and the scope of the evaluation. Sections 3 and 4 describe the throughput of participants referred to the Scheme and the profile of those accepted. Section 5 analyses in some detail the operation of the Scheme, including its management and coordination, referral and assessment processes, treatment and the court process. Section 6 examines the treatment

received by CARDS participants and their level of compliance. Sections 7 and 8 analyse participants' experiences and perceptions of the Scheme. Section 9 analyses participants' contact with the criminal justice system before and after the CARD Scheme. Section 10 draws together the preceding sections in order to examine the extent to which the Adult CARD Scheme, in its pilot phase, had made progress toward its objectives.

It should be noted that throughout this report several terms, namely 'defendant', 'participant' and 'client' are used to describe individuals who are referred to and who may subsequently undertake the CARD Scheme, depending on the context of the usage.

DESCRIPTION OF CARDS MODEL

This section provides a description of the model set down for the CARD Scheme. Information contained herein has been drawn mostly from written documents prepared prior to the Scheme's inception. It includes a description of both the background to the Scheme and key features of the model, such as the Steering Committee, staffing arrangements, target group and eligibility criteria. For the most part it describes these aspects as they were intended to operate. However on some occasions it is useful to include changes to this, or aspects of the model further clarified during its implementation. In this sense, some content in this section overlaps with Section 5, 'The Scheme in Operation'.

Background to the Scheme

CARDS is a Magistrates Court referral scheme designed to ensure that drug offenders appearing before the Court on minor and summary offences have priority access to drug treatment as part of the court process.

CARDS is a harm minimisation initiative consistent with State and Australian Government drug strategies. It is funded by both the State and Australian Government. Based on research which identifies linkages between illicit drug use and criminal behaviour, CARDS aims to minimise the harm to the community and to the drug offender by ensuring timely and appropriate treatment, thereby reducing the need for, and impact of, a criminal lifestyle.

The Scheme is based on the principle of therapeutic jurisprudence. Essentially this principle promotes the role of the criminal justice system to act as a therapeutic agent in order to prevent future crime, as well as administering appropriate justice. CARDS aims to capitalise on the motivation that may be produced in clients by their coming into contact with the criminal justice system, by providing them with the opportunity to address their drug dependence at a critical time in their lives.

CARDS has been designed to fill the gap between the Police Drug Diversion Initiative (PDDI) and the Drug Court. Under the PDDI, police can refer drug offenders detected for a simple possession offence directly into a brief health intervention. At the other end of the spectrum, the Drug Court provides a 12-month therapeutic program for offenders, involving weekly court appearances and regular monitoring as an alternative to a period of imprisonment. CARDS fits between these initiatives and is designed for those drug offenders suitable for release on bond or bail, who it is believed would benefit from some form of drug treatment or counselling.

The objectives of the Scheme are to:

- Ensure there is an option for court referral into drug assessment and treatment services available;
- Encourage drug users to seek treatment by capitalising on the reality that the drug using defendant has entered into the criminal justice system as a result of being charged for drug related crime; and
- Reduce the risk of further offending to support drug use and associated criminal activity, as well as harm to themselves or others.

The CARDS program aims to:

- Provide drug intervention into drug related criminal activity;
- Increase defendant's access to health treatment options; and
- Reduce the likelihood of defendants appearing on multiple occasions in the Magistrates Court.

As indicated previously, the information below relates to the intended model at the outset of the Pilot Scheme. Deviations from this model that occurred in implementation and operation of the Scheme are explained in the main body of the report, primarily in the section titled "The Scheme in Operation".

Pilot Court Sites

Implementation of the adult CARD Scheme commenced in June 2004, and operated as a pilot until June 2006. Initially it was piloted at three Magistrate Court sites; Port Adelaide (including the Nunga Court) commencing in June 2004, Adelaide in October 2004 and Murray Bridge in February 2005.

Starting dates for the pilot sites were staggered and each location was chosen on the basis of the Steering Committee's desire to involve Indigenous defendants in the Scheme and operational concerns. Port Adelaide operates the Nunga Court which processes Indigenous defendants. The Adelaide Magistrates Court, which is centrally located and administratively complex, provided a unique opportunity to pilot operational aspects of CARDS. Murray Bridge provided a regional context for the CARDS pilot, and importantly also operates an Aboriginal Court which processes significant numbers of Aboriginal defendants. Indigenous defendants can also access CARDS through the general lists at participating Magistrates Courts.

The CARDS Model

The Steering Group Committee

The CARDS Steering Group was established to oversee the development and implementation of CARDS at a strategic level. Its Terms of Reference are provided at Appendix A. The Steering Group comprised of a broad range of individuals representing the range of agencies involved in the Scheme. Whilst some personnel and limited agency changes have occurred, during the implementation representatives have generally included:

- Magistrates (including the Chief Magistrate as Chairperson);
- Representatives of the Courts Administration Authority, including the Manager, Specialist Courts Unit, the CARDS Coordinator and a representative from the Magistrates Court Division;
- A registrar from the Adelaide Magistrates Court;
- A representative from SAPOL Prosecutions Section;
- Representatives from the then Department of Human Services;¹
- The Project Manager from the Justice Strategy Division, Attorney General's Department;
- A representative from the Department of Correctional Services;
- A representative from Drug Alcohol Services South Australia (DASSA) and the Aboriginal Drug and Alcohol Council (ADAC);
- The Chief Executive of the Victim Support Service; and
- A representative of the Commonwealth Department of Health and Ageing.

In mid 2005 the CARDS Steering Committee merged with the Drug Court Management Group, forming a combined committee to oversee both initiatives.

¹ From July 1st 2004 this Department was replaced by two separate entities, the Department of Health and the Department of Families and Communities.

Target Group and Eligibility Criteria

In the original model at the outset of the Scheme, eligibility criteria required that the potential client:

- be arrested for possession or use of an illicit drug, excluding indictable drug offences, or
- committed the crime whilst under the influence of an illicit or licit drug, excluding alcohol, or
- committed the offence to support an illicit drug habit.

The offence(s) with which they are charged must be summary or minor indictable in nature. Major indictable offences preclude an offender from inclusion in the Scheme and these include sexual offences, serious assault occasioning actual bodily harm or worse, or an indictable drug offence. Any illicit drug qualifies in terms of the criteria listed above, including cannabis. Alcohol is excluded but may be a secondary problem for clients. To be eligible the client must also:

- be an adult at the date of commission of the offence(s);
- have a treatable licit or illicit drug use problem;
- be considered suitable for release into the community on bail or bond;
- give informed consent to participate in the Scheme;
- have a matter before one of the participating Magistrates Courts; and
- not be on any other court ordered drug treatment program, such as the Drug Court.

Admission or discussion about illicit drug use by clients will not affect the current charges, the outcome of those charges or lead to the creation of new charges. The information is used by the court only to determine if CARDS treatment is appropriate.

The CARDS Team

The Courts Administration Authority (hereafter CAA) were responsible for the implementation and management of the Scheme. This was overseen by the Manager, Specialist Courts Unit, and the Project Manager, Justice Strategy Division, Attorney-General's Department. An implementation timeframe was used as a guide and adapted on an as-needs basis.

The budget for the CARD Scheme made provision for:

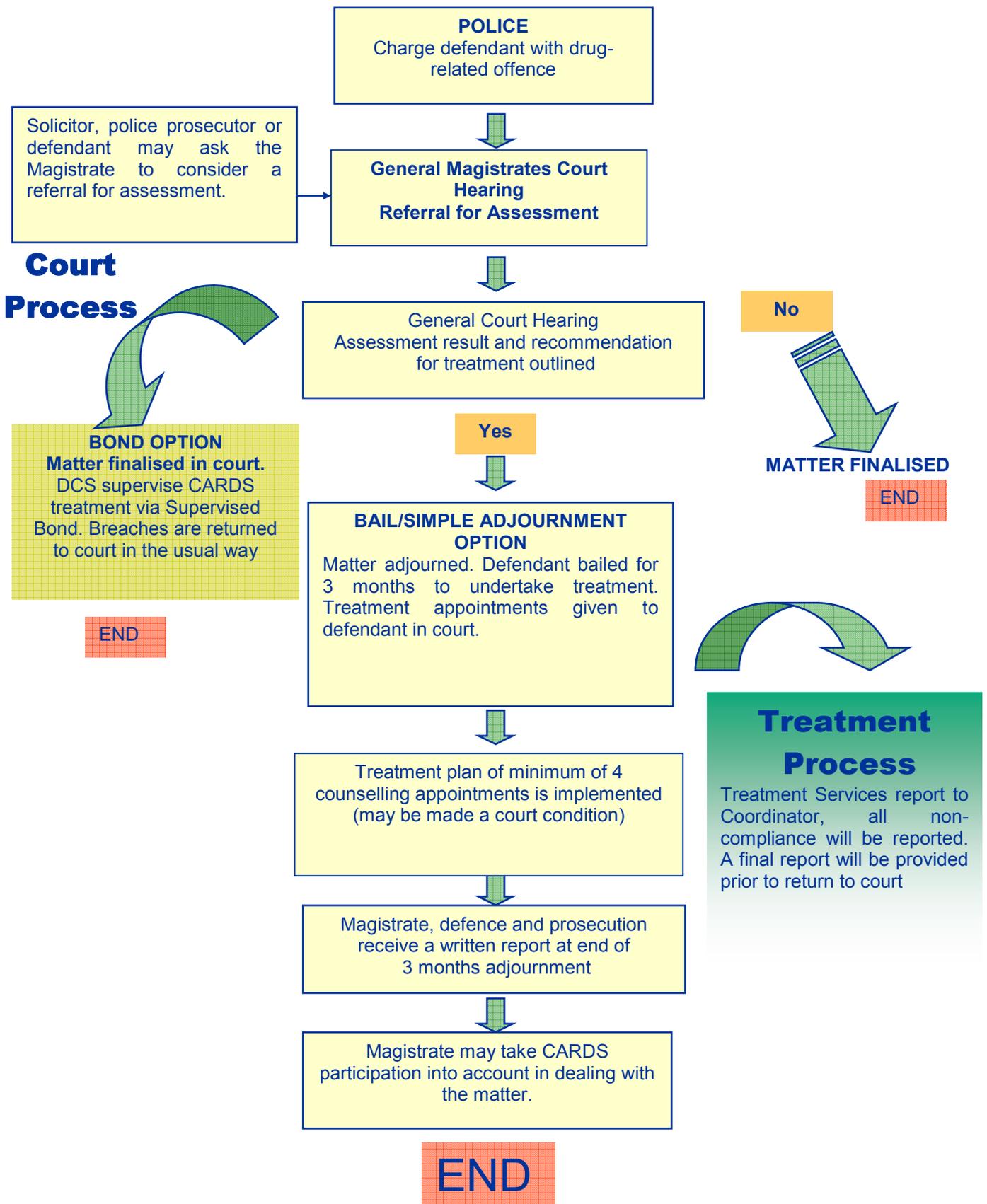
- 1 Coordinator (ASO5)
- 4 Assessors (ASO4 or PSO1)
- 1 Administrative Officer (ASO2)

Together, these staff comprise the "CARDS team".

Acceptance Onto and Progression Through CARDS

Prior to a description of referral, acceptance and treatment processes, it is worthwhile providing a flowchart (Figure 1) to illustrate these processes and the progression to completion of CARDS. Extra detail is provided following Figure 1.

Figure 1 CARDS Process Flowchart (Source: CARDS Team)



Referral and Acceptance onto CARDS

Referral to CARDS can come from a range of sources. Most common is referral by a magistrate when the offender is attending court on new charges. Referral can also be made by solicitors and police prosecutors. In addition, it is also possible that clients participating on CARDS via bond, may be referred by a DCS Supervising Officer (see below).

When a referral to CARDS is received, the matter is adjourned for an assessment of the defendant to take place by a CARDS assessor. On completion of this assessment, the magistrate receives a report from the CARDS assessor regarding the defendant's suitability for CARDS intervention. If the magistrate chooses to refer the defendant to CARDS there are two options, either pre-sentence or post sentence.

The pre-sentence option involves the matter being adjourned or a bail condition being placed on a client for them to attend counselling as part of CARDS. It is optional as to whether the magistrate takes a plea at this stage. An adjournment will usually be for a three-month period consistent with the intended length of time in which clients are to attend four sessions of counselling. At the end of three months, the defendants return to court and the magistrate finalises the matter, taking into account their participation in the Scheme.

As a post-sentencing option, CARDS is supervised by the Department of Correctional Services. Under this option, the defendant must plead guilty and the matter is then finalised by the magistrate by placing the offender on a supervised bond with the condition that they attend drug counselling. If all four counselling appointments are attended and no further offending occurs, the matter is resolved on expiration of the bond. The bond can be a simple bond or a bond suspending a sentence of imprisonment.

Treatment

If defendants are assessed as suitable for CARDS, the CARDS assessor will recommend that they attend four sessions of counselling with a specialist clinician. This will then be mandated by the magistrate as part of their bail or bond conditions. At the outset of the Scheme Drug and Alcohol Services South Australia (DASSA) were designated as the sole agency responsible for treatment provision during the pilot.

Four sessions of counselling is the minimum defendants need to complete to meet the conditions of their bond or bail. Defendants can engage in more intense and ongoing treatment with their clinician on a voluntary basis if they wish.

It was intended that dedicated Aboriginal Drug Counsellors be available in the contracted drug treatment agencies, which Aboriginal clients could specifically choose to see instead of a mainstream worker. Aboriginal Justice Officers (AJO's), based in the courts, would also be able to explain the Scheme and to support defendants through the assessment process. Assistance with transport and support through appointments may also be available to Indigenous clients from the Aboriginal Drug and Alcohol Council (ADAC).

Failure to attend treatment appointments is in breach of the bond and bail conditions and could result in a defendant's arrest and the matter being brought back to court.

Anticipated Throughput

It was anticipated at the commencement of the Scheme that approximately 300-350 defendants per year would participate in the CARD Scheme statewide. The take up rate of offenders participating in the Scheme was to be monitored and if numbers were lower than anticipated, or did not match the level of employment provided to administer the Scheme, then measures would be put in place to address this.

EVALUATION SCOPE

Evaluation Objectives

An evaluation of the Adult CARDS pilot commenced in June 2004 and was undertaken by the Office of Crime Statistics and Research (OCSAR). The scope of the evaluation had two aspects which focused on CARDS processes and outcomes respectively. The process evaluation sought to monitor and observe project implementation, coordination and operational procedures. The outcome evaluation sought to establish the extent to which specified objectives had been achieved. The main evaluation period was of two years duration, from June 2004 to June 2006.

The evaluation aimed to assess the extent to which the CARD Scheme achieved its specified objectives (as listed in the Program Description). This required a focus on both process and outcome aspects of the CARD Scheme. The specific objectives of the evaluation are listed below, and are separated into those based on process and those based on outcomes.

Process-Related Evaluation Objectives

- To determine to what extent CARDS processes were implemented and operated as intended in relation to referral, assessment, recommendation, health treatment, supervision by the Department of Correctional services and final sentencing. Also, what factors increased its operational success or created barriers.
- To determine what level and categories of participants undertook CARDS assessment and health treatment.
- To identify factors or reasons why CARDS processes operated or didn't operate as intended.
- To make recommendations regarding operational improvements for the CARD Scheme.

Outcome-Related Evaluation Objectives

- To determine whether, and to what extent, the nature and level of detected offending by CARDS participants changed during and after their participation in the Scheme, compared with their pre-participation levels.
- To identify the extent to which CARDS participants reported reduced illicit drug use and improved health and social functioning during their participation in the CARD Scheme and following its completion.
- To identify factors or reasons why CARDS objectives were either achieved or not achieved.
- To make recommendations regarding future outcome targets for any development or expansion of the CARD Scheme.

Finally, where possible, the evaluation aimed to consider the impact of the CARD Scheme on the Department of Health and the Justice Portfolio and its contribution to South Australia's response to COAG National Illicit Drug Strategy.

A number of efforts were made to incorporate the perspective of victims of crime into the evaluation of CARDS. Despite the goodwill of numerous stakeholders to this task an achievable way of capturing victims' views of the Scheme (which respected their privacy and wellbeing) was not able to be settled on. This is therefore an important limitation of the evaluation design.

Ethics and Reporting arrangements

For the purposes of the evaluation, the Project Manager, Justice Strategy Division, Attorney-General's Department and Manager, Specialist Courts Unit, Courts Administration Authority were identified as the primary contacts.

Ethics approval for the evaluation was obtained from the Department of Health and Aboriginal Health Human Research Ethics Committees.

Evaluation Methodology

The evaluation was based on a mixed-method approach incorporating both quantitative and qualitative techniques in order to appropriately inform the stated evaluation objectives.

The main data collection methods utilised were:

- Stakeholder interviews with a range of professionals involved in aspects of the Scheme's implementation and operation;
- Pre and post-treatment surveys of clients;
- Interviews with clients upon completion of CARDS;
- Analysis of client data and other data sources; and
- Liaison and evaluator observation of aspects of the Scheme.

Each of these data collection methods is outlined in detail below.

Key Stakeholder Interviews

Stakeholder interviews were conducted at two main periods during the evaluation. The first round of interviews with key program-related stakeholders was conducted in mid 2005 (July and August), whilst a second round of interviews commenced in March 2006. A number of stakeholders interviewed in the first round of consultations were also interviewed in the second round. Essentially, it was aimed to speak to relevant stakeholders from a range of backgrounds at more than one period during the Scheme's operation. Outside of these times, some interviews were also undertaken that were not possible during the major interviewing periods. Where a face-to-face interview was not possible, a telephone interview was conducted.

Stakeholders interviewed represented the following major categories. The numbers in parentheses indicate the number of discreet individuals consulted within each category over both rounds of stakeholder consultation.

- CARDS Project Manager (1)
- CAA Specialist Court Manager (1)
- Scheme Coordinators (2)
- CARDS Assessors (3)
- DASSA and OARS Management (4)
- DASSA and OARS Treatment Providers (16)
- DCS Management (1)
- Court Clerk (1)
- DCS CARDS Coordinator (1)
- Aboriginal Justice Officers (2)
- Magistrates (8)
- Defence Lawyers (9)
- Police Prosecutors (3)
- CARDS Administration (1)
- CARDS Appointment Line Administration (2)

Approximately two-thirds of stakeholders were interviewed as part of both rounds of stakeholder interviews. Generally, a similar number of interviews took place across the first and second round, although in the second round a greater number of treatment providers were interviewed.

Interviews were semi-structured and with the interviewee's permission, were generally audio recorded to allow more precise transcription. As their name implies, semi-structured

interviews involve some level of set or predetermined questions, whilst still allowing the opportunity to explore unexpected issues and responses, or to probe further into interesting points. The interviews were thematically structured and targeted towards informing the evaluation objectives. Most of these interviews were of approximately 60 minutes duration. Follow up with stakeholders to clarify responses or seek additional information was undertaken as required. Copies of interview schedules are available from OCSAR on request.

Pre and Post-Treatment Survey of Clients

A survey was developed for the evaluation to gather information from CARDS participants regarding a range of health and social aspects of their lives. This survey included the standardised SF12 Health Survey, which comprises 12 items, along with an additional 20 items addressing further social-related issues and the client's participation in CARDS. The survey was designed to be undertaken both prior to and post CARDS involvement, in order to identify any changes that may be related to participation in the Scheme. Whilst the vast majority of the pre and post surveys were identical, some minor alterations to a limited number of questions regarding aspects of CARDS participation were required in the post survey.

The survey was a "paper and pencil" survey requiring the client to complete it by reading and responding to the items. Initially the survey was provided to clients by the CARDS assessor. Where a client completed the survey in the presence of the assessor, assistance was provided, if necessary, to aid with reading or comprehension of particular questions. Clients were also given the option of taking the survey away, and returning it by reply-paid envelope to the evaluator. However, it was noted that only a low proportion of clients completed and returned the survey. In response to this, an alternative process was implemented whereby if the CARDS participant gave permission to be contacted, the evaluator contacted them direct and generally undertook the 32-item survey via telephone, - a process which was reported to take approximately 15 minutes per client. On some occasions the survey was also sent to clients with a reply-paid envelope. Whilst differing methods of administration could possibly influence aspects of client responding, the use of different approaches was essential in trying to obtain satisfactory client feedback via the questionnaire.

In all, 72 pre-CARDS questionnaires were completed by clients. This included both clients who went on to successfully complete or not complete CARDS. Twenty-eight clients, all of whom successfully completed CARDS, undertook the post-CARDS questionnaire. Fourteen participants completed both a pre and post CARDS questionnaire. Due to the transient lifestyle of many CARDS participants it proved difficult to track individuals after CARDS had been completed. Despite various attempts at contact, including by telephone or post, the number of clients completing post-CARDS questionnaires remained lower than those completing pre-CARDS questionnaires. Copies of the pre and post surveys are available from OCSAR on request.

Interviews with Completing Clients

Interviews were conducted with individuals who had successfully completed CARDS, were able to be contacted, and agreed to participate. A semi-structured interview schedule was used on each occasion. A copy of the interview schedule is available from OCSAR on request. The interviews were semi-structured in nature, addressing issues such as the participant's previous drug experiences, CARDS referral and acceptance processes, treatment experience and perceived benefits and outcomes from their participation. Each interview was audio-taped and transcribed.

Recruitment for the interviews commenced in June 2004. However the majority of interviews were conducted between May 2005 and June 2006. As at the end June 2006, 93 individuals had successfully completed at least one episode² of CARDS, and of these 29 (31.2%) were interviewed. Multiple attempts were made by the evaluator to contact each individual who

² Note several individuals had completed more than one 'episode' of CARDS, taking the number of successful completions to 100.

successfully completed CARDS and had given permission to be contacted. Many individuals were not able to be contacted. Of those that were contacted, some declined to participate³ but many simply did not attend the interview as scheduled. Often several appointments were made with these individuals and on each occasion they failed to present. Early in 2006 funds were made available to reimburse interview participants of travel and other expenses that may be associated with attending the interview via \$25 “Coles-Myer” gift card.

Face-to-face interviews were arranged to occur at a location convenient to the participant. On two occasions, due to the subsequent incarceration of clients, these interviews were undertaken within correctional facilities. On a couple of occasions where a convenient time or location could not be arranged, telephone interviews were conducted as an alternative to face-to-face interviews.

Analysis of Client and Other Data Sources

There were three main sources of data utilised in relation to assessment, treatment and contact with the criminal justice system. It should be noted that some of this data was not collected with this particular evaluation in mind, as it was recorded by other agencies for operational purposes. Therefore, this data was only used to the extent that it is helpful in informing the evaluation objectives.

Central to the evaluation was the CARDS database. This database was developed by OCSAR in collaboration with CARDS staff. The database was designed to assist with recording data from the assessment of potential clients by CARDS assessors and monitoring clients’ progression through the Scheme. It also provided detailed demographic information regarding clients. Downloads of the database were obtained by the evaluator at regular intervals.

In addition, DASSA also kept an internal database. This database was not specifically designed for CARDS, but reflects the agency’s ongoing process of recording the drug and alcohol services that they provide. A database pertaining to clients referred from CARDS was provided to the evaluator. This provided some additional data beyond that available in the CARDS database, although it utilised a slightly smaller sample of CARDS clients, as not all clients were treated via DASSA. DASSA were also responsible for the operation of the CARDS Appointment Line (CAL), which is also used for other state-based drug diversion programs. Information regarding appointments scheduled via CAL for each client was provided by facsimile to the evaluator.

Specific information regarding offending by clients both prior to and following CARDS involvement was provided to the evaluator by data extracts from OCSAR. This data is sourced from key criminal justice agencies, including the courts and is held by OCSAR as the State’s official source of crime statistics and research based upon these statistics. Analysis of this data was used to provide detail regarding the extent and nature of client offending prior to their involvement with CARDS, the range and type of charges that they entered the Scheme upon, and the extent and nature of their offending following involvement in the Scheme. Importantly, it also allows a statistical comparison of offending prior to and following involvement in CARDS.

Evaluator Observation and Liaison

The evaluator was involved in a range of activities, meetings and liaison with key personnel involved in the Scheme. This served to promote participation of stakeholders in the evaluation and better informed the evaluator regarding the Scheme itself. This activity included attendance at meetings of the CARDS Steering Group Committee, regular meetings with CARDS staff, engaging a range of stakeholders to assist with data requirements and observation of court processes. The evaluator was also familiar with a range of relevant documentation including procedure manuals for various stakeholder groups involved in the Scheme. In addition, a range of briefing papers and client statistical updates were produced

³ Though they were often prepared to complete the post-questionnaire over the telephone.

throughout the evaluation period to ensure that key stakeholders were regularly informed of the Scheme's progress and alerted to any matters requiring attention.

This liaison role also reflected an *action research* element to the evaluation, which involved the evaluator identifying emerging and pressing issues associated with the Scheme and informing relevant stakeholders in a timely manner so that such issues could be appropriately addressed or considered.

Whilst not a structured evaluation method in the sense of the other data collection methods outlined in this section, this evaluator participation was of great importance in assisting the evaluation process.

THROUGHPUT OF PARTICIPANTS

Introduction

This section provides detail regarding the throughput of clients from referral through to CARDS completion. All information reflects data available as at 27 June 2006 - which represents two complete years of data from the inception of the Scheme.

Number of Referrals

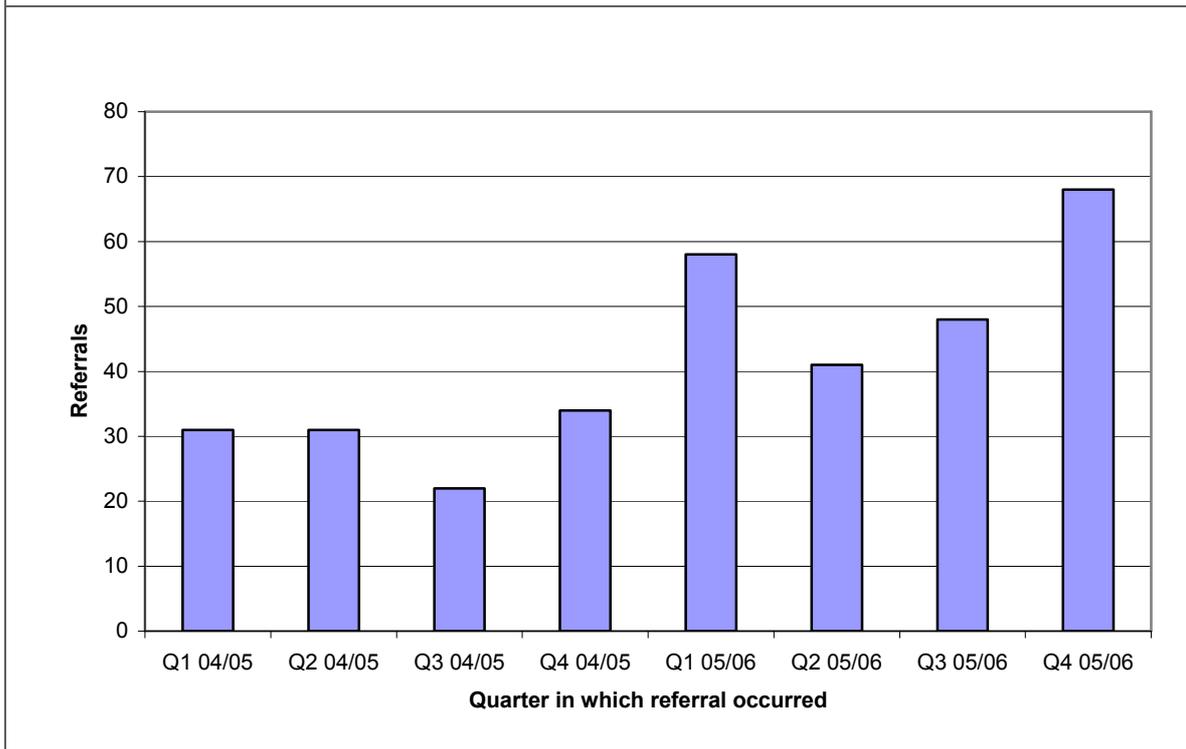
In the two years from late June 2004 to June 27th 2006, 333 referrals were made to CARDS. Of these, 33 referrals involved individuals referred to CARDS for a second or third time. Table 1 presents the 333 referrals across each of the Magistrates Court sites where CARDS operated during this period. It also provides an overview of referrals by the quarter from July-September 2004. The shading indicates that CARDS had not officially commenced at a particular Magistrates Court at this time. Both Port Adelaide and Adelaide Magistrates Court had some referrals in the week or two prior to their official launch.

Month/Year	Port Adelaide	Nunga Court	Adelaide	Murray Bridge	Mount Barker	Elizabeth	Total
June 2004	8	-	-	-	-	-	8
Qtr 1 - Jul-Sept 2004	20	2	1				23
Qtr 2 - Oct-Dec 2004	13	4	14				31
Qtr 3 - Jan-Mar 2005	8	1	13				22
Qtr 4 - Apr-Jun 2005	14	2	17	1			34
Qtr 5 - Jul- Sept 2005	18	2	34	3	1		58
Qtr 6 - Oct-Dec 2005	16	2	19	3	1		41
Qtr 7 - Jan-Mar 2006	12	2	26	1	-	7	48
Qtr 8 - Apr-Jun 2006	17	3	23	5	1	19	68
Total	126	18	147	13	3	26	333

As can be seen from Table 1, Adelaide Magistrates Court has provided the most referrals to the Scheme, closely followed by Port Adelaide Magistrates Court. The numbers are closer if the Nunga Court at Port Adelaide is grouped together with the Magistrates Court. This is consistent with these being large courts and also the first in which CARDS commenced. Murray Bridge and Mount Barker have provided limited referrals, whilst Elizabeth Magistrates Court began solidly in February 2006, particularly in its first full quarter to June 2006.

As shown in Figure 2 the number of referrals to CARDS, per quarter, has continued to increase. The first full year of operation (including referrals received late June 2004) to June 2005 saw 118 referrals. With additional courts operating in the second year, the number of referrals rose to 215. This equates to an average of almost 10 referrals per month in the first year of the pilot and almost 18 referrals per month in the second.

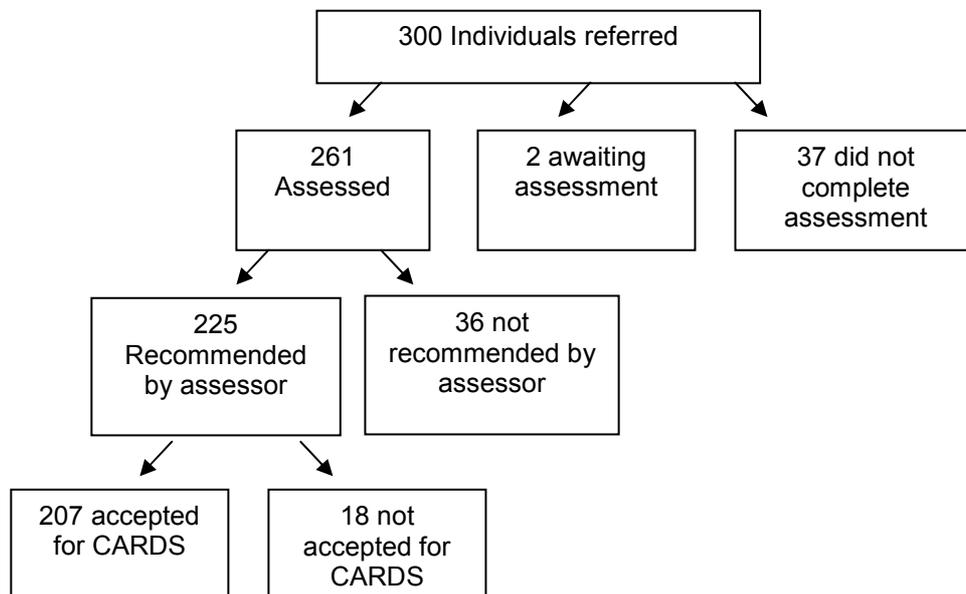
Figure 2 Total referrals to CARDS by quarter



Progression of Clients from Referral to Acceptance onto CARDS

Prior to outlining the profile of clients accepted onto CARDS, a flowchart (see Figure 3) is useful in presenting the progression of clients from referral to acceptance onto CARDS and the relative numbers involved up to 27 June 2006. Unlike the referrals outlined above, this data is based on the individuals involved in CARDS. For those individuals that were referred to CARDS on more than one occasion, their first referral only is considered.

Figure 3 Flow chart showing progress of all individuals referred to CARDS

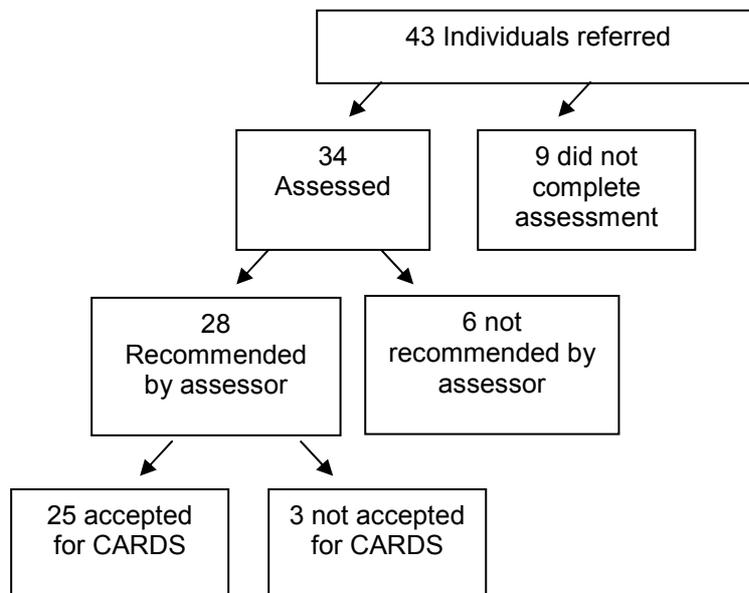


To explain the flowchart in Figure 3, approximately two-thirds (207) of the 300 individuals referred to CARDS were ultimately accepted into the Scheme. The number of clients accepted into the Scheme in a two-year period is considerably below the 300 to 350 clients that were anticipated by Scheme organisers to participate each year.

In between initial referral and acceptance onto the Scheme, potential clients were filtered out through their own failure to attend an assessment (37 individuals), not being recommended by the assessor following assessment (36 individuals) and not being accepted by the magistrate to participate in the Scheme (18 individuals).

Of this sample of 207 clients, 25 were Indigenous. Similar to the flowchart provided of all clients from referral through to acceptance onto CARDS, a flowchart is provided of Indigenous clients' progression onto the Scheme (See Figure 4).

Figure 4 Flow chart showing progress of Indigenous individuals referred to CARDS



Of note, is the proportion of those referred who were actually accepted into the Scheme and indicated their willingness to participate. For all individuals, this proportion was 69.0% (207 accepted from 300 referrals), but for Indigenous clients this proportion was lower at 58.1% (25 accepted from 43 referrals). This difference can largely be accounted for by the larger proportion of Indigenous clients who did not complete an assessment for CARDS (n=9, 20.9%), compared to the overall group (n=37, 14.2%), which does include Indigenous clients. When only considering non-Indigenous clients, the proportion was lower at 12.3% (n=28).

Progression of Clients from Acceptance to Current Status

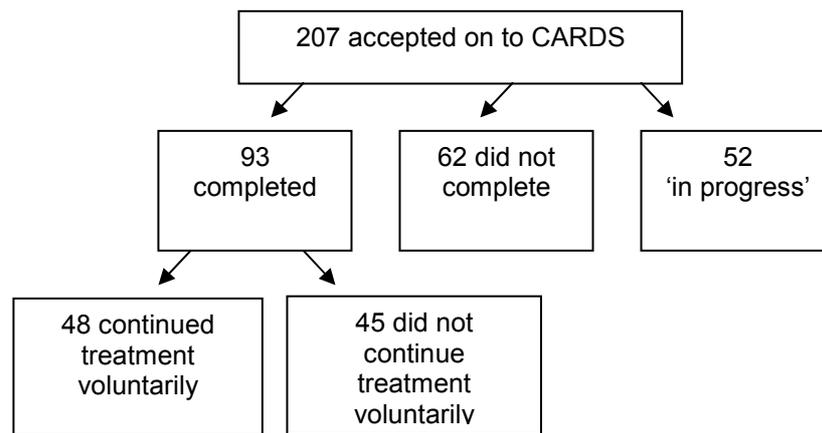
Of 207 clients accepted onto CARDS by June 27 2006, the CARDS database revealed their current status at that date, which included:

- 93 who had successfully completed CARDS;

- 62 who failed to complete; and
- 52 that were at various stages in treatment.

The completion of 93 of a possible 155 clients represents a completion rate of 60%. Of the 93 who completed, 48 were indicated by their clinician to have continued their treatment voluntarily, whilst 45 chose not to continue once they had completed the required four sessions. This progression is represented in Figure 5

Figure 5 Flow chart showing progression of individuals after acceptance onto CARDS



For Indigenous clients, of 25 accepted into the Scheme, as at the 27th of June 2006, seven had successfully completed the Scheme's requirements, 12 failed to complete, whilst six were still in progress. Excluding those currently in progress, this represents a completion rate of 36.8%. Whilst the numbers of Indigenous clients are small, a comparison to the overall client group (which still includes Indigenous clients) reveals that Indigenous clients are less likely to complete the Scheme. This was confirmed statistically in a chi-square analysis.⁴

Recommendation 1

It is recommended that consideration be given to ways of increasing the retention and successful completion of CARDS by Indigenous defendants.

⁴ Refer to comparison of completers and non-completers in the section titled, 'Treatment Received and Compliance with Treatment by Clients'.

PROFILE OF CLIENTS ACCEPTED ONTO CARDS

Introduction

This section provides a summary of the profile of those accepted onto CARDS. Greater detail of these participants' profiles is available in the most recent *Adult CARDS: A Statistical Overview of the Pilot from Inception to June 2006* (Briefing Paper Number 3, Issue 4). The mentioned Briefing Paper provides a detailed profile of all individuals referred, those assessed and not assessed, those recommended and not recommended for CARDS by the assessor, those who did not accept involvement in CARDS and those who either completed or did not complete CARDS. All information reflects data available as at 27 June 2006.

Age, Gender and Indigenous Status

Of the 207 individuals who ultimately became clients of the Scheme, 156 (75.4%) were male and 51 female (24.6%). Table 2 below provides a breakdown of the age and gender of these CARDS clients.

Age	Male		Female		Total	
	No.	%	No.	%	No.	%
18-24	30	19.2	17	33.3	47	22.7
25-29	39	25.0	14	27.5	53	25.6
30-34	43	27.6	4	7.8	47	22.7
35-39	23	14.7	8	15.7	31	15.0
40-44	12	7.7	5	9.8	17	8.2
45-49	8	5.1	3	5.9	11	5.3
50+	1	0.6	0	-	1	0.5
Total	156	100.0	51	100.0	207	100.0

Of those individuals accepted onto CARDS, 86.0% were under 40 years of age. There was a relatively even spread of those aged 18-24, 25-29 and 30-34 years, whilst relative proportions reduced in the older age category. The mean age of the sample was 30.7, whilst the median age was 30. Overall, females (mean 29.6, median 28) were slightly younger than males (mean 31.0, median 30.5). Of the 25 Indigenous clients on the Scheme, 18 were male and seven female, and all were under 40 years of age.

Drug Use

Of those individuals accepted onto CARDS, by far the two most common drugs used were amphetamines and cannabis. This was true regardless of gender, Indigenous status or age. Just under three-quarters of clients reported using amphetamines (n=153, 74.3%), whilst two-thirds (n=137, 66.5%) reported using cannabis. Heroin was the next most common drug used, with around one-quarter of clients reporting its use (n=55, 26.7%). The remaining drugs were all used by 10% or less of clients. Table 3 provides a more detailed overview, with a distinction made between male and female clients.

Drug Type	Males		Females		Total	
	No.	%	No.	%	No.	%
Amphetamines	113	72.4	40	80.0	153	74.3
Heroin	38	24.4	17	34.0	55	26.7
Cannabis	116	74.4	21	42.0	137	66.5
Benzodiazepines	11	7.1	10	20.0	21	10.2
Alcohol	9	5.8	2	4.0	11	5.3
Ecstasy	9	5.8	4	8.0	13	6.3
Morphine	12	7.7	3	6.0	15	7.3
Cocaine	3	1.9	0	-	3	1.5
Methadone	2	1.3	0	-	2	1.0
Other	9	5.8	3	6.0	12	5.8
Total	156	-	50	-	206	100.0

unknown = 1

Worth noting with respect to gender differences are the much higher use of cannabis by males (74.4%) than females (42.0%), and the higher use by females versus males of heroin (34.0% compared with 24.4%) and benzodiazepines (20.0% compared with 7.1%).

Whilst there were no age differences in drug use worth reporting, a comparison of Indigenous and non-Indigenous clients revealed that a wider range of drugs were used by non-Indigenous clients, with no Indigenous clients reporting use of ecstasy, morphine, cocaine or methadone. Heroin use was more common amongst Indigenous (n = 11, 44.0%) than non-Indigenous clients (n=44, 24.6%), as was cannabis use (Indigenous clients, n=19, 76.0% vs non-Indigenous clients, n=116, 64.8%).

Level of Education Attained and Self-Reported Literacy

Of those clients whose level of education attained was known (9 unknown), the majority (n=126, 63.6%) were educated to Year 10 or below. Detail of educational level attained across all clients, with a distinction between male and female clients, is provided in Table 4.

Education Level	Males		Females		Total	
	No.	%	No.	%	No.	%
Year 6	1	0.7	0	-	1	0.5
Year 7	3	2.0	4	8.3	7	3.5
Year 8	15	10.0	2	4.2	17	8.6
Year 9	24	16.0	8	16.6	32	16.2
Year 10	57	38.0	12	25.0	69	34.8
Year 11	35	23.3	13	27.1	48	24.2
Year 12	6	4.0	6	12.5	12	6.1
Year 13	1	0.7	0	-	1	0.5
TAFE/App	5	3.3	2	4.2	7	3.5
University	3	2.0	1	2.1	4	2.0
Total	150	100.0	48	100.0	198	100.0

unknown = 11

Post Year 10 education was more likely amongst female clients (n=22, 45.8%) than male clients (n=50, 33.3%). This difference was largely accounted for by the much higher proportion of female clients finishing Year 12. Indigenous clients (n=19, 82.6%) were more likely than non-Indigenous clients (n=106, 60.6%) to have Year 10 as their maximum level of education attained. There were no noteworthy differences in clients' educational level attained on the basis of age.

Clients reported their own level of literacy as either good, fair or poor. Over 60% (n=122) of 195 clients who disclosed this information rated their literacy as good. A further 30% (n=59) rated their literacy level to be fair, whilst approximately 7% (n=14) reported their literacy level to be poor. Females (n=34, 72.3%) were more likely than males (n=88, 59.5%) to rate their literacy as good, whilst non-Indigenous clients (n=111, 64.9%) were more likely to report good literacy than Indigenous clients (n=11, 45.8%). In general, age differences in self-reported literacy were minimal, with the exception of 18 to 24 year olds, who were much less likely to rate their literacy level as good (n=24, 52.2%) than the other age groups combined (n=98, 65.8%).

Employment Status, Accommodation Status, Income and Debt

Approximately four-fifths of CARDS clients who provided information regarding their employment status were unemployed (n=160, 80.8%). Of the 29 with some form of paid work, only 11 were full-time workers, with 13 casually employed and five working part-time. Females were less likely to be in paid employment (n=5, 10.0%) than males (n=24, 16.2%). Four males and three females were on a pension, whilst two females were studying. Of 25 Indigenous clients, one each was employed full-time, employed casually, studying or on a pension. The remaining 21 (84%) were unemployed, which was slightly higher than the unemployed rate of non-Indigenous clients (n=138, 80.2%). When considering employment status on the basis of age category, those aged 18 to 24 (n=30, 69.8%) were much less likely

to be unemployed than other age groups (ages 25-29, n=44, 84.6%; ages 30-34, n=36, 78.3%; ages 35-39, n=27, 93.1%; and aged 40 and over, n=23, 82.1%). This lesser level of unemployment in those aged 18 to 24 was mainly due to a higher number of casual rather than full or part-time workers, along with the only two clients in the sample to be currently studying.

The accommodation status of clients was derived from data held by DASSA rather than the CARDS database. It comprises detail for 161 clients who received treatment services from DASSA. The vast majority of these clients (n=143, 88.8%) indicated that they lived in a private residence. Seven lived in a hostel or supported accommodation facility, two indicated that they were homeless, and one was living in a medical facility. Eight clients either lived in some other form of undefined accommodation, or no information was available concerning their accommodation status.

The main income source of clients was also derived from data held by DASSA. The majority (n=126, 78.3%) relied on a government pension or benefit. Twenty-five clients (15.5%) gained their main income from employment. The remainder received their main income from a study allowance (n=2), a partner or family (n=1), or did not state their main income source (n=5).

Clients were asked to provide information concerning their level of personal debt. The majority of 207 clients in the CARDS database reported some level of personal debt (n=119, 57.4%). This ranged from less than \$1,000 to in excess of \$40,000. The self-reported debt levels of CARDS clients is presented in Table 5, which distinguishes male and female clients. Caution should be used in interpreting data concerning client debt levels, particularly given their self-reported nature and the fact that no data is available concerning clients' assets, which may offset some debts.

Debt	Males		Females		Total	
	No.	%	No.	*	No.	%
no debt	70	44.9	18	35.3	88	42.5
amount unspecified	18	11.5	9	17.6	27	13.0
less than \$1,000	8	5.1	2	3.9	10	4.8
\$1,000 - \$4,999	27	17.3	8	15.7	35	16.9
\$5,000 - \$9,999	13	8.3	6	11.8	19	9.2
\$10,000 - \$14,999	6	3.8	2	3.9	8	3.9
\$15,000 - \$19,999	7	4.5	3	5.9	10	4.8
\$20,000 - \$29,999	5	3.2	0	-	5	2.4
\$30,000 - \$39,000	0	-	2	3.9	2	1.0
\$40,000 +	2	1.3	1	2.0	3	1.4
Total	156	100.0	51	100.0	207	100.0

For those with debt, the most common extent of that debt was between \$1,000 and \$4,999. Females (n=18, 35.3%) were less likely than males (n=70, 44.9%) to have no debt whatsoever. A higher proportion of Indigenous clients (n=15, 60.0%) than non-Indigenous clients (n=72, 40.0%) reported no debt. The maximum debt for an Indigenous client was

between \$10,000 and \$14,999. Twenty non-Indigenous clients had debts exceeding this range. There were no discernable differences between clients' debt levels based on their age.

Offending

Offending histories of a sample of clients accepted onto the Scheme are provided in the later section of this report titled, "Contact with the Criminal Justice System". It provides an offending profile of clients both five years and six months prior to their involvement in CARDS.

THE SCHEME IN OPERATION

This section analyses the operation of the CARD Scheme through examination of evidence acquired from documents and interviewing stakeholders involved in the management and coordination, referral and assessment, treatment and court processes of the Scheme. These categories are utilised to structure the following discussion, although some matters require limited repetition across more than one category.

Management and Coordination

Training and Informing Key Stakeholders

Prior to the implementation of CARDS at each site, consultation and training sessions were organised with the relevant agencies and stakeholders involved in the operation of the Scheme. This process was undertaken to ensure that stakeholders were familiar with the CARDS model and to prepare them to carry out their specific roles. Additional consultations or meetings were arranged with stakeholders who identified as not being able to attend. In addition to this, extensive information packages (including an electronic copy of the draft operational manual) were prepared and distributed to key stakeholders.

Previous evaluation briefing papers identified that notwithstanding these efforts, not all stakeholders had attended the consultations or had read the information provided. Magistrates, in particular, were likely to report that the information was too long and that they did not have time to 'wade through it'. In response to this, the CARDS Team initiated several other strategies to inform stakeholders of the initiative. This included visits to individual magistrates and 'cold canvassing' of legal firms.

A number of clinicians (treatment workers) reported not having received information relating to CARDS, or could not recall having attended the consultation / information sessions or having received training. This may have related to information being provided as part of in-service training at DASSA, where CARDS may not have been the sole focus. Some of those who could recall having attended such a session reported that they still lacked confidence in their understanding of the CARDS model. It is likely that this contributed to the reluctant acceptance of CARDS by some clinicians - who perceived that the Scheme 'was thrust upon them without consultation'. In response to this the CARDS team organised a forum (held on two occasions) at which information regarding the Scheme was presented, stakeholders' respective roles in the Scheme were discussed and the importance of inter-agency collaboration was stressed. The forums were well attended and most of those interviewed felt they had been worthwhile. Magistrates and lawyers reported benefiting from the forums as they received an insight into the type of treatment that was given to clients and the problems that were encountered when dealing with such diverse clients. One stakeholder reported that the forums served to reinforce the need for stronger communication and greater cross-pollination amongst stakeholders in order to develop trust and garner greater credibility for the continuation of the Scheme. Several clinicians stressed that they had not felt that the forums provided an opportunity for concerns to be raised, or for there to be frank dialogue, and that a meeting where CARDS was talked about was still required.

The CARDS process manuals were initially to be allocated to all DASSA clinics involved with CARDS so that clinicians would have access to these. This could have alleviated the problem for those who felt less informed. However, it was reported that not all clinics received a copy or clinicians were not aware that a copy was available.

At the final round of interviews, some clinicians still reported not having seen or received written information with respect to CARDS (such as the operational manual). Similarly, treatment workers appointed since the forums reported that they had not received any

information (or training) with respect to CARDS. A few lawyers also reported not being aware of CARDS operating at particular court sites which they attended.

Recommendation 2

It is recommended that CARDS management consider ways to ensure the provision of training and written information is received by all relevant agency staff and that this take account of the needs of existing and newly appointed staff.

Recommendation 3

It is recommended that CARDS and DASSA management consider creating additional opportunities for staff from both agencies to discuss their respective concerns in relation to the implementation, rollout and procedures associated with CARDS. Included in this should be consideration of the respective roles and workload allocation for both CARDS assessors and DASSA clinicians.

Communication and Collaboration between Stakeholders

Regular meetings between the CARDS team, CARDS staff and magistrates, and the Steering Committee were seen by most to provide sufficient opportunities for flexible and innovative problem solving of issues as they arose and the development of necessary collaborative working relationships. However, those involved in the provision of health treatment services were less likely to be satisfied with the communication and decision-making with respect to the Scheme – both within their own agency and between DASSA and other CARDS personnel.

Some DASSA staff expressed concern as to whether or not they were regarded as equal partners in the Scheme, the extent and timing of their being consulted by the CARDS Team, the expectations 'imposed' by CARDS staff and the weight given to their views. This contributed to resentment on their part that the needs of other agencies had been prioritised over their own, and that CARDS clients had unreasonably increased their workload.

The CARD Scheme was also reported to have brought to the fore communication issues within DASSA. These included a split between policy/program development and service delivery, which clinicians reported meant that they were not consulted during the development of CARDS, and communication difficulties with managers which meant that these same staff were 'out of the loop' in receiving relevant or timely information relating to CARDS.

Positive attempts are being made to resolve outstanding communication issues via closer working relationships between CARDS and DASSA senior management and the hosting of future forums – such as those previously mentioned. Several stakeholders stressed that the forums must also be matched by opportunities for agency staff to openly and constructively raise difficult issues and work together on a face-to-face basis to improve communication and relationships.

Staffing

The CARDS Coordinator was appointed approximately six months prior to the rollout of the Scheme (January 2004). The Coordinator's role was initially to finalise the model, establish operational processes, provide information and training as appropriate and consult with stakeholders. These stakeholders included magistrates, court staff, Aboriginal Justice Officers (AJOs), lawyers, police prosecutors, treatment providers and administration staff.

Just prior to the Scheme's implementation at the first site (Port Adelaide) a CARDS assessor was appointed along with the Department for Correctional Services (hereafter DCS) Coordinator. A second CARDS assessor was appointed in October 2004 to coincide with the start-up of CARDS at Adelaide Magistrates Court. As indicated below, additional assessors

were appointed as the Scheme expanded to additional Magistrates Courts and Youth CARDS commenced⁵. CARDS assessors were responsible for the assessment of defendants who were referred to the Scheme. The DCS CARDS Coordinator role included training DCS staff regarding CARDS and overseeing clients attending CARDS on a bond condition. An Administrative Services Officer was also appointed to assist the CARDS team.

After the rollout of CARDS to Murray Bridge in February 2005, one assessor took on the role of Country Liaison Officer and a third assessor was appointed to assist with the expansion of CARDS across additional court sites. After appointing staff members and proceeding with the implementation of CARDS at Murray Bridge, it became apparent that numbers being referred to CARDS did not warrant the number of CARDS staff appointed. Due to this, one assessor elected to take up a position with another program. The Country Liaison Officer then combined their own role with that of the assessor. In mid 2006, when many aspects of the CARD Scheme were implemented, the CARDS Coordinator elected to move from the Adelaide CAA office to Christies Beach to carry out the combined role of Coordinator/assessor. When combined with Youth CARDS, this ensures that there is a full-time assessor at each designated Court site except Murray Bridge and Mount Barker. At these locations, appointments are pre-booked and the Country Liaison Officer/assessor travels to the site to conduct assessments as necessary.

Whilst CAA management stressed that members of the CARDS team were conscientious and dedicated, the lower than anticipated referrals to the CARD Scheme (as discussed below) led to a number of staffing issues. The lack of work led to poor staff morale, boredom, assessors feeling that they were not being challenged, concern about a lack of appropriate opportunities for practicing and developing skills and a perception that assessors are 'dumbed down' in their role. It also created tension and concern among CARDS staff regarding the future of the Scheme and led to staff actively looking for other positions.

These issues raised challenges for CAA management and the CARDS Coordinator in managing a team whose role is at times unsatisfying and frustrating. In response to these issues assessors were encouraged to use their time to promote the scheme and to take on related project work. Where possible, management have also sought to 'challenge' assessors by expanding their job role. For example, one option currently under consideration is a greater 'case management' role for assessors.

Management of Lower than Anticipated Referrals

The number of referrals for CARDS assessment has been lower than anticipated. As the section 'Description of CARDS' indicated, the modelling which took place prior to the implementation of CARDS suggested that there would be between 300 and 350 referrals per annum to CARDS statewide. Proportionately the number of defendants referred to CARDS at the pilot sites has fallen well short of this. This said, cumulatively the numbers referred in the second year are higher than the first. This pattern is consistent with other pilot court based schemes.

This lower than anticipated number of referrals was initially explained in terms of the Scheme being 'new' and therefore awareness would take time to build. Some stakeholders suggested that the roll out occurred too quickly and staff were appointed before the Scheme was sufficiently under way, therefore being left with limited work. An alternative viewpoint was that staff were needed on board in order to create the momentum to obtain referrals. Both viewpoints appear valid. A number of strategies have been adopted in an effort to increase the number of referrals. These include, as previously mentioned, visiting individual magistrates and legal firms, as well as several others outlined below.

assessors were initially based at the Specialist Courts Unit and attended court only when an appointment had been scheduled for a defendant to be assessed. Assessors then took on visiting courts twice weekly to check for potentially suitable defendants appearing in court that week. It was anticipated that this 'hands on' approach would improve the referral numbers by increasing awareness of CARDS via the physical presence of assessors in the court building.

⁵ Note Youth CARDS is the subject of a separate evaluation report.

This strategy had some limited success. A further development in the second year of the pilot was to base a CARDS assessor at various metropolitan Magistrates Court sites – and for that assessor to be responsible for both adult and youth CARDS assessments⁶. Again, it was anticipated that this daily physical presence would increase awareness and understanding of CARDS, and also provide the opportunity for assessors to carry out ‘on the spot’ assessments. On these occasions the magistrate could adjourn the hearing for a short time while the assessor conducted the assessment and then return to court to provide a verbal report. This approach had other advantages – such as improving the level of attendance by defendants and reducing the number of court appearances, thus ensuring that delays in ‘processing’ defendants were kept to a minimum. However, as a strategy to increase referrals it has had mixed success. At some sites there were marked improvements in the number of defendants referred for assessment, while at others it appeared to make almost no difference. The success of this strategy appears to rest on the magistrates’ ability to identify suitable defendants and their willingness to make referrals to CARDS.

Another strategy developed to increase referrals, and at the same time to respond to concerns from magistrates about the extra court appearances required for CARDS clients and their (sometimes) inability to identify appropriate defendants, was the introduction of self-referral. This allowed defendants (or their lawyers) to contact the CARDS team and arrange an assessment (and a report to be forwarded to the court) prior to their court hearing. CARDS staff widely distributed printed material about the Scheme to relevant agencies and law firms, as well as positioning it in prominent places at the courthouses where individuals who may be eligible for CARDS would be likely to see it. This strategy has led to some referrals. However it does not appear to have made a marked difference to overall referral numbers.

The rollout of the Scheme to additional metropolitan courts was a further attempt to increase the number of referrals, and also to improve use of capacity amongst existing assessors. CARDS was rolled out to the Mount Barker Magistrates Court in July 2005, Elizabeth Magistrates Court in February 2006 and Christie’s Beach Magistrates Court in November 2006. The expansion to additional court sites has increased the total numbers of referrals per month to CARDS. However the numbers remain well below those originally anticipated and the workload per assessor at most sites is well below satisfactory. Again, the success of this strategy appears to rest on the particular magistrates’ ability to identify suitable defendants and their willingness to make referrals to CARDS.

Overall, the number of referrals to CARDS has increased in the second year of the pilot and there is evidence of continued growth in the latter part of 2006. However this still falls short of using existing CARDS capacity and appears to be heavily reliant on the cooperation of individual magistrates. In turn, this continues to create issues for CAA management with respect to the efficient and effective use of resources and in providing meaningful work roles for CARDS staff.

Recommendation 4

It is recommended that the CARDS Steering Group and management continue to monitor the number of referrals to CARDS and to develop further strategies to identify suitable defendants and ensure their referral to CARDS. Consideration of such strategies may well require the involvement of magistrates and lawyers in their development and implementation.

Role of the Department for Correctional Services

The CARDS model and budget provides for a half time CARDS Coordinator within the Department for Correctional Services (DCS) whose role is to oversee DCS supervised CARDS clients and provide information / support to DCS staff in relation to CARDS.

⁶ By the end of 2006 assessors were based at the Adelaide, Christies Beach, Elizabeth and Port Adelaide Magistrates Court. CARDS assessments were also able to be accommodated from Holden Hill, Mount Barker and Murray Bridge Magistrate's Courts.

DCS stakeholders expressed the view that their participation in CARDS required rethinking and needed to be appropriately resourced, or alternative methods found to fulfil their current function for some CARDS clients, namely the supervision of an order by the court. Some concern was expressed that CARDS potentially widens the group of individuals in contact with DCS, by making the Scheme a condition of bail or bond. Alternatively, the notion of CARDS participation being voluntary for some individuals and a condition of bail or bond for others (which DCS staff are obliged to enforce), also sat uncomfortably with DCS staff. More recently, many magistrates appear to have moved away from attaching any bail or bond condition as to CARDS participation. Such an approach was seen to reduce the need for DCS intervention, and possibly raises questions regarding the effective use of staff resources.

DCS staff reported that the level of support they currently provide in the supervision of CARDS clients was, in their view, inadequate for the clients to maintain motivation and successfully complete the Scheme. In suggesting that they be given a greater involvement in supervision of the order, probation officers advocated that client motivation could be better maintained if these officers provided support following missed appointments, along with general support between appointments. It should be noted that DCS staff primarily only supervise clients who enter the Scheme as a condition of bond - which was a minority of all CARDS clients. Increased client support has also been raised as a possible expanded role for CARDS assessors. This issue is further discussed under 'Treatment Effectiveness'.

Recommendation 5

It is recommended that discussions be held between the CARDS Steering Group, CARDS management and DCS management with respect to the ongoing role and resourcing of the Department for Correctional Services in relation to CARDS.

Data Collection

At the outset of the CARD Scheme an Access database (the 'CARDS Database') was designed by OCSAR in consultation with CARDS staff. It collects information with respect to demographics and throughput of CARDS clients for operational and reporting purposes and to aid in the evaluation process. After the first year of the pilot, an assessment was made of the data collected and alterations were made to improve the quality and adequacy of data collection and the reporting processes. From time to time, CARDS staff have encountered problems with the database which appear to relate to system configuration, software limitations, or human error. Throughout the evaluation period OCSAR staff have monitored data quality and resolved any problems with the database. There has been some discussion of the development of a new Specialist Courts Unit database to accommodate all programs run by the Unit. Notwithstanding this, arrangements will need to be made for ongoing database technical support and monitoring of data quality.

Recommendation 6

It is recommended that CARDS management give consideration to arrangements for ongoing database technical support and for the monitoring of CARDS data quality.

Referral and Assessment

Contribution of Stakeholders to Referrals

A defendant be referred to CARDS from a range of sources including magistrates, police prosecutors, lawyers and Department for Corrections staff. Self-referral was later added as a response to lower than anticipated referrals. In practice, based on the CARDS database and

stakeholder feedback, the vast majority of referrals come from magistrates. The Adelaide and Port Adelaide Magistrates Courts generated the majority of referrals since their respective commencement and this trend continued throughout the pilot term.

Amongst those who had participated in one of the CARDS training sessions, or met one-on-one with CARDS staff knowledge of the scheme was consistently reported to be high. However, for some, information regarding CARDS had been relayed only 'in passing'. A police prosecutor and a lawyer both reported being given a verbal description of CARDS in order to 'bring them up to speed'. This situation was reported to occur particularly when there is a turn over of staff or staff members are brought in at short notice (perhaps, at least initially, from locations where CARDS was not available). It is possible that such individuals, who are not familiar with the process, may be reluctant to suggest a referral.

There was a perception amongst some stakeholders early in the pilot that lawyers and police prosecutors and even some magistrates were not contributing to the referral process and that the CARDS message is 'not out there'. In the final round of interviews that perception continued to exist, along with a view that lower than anticipated referral numbers are still due to a lack of cooperation between stakeholders.

Magistrates and lawyers alike reported that it was often difficult to identify defendants who may be suitable for CARDS. The details of a defendant did not always make it clear that drug use was a contributing factor in their criminal activity. Some magistrates reported that they relied on the type of offences alleged to have been committed by the defendant to signal whether they may be related to drug use – and therefore to identify an individual for CARDS referral. There is also the perception amongst most magistrates that assistance in identifying clients is limited from both lawyers and police prosecution, therefore leaving the responsibility to identify clients heavily upon the magistrate. They suggest that prosecution and defence be further encouraged to liaise as to a defendant's suitability for CARDS and be more active in the referral process. One magistrate suggested that an important area for development might be to better promote CARDS to defence lawyers because, in their view, there is no sanction for a client not completing the Scheme - which may make it a more attractive option.

Lawyers consistently reported that in making a decision as to whether to suggest a referral to CARDS they weighed up whether or not CARDS participation was likely to help or hinder their client's chances of obtaining bail, both now and in the future, as well as how the court may interpret failure to complete CARDS at the point of sentencing. While magistrates did not report that they would be likely to impose a harsher penalty if the defendant failed to complete CARDS, there was a consistent perception amongst lawyers that failure to complete CARDS would be viewed unfavourably by the magistrate – and therefore for clients who they thought may not succeed, they were unlikely to suggest CARDS. An explicit, agreed position as to how non-completion of CARDS would be taken account of by the magistrate (if this were possible) might assist to increase lawyers willingness to identify their clients as suitable defendants.

Police prosecutors maintained that their role in the CARDS process was minimal and it was suggested that, due to the nature of their role, CARDS referrals were not always an immediate concern. Police prosecutors moving across many court locations was reported to be a barrier to their referring to CARDS. For example, one prosecutor who had maintained his position in a particular court reported that CARDS referrals became part of the routine as the magistrate in that court was a keen proponent (this perception was not backed up by referral numbers from that court). However at other court sites, magistrates were reported not to regularly mention CARDS. This was reported to make it more difficult for prosecutors to consider when CARDS may be appropriate.

Differing organisational objectives were also reported as being likely to affect stakeholder commitment to CARDS referrals. It was explained that particularly from a police prosecution stance, the objective is to secure a prosecution and a Scheme like CARDS may delay that process. This, coupled with the current approach of magistrates to 'invite' an individual to take part in CARDS, may be seen by police prosecution as 'fluffing around' with individuals when they should be processed through the courts. It was suggested that police prosecutors would be more likely to make referrals to CARDS if there were conditions of bail or bond, as they would consider it to be formally legitimised with checks and balances. The stakeholder

further explained that the role of the criminal justice system is to reinforce amongst offenders that they are accountable for their actions, and CARDS is slipping with the invitation option. The stakeholder summarised their position in stating *“If the justice system is to play a constructive role it needs to apply therapeutic jurisprudence in a more assertive manner”*. Views such as these make it unlikely that police prosecutors will actively suggest a referral to CARDS or similar schemes.

Both magistrates and lawyers reported that their perceptions of a defendant’s motivation to address their drug issue affected whether or not they were likely to make a referral to CARDS. It is possible that as a result of their perceptions, defendants who may have benefited from CARDS were not offered the opportunity. This point is particularly notable given, as reported later in this report, the assessment process and treatment sessions served to increase motivation to address drug use amongst some participants.

Impact of Eligibility upon Referrals

In addition to those issues previously discussed, the evaluation identified two possible factors relating to eligibility criteria which may contribute to fewer referrals to CARDS than anticipated. Each is discussed below.

Firstly, the eligibility criteria for CARDS which prohibits individuals with a history of violence and excludes individuals with major indictable offences from being referred, was felt by many stakeholders to adversely affect the number of defendants referred to CARDS. This particularly affected Indigenous individuals, many of whom were considered appropriate for referral but were currently unable to access the Scheme due to their offending history, including violent offences. In this regard, the model was reassessed and it was agreed through the CARDS Steering Group to assess those with a history of violence on an individual basis to ascertain whether or not they would be appropriate as participants.

After consultation with the Steering Group, the CARDS team are also looking at the feasibility of incorporating into the assessment a screening tool to flag the risk of violence (after a check has been made regarding current charges). If there was some suggestion of a possible risk of violence, a further psychological assessment tool would be used. If the individual returned a score of concern on this tool a risk management plan would be developed with the treating agency in conjunction with the referral taking place. In this way, any acute risk to the treating agency would be highlighted and managed and the agency could be reassured that issues of worker safety have been addressed.

Secondly, stakeholders queried whether the level of offending and extent of drug use permitted amongst defendants referred to CARDS was greater than that in other states offering similar schemes. This led to some suggestion that many of the Scheme’s target group may simply not be coming before the court because lower level drug offences are dealt with under other initiatives, and ultimately, this may affect the number of defendants available for referral. In this sense some stakeholders questioned whether the ‘pool’ of individuals suitable for CARDS was in fact as large as initially thought and whether the Magistrates Court was the best avenue for identifying these individuals.

Indigenous Referrals

Beyond the eligibility requirements outlined above which may preclude Indigenous offenders from participating in the Scheme, a further possible reason provided by some stakeholders for lower than anticipated Indigenous referrals was that CARDS, in its current format, may not meet the needs of Indigenous defendants. A stakeholder with a role that interacts with Indigenous people believed that because of the complex lifestyle that many Indigenous people lead, the CARDS model may be “too light” to have any major influence. This may have reduced the likelihood of Indigenous clients seeking access to the Scheme.

A suggestion was made to increase the involvement of Aboriginal Justice Officers (AJO) in order to help the Indigenous community to gain a better understanding of the CARD Scheme, and thereby increase their willingness to be involved. Contact with AJOs for Indigenous

clients was described as part of the process in the original draft Operational Manual. This document stated that when an Indigenous client was referred, the Sheriff's Officer would introduce the client to the AJO at the court so that they could receive information and assistance regarding CARDS. However, the AJOs interviewed reported that this never occurred and they felt that they were not routinely considered as part of the CARDS process for Indigenous clients.

Several stakeholders noted that while CARDS was, in some respects, likely to be a more appealing program than the Drug Court, it still may not be suited to the needs of Aboriginal defendants. More broadly, they referred to the lack of a proper array of treatment and court options suited to the Indigenous community, which provides a barrier to both referral and participation by Indigenous offenders. At the time of writing CAA management and the Project Manager, Justice Strategy Division were investigating the establishment of an intervention program to be piloted at the Nunga Court which may address these concerns.

Changes to Assessment

After referral to CARDS, defendants are required to undertake an assessment (with a CARDS assessor) to determine whether or not they are suitable to be accepted into the Scheme and to undertake treatment. CARDS staff were satisfied that the assessment tool was appropriate and that measures were in place to discuss assessment at their team meetings (if required) and that the findings based on the tool could be adequately entered into the database.

Assessors reported that in recent months the majority of assessments were conducted 'on the spot'. That is, the magistrate defers the defendant's case until later in the list while the assessor conducts the assessment and then returns to court to provide a verbal report. Their view was that this has streamlined the court process as it eliminates the need for a two-week adjournment for the assessment to take place. However, a downside was that assessors can feel under pressure to complete the assessment in a lesser amount of time than they might normally. In their view this constrains their ability to build rapport and trust with the client or make efforts to increase the client's motivation to accept treatment, and potentially means that the assessment may be less thorough than that conducted under the other circumstances.

Notwithstanding some of the challenges associated with the assessment process, interviewees were generally satisfied with the way assessments were carried out. The expertise and professional knowledge of the assessors is highly respected by referring magistrates and lawyers and no decision by an assessor had been questioned either by a lawyer or magistrate in the Scheme.

Treatment

This section examines a range of issues that arose during the operation of the Scheme in relation to treatment. Unless otherwise indicated, all references to treatment agencies pertain to DASSA, as under the model they were the agreed providers and the vast majority of CARDS' participants have undergone treatment at this agency.

Appointment Booking

When a client is accepted for CARDS treatment they are required to attend four 'treatment' sessions with a designated clinician. The appointments are made by CARDS assessors through the CARDS Appointment Line (CAL). It provides a centralised mechanism for the recording and booking of appointments. During the pilot treatment was provided exclusively by DASSA. CAL also has access to a number of other IDDI funded treatment providers. The communication is reported to be both efficient and effective and there is a high degree of satisfaction with CAL from both CARDS staff and treatment provider perspectives. DASSA administrative staff and clinicians mostly reported being sufficiently knowledgeable of the appointment process based on the information sessions held at the inception of the CARD

Scheme and through effective communication since. However, it was evident that a few clinicians were not familiar with all aspects of the CARDS process.

According to procedure, the assessor will ring the CAL to book a client onto treatment where four appointment times are arranged. The appointment booking system appears to be working consistently with this original model. However, it has been reported that on some occasions assessors bypass CAL to book a specific clinician who they regard as being more appropriate for a particular client. This can cause confusion as information may not reach CAL personnel and mandated appointment slots may not be used or data not recorded systematically for all clients. This has possible ramifications for determining resource needs and usage, and in turn may impact on arguments for future IDDI funding needs.

Another problem recently arose when an alternative drug treatment agency, Offenders Aid & Rehabilitation Services (OARS), was employed to work with CARDS clients in addition to DASSA. Prior to this, the CAL recorded all client bookings for treatment and these details were held on a database at DASSA, monitoring of client numbers was straightforward and all clients were seen by workers accredited under the Illicit Drug Diversion Initiative (IDDI). Clients referred to OARS were not booked through the CAL and therefore there was no record of the client on CAL and standardised data for those clients was not collected. A process whereby all appointments are made through the CAL has now been incorporated to resolve this issue. However issues regarding the treatment data collected by providers other than DASSA still needs to be addressed.

Recommendation 7

It is recommended that all appointments for CARDS continue to be booked through the CARDS Appointment Line.

Recommendation 8

Should CARDS expand its use of treatment providers beyond DASSA, it is recommended that steps be taken to ensure the standardisation of data collection across agencies and that consideration be given to ensuring these data are sufficient for ongoing monitoring and evaluation purposes.

DASSA clinicians have expressed concern over the high number of missed and rescheduled appointments and the impact which this has on their workload and the availability of appointments for other clients. (Refer also to Section titled "Treatment Received and Compliance with Treatment"). Given the limited time available for the four appointments to be completed, on those occasions where appointments were missed it was often necessary to 'fit in' the client within a week of missing an appointment, in order to keep to the schedule of appointments and ensure the completion of the minimum treatment requirements before returning to court.

The difficulty of 'fitting in' four appointments was exacerbated on occasions where magistrates adjourned the matter for only two months, rather than the three months recommended in the model. This was described to have a negative 'knock-on' effect, causing difficulties with clients being able to comply with CARDS requirements and placing more pressure on clinicians. The CARDS assessors now monitor this and have contacted magistrates for an extension to any short adjournments, which have been granted without problem.

In an attempt to improve attendance at treatment sessions, a procedure has been implemented whereby the CARDS assessor contacts the client to remind them of their first treatment appointment and DASSA clinicians contact them prior to each subsequent appointment. Clinicians report that this approach has been implemented by DASSA, but adds to what some describe as an already burgeoning CARDS workload.

Treatment Limitations or Barriers

Clinician feedback via interviews has revealed that DASSA as a whole is able to meet the current level of demand for CARDS treatment services. In part this is due to the relatively low numbers being referred and the operation of CARDS being confined to predominantly the metropolitan area. The expansion of CARDS into further regional areas, where limited appointments are available, or significant increases in the number of CARDS clients - or clients in other related programs (eg Police Drug Diversion or Drug Courts) may alter DASSA's ability to meet the demand for treatment services. However, several current limitations with respect to treatment were identified. These are outlined below.

Clinics available for CARDS clients are mainly located within the Adelaide Metropolitan Area (clinics for CARDS clients are also available at Murray Bridge and Victor Harbour). One particular issue is that only one DASSA clinic, the Northern Drug Service in Elizabeth, caters for clients after normal working hours. The lack of services after hours can be problematic as it limits access to those who work and/or do not live nearby. Of those clients who worked, many reported via interview the need to reschedule appointments due to their work commitments. Even with lower than anticipated referrals, after hours services are limited and could become unmanageable if referrals increase.

There was also some suggestion that certain clinicians are able to 'pick and choose' which clients they see and that some will only work with motivated clients. This has reportedly led to some clinicians electing not to see CARDS clients. Such an approach was labelled by one stakeholder as 'unprofessional' as clinicians are appropriately trained and expected to work with a range of clients and to increase client motivation where necessary. Further, this approach could influence treatment outcomes and hence the overall outcomes of the Scheme.

Throughout the pilot period it was evident that some clinicians continue to feel uncomfortable working with what they perceive to be 'mandated' or 'involuntary' clients. Such clinicians often had different (usually lesser) expectations of what could be achieved during treatment, were likely to report the client's motivation as being a barrier to treatment, and resisted reporting information back to the court regarding non-compliance.

Recommendation 9

It is recommended that consideration be given to ways to address the reluctance of some clinicians to working with CARDS clients and the appropriate distribution of this type of work.

A further inconsistency in the approach to treatment between clinicians was the range of issues they attempted to address. For example, some clinicians reported treating CARDS clients differently to 'voluntary' clients in so far as they focused solely on CARDS clients' drug use - due to the perceived requirement that they 'deal with' CARDS clients in four appointments. In this sense they felt restricted (due to the lack of time) from dealing with 'other' issues which may detract from treating the drug use. In contrast, other clinicians reported prioritising client problems beyond drug use, such as homelessness, depression and debt - in much the same way as they would with non-CARDS clients.

Requirements of the CARD Scheme were that those accepted would complete four appointments with a clinician within a three-month period (according to the CARDS model). However, upon completion of the four sessions, clients were to be given the opportunity to continue with treatment on a voluntary basis if desired. It became evident that due to a lack of knowledge, some clinicians were not always offering a continuation of treatment to the client, or that the offer was made in vague terms. In contrast, other clinicians reported using the first four sessions to engage the client and 'expected' the client to continue the treatment episode as long as required. This suggests that different levels of treatment may be being offered to clients.

For clients who were motivated to continue treatment beyond CARDS requirements, an issue sometimes existed in the time taken to actually get an appointment. Clinicians at some clinics reported that there could be a five week wait for a CARDS client to get back into treatment as all 'voluntary' appointments were booked up. However at other clinics clients were able to accommodate clients within a week after CARDS treatment was completed. This highlights differences in clinic locations and may depend on the number of CARDS appointments allotted to each site or an uneven distribution of clients to specific clinics. It also raises questions with respect to the timeliness of service and whether administratively these clients should continue to use CARDS priority appointments or 'voluntary appointments'.

Recommendation 10

It is recommended that an agreed position be reached to whether CARDS clients who elect to continue treatment beyond the four required sessions continue to use CARDS priority appointments or be treated as voluntary clients for DASSA purposes, and that all CARDS clients (with ongoing drug related issues) be proactively encouraged to continue treatment.

Indigenous Services

In order to provide appropriate services to Indigenous clients, an arrangement was negotiated whereby an Aboriginal Drug and Alcohol Council (ADAC) support worker would further explain the CARD Scheme to Indigenous defendants and their families, provide transportation to treatment sessions and offer general support as required throughout the treatment process.

On the few occasions when the ADAC support worker was called on to support an Indigenous client's participation in the Scheme, positive communication was reported between the ADAC worker and DASSA, and both had collaborated well to ensure the best outcome for the client.

Throughout most of the CARDS pilot there were few, if any, Indigenous clinicians available to provide treatment for CARDS clients. While stakeholders acknowledged that the inability to offer Indigenous clients the choice of being treated by an Indigenous clinician was a significant gap in service provision, some suggested that it posed a limited problem. In their experience, Indigenous clients did not necessarily want to see an Indigenous clinician, and when offered a choice some perceived it as their being 'pushed away'.

A trained ADAC worker has recently taken up the role of treating Indigenous clients but the recruitment of Indigenous clinicians is difficult. One stakeholder reported that treatment provided for Indigenous clients was not appropriate or adequate due to the complex issues impacting on their lifestyle.

As described elsewhere in this report, a high proportion of Indigenous defendants failed to comply with the CARDS requirements. This suggests that the Scheme has not appropriately responded to Indigenous clients' needs and that alternative strategies may be required in order to increase compliance, or develop other suitable drug interventions.

Tracking and Reporting

Processes have been established to ensure the progression of clients through CARDS treatment and the reporting of their treatment progress back to the court. Four issues have emerged within this area. Namely the tracking of client progress during the period designated for treatment, timing of treatment reports being received, the use of a summarised version of treatment reports for the court, and the level of information required in treatment reports.

The CARDS team have established processes within the team to monitor referrals through to the completion of assessment. However, the same level of monitoring does not exist within the treatment phase. A process has been introduced where clinicians contact the client, usually by telephone, when an appointment has been missed to determine why the appointment was missed and to schedule an alternative one. Under the current arrangements

it is not until the third treatment appointment is missed that the CARDS team are informed of the individual's failure to comply. It was suggested that if information regarding missed appointments were available sooner, the magistrate could be made aware and some follow up may be able to occur or the matter may be brought back to court sooner. This may be less relevant if the client has simply been 'invited' to participate on CARDS, but seems particularly pertinent if the client is completing CARDS while on bail or bond.

The second issue relates to the receipt of treatment reports. Processes were developed and implemented whereby clinicians complete a treatment report after the fourth session and return this to the CARDS team. For the most part this process was reported to be operating effectively. However, on some occasions reports were not received in time for the information to be provided to the court and CARDS staff were required to 'chase up' reports. This has been largely resolved via the implementation of a reminder system whereby clinicians are forwarded a reminder that the report is due seven days prior to the final court hearing. There was some suggestion that this continues to be an issue with some clinicians who regularly fail to provide reports in a timely manner.

Early on in the pilot, CARDS staff became concerned regarding the variability in the standard and detail of reports received from clinicians. In an attempt to standardise the information reported to the court, CARDS staff developed a proforma which they complete and forward to the court, based on information contained in the clinician's report. There are some tensions around whether or not CARDS staff should be summarising the report or whether the actual report should be forwarded to the court. Clinicians have expressed concern regarding the possible level of 'interpretation' that may potentially occur, and the lack of any 'checking back' with them about the content. Related to this some clinicians suggested that they would appreciate some acknowledgement that their reports had been received and some information on the court outcomes for that client - as they reported having no 'closure' on a client after treatment was completed.

Treatment reports were described by some magistrates and lawyers as containing 'limited information' and that this impaired their ability to make use of them for sentencing purposes or for defending their client. While magistrates and lawyers consistently regarded it as being acceptable that the assessment report is succinct, some suggested that the treatment report could usefully be expanded on by being more informative in terms of the client's participation. The presence of an assessor in court on some occasions assisted in 'filling in gaps'. From a lawyer's perspective, the treatment report currently was not a useful 'tool' to defend their client. After the previously mentioned forum, clinicians reported they were more aware of what magistrates and lawyers required from the treatment report and the content of these reports was regarded to have generally improved since this time.

Magistrates held varying views as to what was important in the treatment report. One magistrate explained that they were not necessarily looking for the successful completion of four sessions of treatment, rather that the client was making an effort to attend and participate in those sessions. By comparison, another suggested that if a client did not complete all four sessions, it showed that they were not genuine. This difference highlights the contrast among magistrates' views as to what should be emphasised in reports and possibly how they may use that information. One magistrate reported that care needed to be taken when reading into the treatment report as it was based on hearsay rather than evidence. This led the magistrate to suggest that if drug testing were incorporated in the Scheme, the treatment report would have more substance.

Treatment Effectiveness

When asked about their opinion regarding the overall effectiveness of CARDS, clinicians' views were influenced by how they interpreted and defined effectiveness. The Scheme was considered effective in so far as it facilitated access to treatment services. However views as to whether it led to changes in drug use or drug-related offending were more mixed. In this sense they considered that for some clients completion of CARDS may not necessarily lead to outcomes of this sort, whilst for others it may. Conversely, in their view, some clients who had failed to complete CARDS also had positive outcomes simply by having had exposure to treatment services which may be of use to them at a later date. The main barrier to clinicians

perceiving the Scheme as effective in terms of client outcomes was that they had to take a client's word as to whether they had reduced drug use or criminal activity. Several stakeholders, some of whom were clinicians, reported that effectiveness of the Scheme would be better measured via drug testing (such as urinalysis).

When asked whether the treatment process was well suited to the objectives of CARDS, most clinicians indicated their support for the process but were not specific regarding the particular objectives. One clinician emphasised that the objectives of CARDS were "consistent with (the objectives of) our agency".

A theme which emerged from a range of stakeholders in relation to treatment was the need for additional support for CARDS participants, follow up between treatment appointments and concerns over whether or not the treatment requirements were sufficient. Points in relation to the latter emerged primarily from stakeholders who misinterpreted the 'four sessions' as being the definitive treatment regime, rather than the stated intention which was to engage participants in longer term treatment by requiring that they attend a minimum of four sessions. The issue of whether CARDS, as a scheme, should provide other support and follow up to participants appears to remain unresolved and is further discussed later in this report.

Court Processes

Impact on Court Workload

The impact of CARDS on court workload is perceived as significant by some magistrates. For several reasons CARDS, as per the original model, is considered to be a complicated process in an environment which is already overstretched.

Firstly, magistrates, prosecutors and lawyers cited difficulty in determining whether a defendant was suitable for CARDS. This was exacerbated by the time-pressured environment of court and the many other things which magistrates and legal counsel need to keep in mind during proceedings. One stakeholder suggested that due to the high caseload and a need to get through the court list as fast as possible, magistrates may have little time to consider the various options available for a defendant, which may be detrimental to recruitment for CARDS.

Secondly, CARDS participation increases the number of court appearances, which is contrary to directions given to magistrates to reduce the number of appearances for a given matter. However, some other stakeholders viewed more court appearances, rather than less, as desirable for improving the structure of the Scheme and defendants' likely success.

Thirdly, the initial arrangement whereby Sheriff's Officers were required to organise an appointment for the assessment of the defendant, was regarded as complex and time consuming for the court. The recent introduction of assessors at each court site now allows magistrates to call for an 'on the spot' assessment and to hold the matter until later in that court listing while an assessment takes place. The assessor then verbally reports back to the court – which is simpler from a court's perspective and removes the need for an additional hearing.

Support For CARDS Within the Court

There was considerable variation amongst magistrates in their support for, and opinion of, the role of CARDS in the court. This appeared to be particularly influenced by their support for the principles of therapeutic jurisprudence and their preparedness to 'share' their court with other agencies. Some magistrates questioned their role in the midst of other professionals, and some perceived a weakening criminal justice focus with the defendant not being required to enter a guilty plea before being accepted onto the Scheme. One stakeholder suggested that the overall education for magistrates may need to be improved to show that CARDS sits on the continuum of approaches to drug use and offending.

Some magistrates reported being highly sympathetic to attempts to address defendants' underlying drug issues which were linked to their offending, but expressed reservations regarding imposing CARDS as a condition of either bail or bond for reasons outlined in the subsequent section.

As a general principle, magistrates expressed some concern over the extent to which rehabilitation programs ought to contribute to more lenient sentences and balancing this with the victim's or community's expectation of punishment befitting a crime. This said, magistrates and lawyers agreed that successful participation on CARDS was viewed favourably by the court in considering the penalty to be imposed, and that sentencing was more likely to be 'constructive' where the defendant had successfully completed CARDS.

A range of data sources highlighted the variability in the number of referrals to CARDS depending on the magistrates presiding at that pilot site at any point in time. Lawyers and CARDS staff reported that in their experience some magistrates were clearly unwilling to consider CARDS, whereas others were proactive in enquiring as to the defendant's suitability for CARDS and sought every opportunity to make referrals. Given the significant role played by magistrates as 'gate keepers' into the Scheme, it seems important that every effort be made to garner support for the Scheme amongst as many magistrates as possible.

Recommendation 11

It is recommended that CARDS staff and management give consideration to ways of further increasing support for the Scheme amongst magistrates.

Choice of Bail or Bond Option

The CARDS model includes an option for defendants, if accepted on to the Scheme, to undertake the treatment as a condition of either bail or bond.

If asked to choose between the bail or bond option, most magistrates preferred the bail option because it gave the defendant an opportunity to participate and demonstrate that they had made changes which could be taken into account during sentencing. Lawyers similarly thought that their clients would be more likely to comply whilst on bail. However, two lawyers representing predominantly Indigenous clients thought that the bond option was likely to be preferred by their clients, because their clients often preferred to have the court matter finalised as quickly as possible, and because the bond condition was perceived to be 'stricter' and therefore make clients more inclined to attend treatment.

Notwithstanding the above, there is uncertainty and disagreement about whether CARDS should in fact be a condition of either bail or bond. In contrast to the original approach, many magistrates are now moving away from making CARDS a condition of bail, as this was problematic in that a breach of bail could technically attract a sanction which was contrary to the 'voluntary' nature of CARDS. The approach now is leaning more to 'inviting' the defendant to attend CARDS during an adjournment of the hearing. Some magistrates are also taking advantage of a 'Griffiths' remand in place of a bond. This is a sentencing option where the court grants an adjournment in the sentencing process to give the defendant an opportunity to demonstrate their prospects of rehabilitation, in this case by attending CARDS. In both cases, the voluntary nature of CARDS is maintained with no requirement of sanction if not completed. This has been reported by one stakeholder to be 'a good variation' to the original CARDS model.

Another recent variation has been for a magistrate to make it a condition of bail for the client to attend a CARDS assessment – but not to impose any condition as to attending treatment. In this instance, the client attended an initial treatment appointment after being accepted and then did not attend the next appointment. When the clinician contacted the client to arrange another appointment, the client insisted that the bail requirement was only to attend the

assessment. The bail condition in this case was seen as 'downplaying' the treatment element of CARDS.

Procedurally, one detrimental effect of 'inviting' a client to attend during an adjournment of their court hearing is that the referral is not always sent through the official electronic mailbox route to the assessor and instead is sometimes being relayed to the assessor by word of mouth from a court clerk, or by a client simply turning up at the assessor's office. Both administratively and for reporting purposes, it seems important that all referrals go through the proper channels.

Recommendation 12

It is recommended that consideration be given to whether the option of 'inviting' a defendant to participate on CARDS should formally be included in the model, the implications of this change considered and monitored, and any changes in outcomes of the Scheme reported on.

TREATMENT RECEIVED AND COMPLIANCE WITH TREATMENT BY CLIENTS

Introduction

This section provides details regarding the treatment received by clients and the extent to which clients complied with the treatment requirements of the Scheme. This section is entirely based upon quantitative program data rather than any stakeholder or client views and opinions, which are contained in the sections, 'The Scheme in Operation' and 'Participants' Experiences and Perceptions of the Scheme'. The section utilises two separate databases, namely the DASSA treatment database and the CARDS database, as the two provide different detail regarding the treatment received by clients and their level of compliance with that treatment.

The CARDS database includes all 207 individuals referred and accepted onto the Scheme up to June 27 2006. An analysis of the 155 clients to have completed their CARDS involvement (either successfully or otherwise) by this date will be used to inform a comparison of the likelihood of completion (and therefore compliance) between clients based on a range of demographic and drug using information.

The DASSA database contains data for clients referred to DASSA for treatment who actually received treatment (that is, those who attended at least one treatment appointment) by the 27th of June 2006. It will be used to inform:

- the treatment provided to clients;
- the end of the treatment episode (including reasons for its end and whether clients were referred elsewhere upon CARDS completion); and
- the extent to which clients attended and missed treatment sessions.

The DASSA database was de-identified when provided to OCSAR such that it does not provide names, CARDS ID or PINs (Personal Identification Numbers), nor does it provide a specific indicator that CARD Scheme requirements had been completed (successfully or otherwise) by a specific client. Therefore, it is not possible to precisely match these records to those in the CARDS database.

It should be noted that the DASSA data does not include clients referred to other agencies for treatment, which includes six clients referred to OARS and one client referred to Second Story. The DASSA data also excludes 35 clients referred to DASSA but who never attended a session within four to six weeks of their initial appointment. However, the DASSA database still allows us to undertake analyses that pertains to a majority of clients accepted onto CARDS. In all, it provides us with data concerning the treatment activity of 161 clients who actually received treatment (that is, those who attended at least one treatment appointment) by the 27th of June 2006. This DASSA data includes 19 clients who did not have CARDS listed as the referral source, but the diversion type was listed as CARDS. This group may involve clients who volunteered their involvement in CARDS rather than being referred as a CARDS client via the Magistrates Court. In analysing the data from this database, the decision was made to analyse only the first or major treatment episode of each client. Seven clients had two episodes of treatment. In all but one case, the first treatment episode was included as it involved equal or more contact with the treatment service than the second episode. However, for one client who began a new treatment episode with a different DASSA unit after just one session, their second episode was flagged as the major episode due to many treatment sessions being attended as part of this second episode of treatment. Several analyses are undertaken with a smaller group of 118 clients from this database, these being

clients who have a known end date to their episode of treatment and are definitely not currently in progress on CARDS as part of their first episode of treatment.

Treatment Provided to Clients

Of the 161 clients for whom data was available in the DASSA database, a range of treatment types were utilised. Most common was counselling (n = 86, 53.4%), followed by rehabilitation (n = 41, 25.4%). It is possible that there may be some level of overlap in these categories in many instances of treatment. Assessment only was provided for 24 clients (14.9%), pharmacotherapy was provided for five clients and withdrawal management for a further client. Four clients were designated as having received “other” treatment types. Where a client attended treatment, the vast majority of attendance was face-to-face at a clinic (534 of 586 sessions attended by clients, 91.1%). Forty-eight sessions (8.2%) involved telephone contact that qualified as a session attended, whilst only four instances of face-to-face contact sessions were undertaken away from a DASSA clinic.

The 161 clients were seen by 15 different DASSA Units. Most commonly attended were Elura (43 clients), Northern Drug Service (32 clients), Adelaide (24 clients), the DASSA Southern Clinic (11 clients) and the Parks Community Health Service (nine clients). The DASSA database does not provide information on which clinicians saw particular clients, so it is not possible to determine the ratio of CARDS clients to DASSA staff. Information regarding particular DASSA Units ability to accommodate appointments required for CARDS defendants or reschedule missed appointments was not available.

The End of the Treatment Episode

It should be noted at the outset of this section that while completing the CARD Scheme requires attendance at four treatment sessions, the reasons for ending a treatment episode, from a DASSA perspective, will be based on clinical judgement of an individuals drug (and related) issues. Therefore, the ‘end of treatment episode’ recorded by DASSA may be greater, lesser, or equal to four sessions - and as such may or may not concur with successful completion of CARDS. The DASSA data is therefore limited in explaining CARDS successful completion rates and the best data we have of this is the 60% successful completion rate contained in the CARDS database.

Of the 161 DASSA clients for whom data were available, 118 clients had a completion date listed for their treatment episode. Of these, 62 (52.5%) were described as having completed their treatment. Of this group, 39 attended treatment on at least four occasions, whilst nine clients attended on three occasions. The remaining 14 only attended on one to two occasions. At least 64 of the 118 clients had attended four or more sessions, yet only 39 of these were listed by the clinician as ending the episode due to completing treatment.

In addition to having completed treatment, the next most common reason for clients ending their treatment episode was ‘ceasing to participate without notice’ (usually via not attending an appointment) or against their clinician’s advice (n=26, 22.0%). However, 14 of these had completed at least four appointments. Other clients were ceased involuntarily for non-compliance (n=5, 4.2%), one of which attended four or more appointments, or via mutual agreement (n=5, 4.2%), two of which attended at least four appointments. A further 12 clients (10.2%) ended an episode due to a change in service provider, treatment type or delivery setting, with five of these attending at least four appointments. Four clients ended an episode due to either involvement in the Drug Court or imprisonment, two of which had already completed at least four appointments.

Upon ending a treatment episode, and for those that had a date listed in the database for the end of this episode, record was made of any further referral that was made for the client. For five clients that had an end of episode date listed, no data was entered regarding any referral made. Of the 113 remaining clients, the vast majority (n=97, 85.8%) were not referred elsewhere. Eight clients (7.1%) were referred to non-residential DASSA services or programs, and four (3.5%) were referred to other community service agencies. Only one

client was referred to a residential-based program, in this case a DASSA program, whilst a further client was referred to a General Practitioner.

The Extent to which Clients Attended and Missed Treatment Sessions

Session Attendance

According to information provided by DASSA 35 individuals referred to DASSA under the CARD Scheme did not attend within four to six weeks of the initial appointment. These 35 clients who never attended are not included in the DASSA database and are therefore not available or included in the analysis. One hundred and sixty-one clients attended at least one session at DASSA. Therefore, of the 196 total clients referred to DASSA, four-fifths (n=161, 82.1%) actually referred received health treatment services from DASSA.

Detail of attendance and failure to attend appointments amongst the 161 clients to have attended at least one session is complicated by the fact that some clients in this group were still in progress on CARDS when this data was received. It is further complicated in that some clients are likely to have finished the CARDS requirements but not completed their treatment episode, and therefore have no end date listed for this in the DASSA database. On this basis, the analysis below regarding attendance at treatment sessions and its representation in Table 6 below, only the 118 clients from the DASSA database that have a specified end date for their episode are included. This group of clients are analysed according to:

- How many attended how many appointments;
- How many failed to attend or be available for how many scheduled appointments; and
- The number of instances of indirect client work undertaken by the clinician on their behalf.

To assist with reading Table 6, the following example is provided based on data in the table: 14 clients attended an appointment on exactly two occasions, 10 clients did not attend an appointment exactly four times, whilst indirect client work was undertaken by the clinician for 35 different clients on one occasion only.

Table 6 Number of Occurrences of Clients Attending, Not Attending or Clinician Undertaking Indirect Client Work on Client's Behalf

Occurrences Across Client Group	Contact Type		
	Attended	Did not Attend	Indirect Client Work
zero times	-	53	64
1 time	22	21	35
2 times	14	13	9
3 times	18	12	6
4 times	42	10	2
5 times	9	6	1
6-10 times	10	3	1
11-20 times	1	-	-
20-30 times	2	-	-
Total	118	65	54
(number of clients with at least one instance of attending, not attending or requiring indirect client work)			

Note: These numbers summarise the total number of clients that had a certain number of occurrences of attendance, not attending, or indirect client work undertaken by the clinician on their behalf.

As can be noted from Table 6 above, four was the most common number of treatment sessions attended, with 42 clients (35.6%) attending on this number of occasions. This is consistent with four treatment visits being the standard for successful CARDS completion. A further 22 clients (18.6%) went on to undertake further treatment sessions beyond the initial four, which would have been voluntary. Therefore, 64 of the 118 clients (54.2%) that are known to have finished their treatment episode attended four or more sessions. Of these 64 clients, 47 (73.4%) completed their episode of treatment within a three-month time frame. A further 17 (26.6%) clients completed four sessions but did not do so within a three-month period.

Of 118 clients that attended at least one session and had an end-date listed for their treatment episode, 65 (55.1%) did not attend at least one session. Of the 65 who missed a session, 21 (32.3%) failed to attend only one appointment, a further 35 (53.8%) did not attend two to four appointments, whilst 9 (13.9%) did not attend five or more scheduled appointments.

Indirect client work may be defined differently by various clinicians, but may include activities on behalf of a client such as making a phone call, preparing case notes or writing a letter, including a reminder letter to attend. Generally, clinicians did not undertake indirect client work for most clients. Sixty-four of the 118 clients (54.2%) analysed had no instances of indirect client work undertaken on their behalf, and a further 35 clients (29.7%) had only one such instance.

Missed Treatment Sessions

For the analysis of the overall number of missed treatment sessions with respect to the number of scheduled appointments, all 161 clients that attended at least one session can be considered, rather than just those who had a specified episode end-date. This is because current data for those in progress is still relevant to the proportion of appointments attended to appointments missed.

Across 161 clients, there were a total of 563 attendances undertaken at treatment sessions and 251 sessions where the client was reported to have not attended. Therefore, in approximately one-third of instances (30.8%) the client did not attend. Not surprisingly, the more a client attended, the more likely they were to attend appointments. This is likely to be explained by the following scenarios. Those who choose to attend beyond the four appointments are likely to do this voluntarily or want to be there. Also, some clinicians would choose to terminate the episode quicker than others on the basis of non-attendance, resulting in a higher proportion of non-attendance, particularly where a client was terminated within the first few set appointments. For clients that attended four or more appointments (n=77), they attended a total of 405 appointments, missing just 131 appointments, or approximately one-quarter (24.4%). For clients that attended three or less appointments (n=84), they attended a total of 158 appointments, and missed 120, or nearly half (43.2%) of their appointments.

Comparison of CARDS Completers and Non-Completers

A detailed overview of the profile of CARDS completers and non-completers is provided in the most recent "Adult CARDS: A Statistical Overview of the Pilot from Inception to June 2006" (Briefing Paper Number 3, Issue 4). Of the 93 clients to have completed CARDS as at 27th June 2006, 71 are males and 22 females. Seven were Indigenous. Of the 62 clients who failed to complete, 44 were males and 18 females. Twelve of these clients were Indigenous.

A series of chi-square analyses were undertaken to compare the likelihood of CARDS completion between clients based on a wide range of demographic and drug using information, including:

- Age
- Gender
- Indigenous status
- Educational levels
- Self-reported literacy levels
- Hepatitis C status
- CARDS site
- Principal drug used
- Age of onset of drug use
- Whether previously received drug treatment
- Whether previously had a drug overdose
- Whether they have at least one family member/relative that is a positive support
- Whether they have at least one friend/associate that is a positive support
- Whether they have a supportive network outside drugs
- Impaired family relationships
- Parental knowledge of their drug use
- The assessor's perception of the client's motivation to address their drug use

This involved a sample of 155 clients who had ended their involvement with CARDS by the 27th of June 2006. Depending on missing data or categorisations that did not cover all clients, the number of cases was sometimes slightly less than this. Further chi-square analyses with a smaller sample were undertaken in relation to the extent of prior offending and seriousness of offence at entry to CARDS. These latter analyses are reported in the section "Contact with the Criminal Justice System".

For the analysis of age, to ensure sufficient numbers across age range levels, those aged 40 and over were grouped together. Age ranges utilised were 18 to 24, 25 to 29, 30 to 34, 35 to 39 and 40 and above. For analysis by CARDS site, clients referred from the Port Adelaide Magistrates Court (including the Port Adelaide Nunga Court) were compared to clients referred from the Adelaide Magistrates Court. These represented the two most common courts from which referrals came, with the referrals from other courts excluded from this analysis. Education was compared on the basis of clients who completed Year 10 or below as their highest level of education, and clients who completed Year 11 or above. Literacy levels were compared on the self-reported levels provided by clients of good, fair and poor. For analysis based on primary drug used, only the top three drugs used by clients, namely amphetamines, cannabis and heroin, were utilised for the analysis. For analysis of the age of onset of drug use, assessor notes were analysed which generally described a timeline or progression of a client's drug use history. In some cases, insufficient information was provided to identify the age of onset and these cases were excluded. The age of onset ranges utilised were 13 and below, 14 to 16 and 17 and above. The assessed level of motivation to address drug use was based on the categorisations made by assessors, which were high, medium-high and low-medium to medium, with the latter two being combined together. Other characteristics analysed were based on a simply binary categorisation, commonly Yes/No.

On the basis of categorised differences in age, gender, CARDS site (Port Adelaide and Adelaide), educational levels and self-reported literacy, clients did not significantly differ in their likelihood to complete CARDS.⁷ Likewise, the client primary drug used by the client was not found to differ amongst CARDS completers and non-completers.⁸ Amongst the sample of 155 clients, approximately one-third were recorded via self-report as being Hepatitis C positive, however, Hepatitis C status (positive or negative) was not found to be significantly different amongst CARDS completers and non-completers.⁹

Indigenous status was found to be a basis for significant differences in the likelihood to complete CARDS (χ^2 (1, n=154) = 4.72, $p = .03$), with non-Indigenous clients significantly more likely to complete CARDS than Indigenous clients. Only seven of 19 (36.8%) Indigenous clients completed CARDS compared to 86 of 136 (63.2%) non-Indigenous clients. Significant differences were also found in the likelihood of completing CARDS based on the assessor's perception of the level of motivation that their client possesses to address their drug use (χ^2 (2, n=152) = 6.133, $p < .05$). Of 24 clients perceived to have a high level of motivation to address their drug use, three-quarters (n=18) successfully completed CARDS. Of 67 clients perceived to have a medium to high level of motivation, 44 (65.6%) successfully completed, whilst of 61 clients perceived to have a medium-low to medium level of motivation, only 30 (49.2%) went on to successfully complete CARDS. This finding suggests that assessors have a good degree of accuracy in their professional judgement of the client's motivation to address their drug use.

Age of onset of drug use, as deduced from assessor's notes, was determined for 141 of the 155 clients to have completed or not completed CARDS. Fifty-four (38.3%) of these were 13 years or under when their drug use commenced, 56 (39.7%) were aged 14 to 16, whilst 31 (22.0%) were aged 17 or over. A higher proportion of those who commenced drug use between the ages of 14 to 16 went on to complete CARDS (69.6%) than those aged 13 and under (51.9%) and those aged 17 and over (54.8%). However, there was not found to be a significant difference in the likelihood of completion of clients based on their age of onset of drug use (χ^2 (2, n=141) = 3.98, $p = .136$).

Of the 155 clients in this sample, 102 (65.8%) had previously received some treatment for their drug use. Of these, 67 (65.7%) went on to complete CARDS. For the 53 clients with no prior experience of drug treatment, only 26 (49.1%) of these went on to complete CARDS.

⁷ Results for age: χ^2 (4, N = 155) = 5.45, $p = .244$; gender: χ^2 (1, N = 155) = .56, $p = .907$; CARDS site: χ^2 (1, N = 146) = .045, $p = .832$; highest educational level: χ^2 (1, N = 155) = .041, $p = .839$; and self-reported literacy level: χ^2 (2, N = 150) = 2.91, $p = .234$.

⁸ Results for primary drug used: χ^2 (2, N = 143) = 0.23, $p = .893$. Across the 143 clients for whom data was available regarding primary drug of choice and which also involved one of the top three drugs used by the sample, 80 involved amphetamines, 39 heroin and 24 cannabis.

⁹ χ^2 (1, N = 155) = .82, $p = .364$.

The chi-square analysis revealed that those clients who had previously received treatment for drug use were significantly more likely to complete CARDS than clients who had not previously received any treatment for drug use ($\chi^2(1, n=155) = 4.02, p = .045$). This may support assessor views expressed in other parts of this report that even if a client is not successful in completing CARDS on this occasion, their exposure to drug treatment and services may prove beneficial to them at a later date. Perhaps related to the above, is the finding that those clients who had previously experienced a drug overdose were more likely to complete CARDS than clients who had no prior overdoses ($\chi^2(1, n=155) = 4.99, p = .026$). It is possible that many clients who had a previous overdose may have been exposed to some form of treatment service as a result of this overdose.

Relationships with family and others were also focused upon. Amongst the 155 clients, 124 clients identified having at least one family member or relative that provided them with positive support regarding their use of drugs. Of these, 82 (66.1%) completed CARDS. However, of the 31 clients who identified no such family member or relative support, only 11 (32.3%) completed CARDS. This difference in completion rates between those clients with and without such support was significant ($\chi^2(1, n=155) = 9.70, p = .002$). In contrast, when the support in question was that of at least one friend or associate, there was no significant difference in the likelihood to complete CARDS amongst clients with or without such support.¹⁰ Similarly, having or not having a supportive network outside drug users was not found to have an influence on the likelihood of completing CARDS.¹¹ Parents of clients having knowledge of their child's drug use was also found to have no influence on the completion rates of clients¹², whilst family relationships categorised by the assessor as being impaired were also found not to influence completion rates in comparison to clients that were not identified as having impaired family relationships.¹³

¹⁰ $\chi^2(1, N = 155) = .62, p = .433$.

¹¹ $\chi^2(1, N = 155) = .76, p = .383$.

¹² $\chi^2(1, N = 155) = .03, p = .866$.

¹³ $\chi^2(1, N = 155) = 2.32, p = .128$.

PARTICIPANTS' EXPERIENCES AND PERCEPTIONS OF THE CARD SCHEME

Introduction

This section provides an analysis of the experiences and perceptions of a sample of CARDS participants who completed the scheme within the first two years of its operation. It includes a profile of those interviewed along with their feedback relating to various aspects of the scheme including: referral, assessment, treatment and where applicable the final court hearing process. A summary of the key emerging issues is provided at the end of the section.

Profile of those interviewed

Twenty-nine individuals who had completed CARDS participated in an interview. Of these, 22 (75.9%) were male and seven (24.1%) were female. Of the 93 individuals who had completed CARDS during this period 72 (77.4%) were male and 21 (22.6%) were female. The proportion of males and females in the sample is therefore similar to the overall profile of CARDS completers.

The age range of those interviewed was also similar to the overall age range of CARDS completers. Approximately one-fifth of males interviewed were aged in each of the 18-24, 25-29, 30-34 and 35-39 year age ranges, with slightly less in the 40+ age group. Of the seven females interviewed, five were aged between 18 and 29 and two were aged 40 or above. Similarly, of the 93 individuals who successfully completed CARDS, just over eight in ten males and females were under 40.

Seven of the 93 individuals who successfully completed CARDS identified as Indigenous (six males and one female). Of the group interviewed, only one (male) identified as Indigenous.

The majority of males interviewed (n=16, 72.7%) cited amphetamine as the principal drug used, followed by heroin (n=5, 22.7%). The remaining male participants reported using morphine, cannabis and benzodiazepines. In comparison, of the entire group of CARDS completers, a lesser proportion of males (n=35, 48.6%) reported amphetamine as the principal drug used, followed by cannabis (n=16, 22.2%) and then heroin (n=15, 20.8%). The remaining males reported morphine, ecstasy or benzodiazepines as their preferred drug. One individual did not specify the type of drug used.

Females who were interviewed equally reported amphetamine (n=3) and heroin (n=3) as the principal drug used and the remaining female nominated a prescription drug as her principal drug used. Of the total females (n=21) who completed CARDS a higher proportion (n=11) reported amphetamine as the principal drug used, followed by heroin (n=4) and cannabis (n=3). Two remaining individuals reported using either morphine or benzodiazepines. One female did not specify type of drug used.

Over half of the individuals interviewed reported being referred from the Adelaide Magistrates Court, just over a third were referred from Port Adelaide Magistrates Court and the remaining individual was referred from the Elizabeth Magistrates Court. When compared to the overall group of individuals referred to CARDS, the number of individuals referred from Adelaide Magistrates Court is slightly over represented.

Overall this information suggests that the proportion of males and females and the ages of those interviewed were similar to the overall group who completed CARDS. However of those interviewed, male amphetamine users were slightly over-represented and females slightly under-represented when compared to the overall group who completed CARDS.

Results

The remainder of this section presents the findings from interviews with individuals who completed CARDS.

Understanding of CARDS

Three-quarters of those interviewed were not aware of the CARD Scheme at the point of their first court hearing. Most reported that CARDS was first mentioned by the magistrate or their lawyer during the court hearing. The remaining interviewees heard about the Scheme (from a variety of sources) prior to their first court hearing. Two heard of the Scheme from their lawyer, two were informed while in prison (one by an OARS worker and the other by an inmate), one heard of CARDS from their partner - who had been given the information from a friend, and two had seen a CARDS pamphlet. One could not recall where he had seen the pamphlet but mentioned it to his lawyer and the other saw the pamphlet in the courthouse and spoke to a Corrections Officer. When asked if the police had any involvement in their referral, only one individual was aware that they had, the remaining individuals were unsure.

Almost two-thirds of respondents reported that they had received enough information to make a decision to accept a referral to CARDS. The sources of information were varied and included: magistrates, lawyers, drug court counsellors and pamphlets. Of the one-third of individuals who indicated that they did not understand CARDS sufficiently to make an informed decision as to whether to participate, most suggested that they “*went into it sort of blind*” or that the information they had received “*doesn't really explain about the avenues...it doesn't tell you nothing about the system*”.

Referral to CARDS

Interview participants were asked to rate on a scale of 1 to 5¹⁴ their experience of the CARDS referral process. Almost one third felt unable to grade the process. However, of the two thirds who did, the vast majority were satisfied with the referral process and graded it as ‘very good’ or ‘good’. Individuals who were satisfied with the process were also likely to comment on the speed with which the decision to participate on CARDS was taken.

It was pretty smooth like it happened all pretty quick. I dunno if happening quick is a good thing or a bad thing. It probably is a good thing though to get it out over the way.

I dunno I just didn't expect it to happen like that. Happen that quick and got the all clear.

Only three individuals provided a negative response and each reported that they had been given insufficient information as to what CARDS was about.

Because the pamphlet wasn't clear on what was on offer, because it was on the spot I was a bit unsure about what was on offer as well, they did clear it up but then I actually found out more through the assessment process.

because I didn't know nothing. Yeah. Well the judge didn't even know nothing about it, so you know, plus I was already worried.

I didn't quite understand what was going on, the judge probably knew, didn't explain it to me anyway.

¹⁴ The scale ranged from very good (1) through to very bad (5).

Many of those who felt unable to grade the referral process also suggested that they had not entirely understood what they were being referred to.

Notwithstanding whether or not interviewees had understood the referral process, no individual reported difficulties in the assessment being organised, and over two thirds reported that, in practice, the referral process had been straightforward. One individual explained:

The magistrate said perhaps I would be appropriate for CARDS. I then had an appointment made with the assessor so the magistrate didn't go through anything besides referring me to the Scheme. That was as far as the referral really went. I sort of jumped in at the deep end but I thought it would be a good thing from what I'd heard.

Others suggested that “*there was no inconvenience and no stress related*”, or that “*everything was pretty well straightforward. That was all taken care of for me*”. One individual reported that the process had been positive but that the magistrate had created some anxiety for them.

I was a bit apprehensive like because the judge said it, it's a lot of work and don't take it on if you don't think you can do it because it's only going to make it bad in court. Yeah the referral process was good but the warning I think he, he, could have kept that to himself.

Another similarly reported being warned by the magistrate that he should take CARDS seriously,

He said it's a lot of work. Don't take it on if you don't intend to do it. He actually mentioned the fella a few days before hand or a week before hand that was just virtually the same thing and he was 38 or something, getting on, and he was saying more or less the same thing to the judge, but he didn't show up to the first appointment and disappeared. It was a slap in the face for the judge.

Reasons for an individual accepting a referral to CARDS were varied. Almost two-thirds of individuals reported that ‘needing help’ was a reason for accepting a referral to CARDS. Of these, one third explicitly reported needing help with a ‘drug problem’, “*I thought it would help me, I do have issues with drugs*”. The remainder identified a need for ‘help’ but were not explicit as to the kind of help they thought they required. For example, “*I realised it was finally somewhere I could get some help*”.

Another consistent theme was that completion of CARDS would be positively looked upon by the magistrate and therefore contribute to a better outcome in court.

They said it was going to help with my charges at the end with the decision and I thought that was a good thing.

The most motivation was the sheer fact that I was looking at jail time.

The judge...he told me that he'd be keeping an eye on me, and if I get through it properly it would be to my benefit.

Only four individuals reported that getting arrested had strongly influenced their decision to accept a referral to CARDS.

Getting arrested was pretty big because I knew I wasn't going to get out because I was on my last chance already.

Several others suggested that it “played a small part”, or that they were unsure if it had influenced their decision.

Interviewees were asked whether they felt any particular things or events influenced (either positively or negatively) the decision to refer them for an assessment. Again responses were varied. Half of those interviewed were clearly aware that the magistrate’s reason for referring was related to their previous history,

I guess overall probably looking into the history of the thing like an offending cycle if you like. A lot of my offending was related to the drug use.

In contrast, one individual reported that (in their view) they expected their previous history would have discouraged the magistrate from making a referral, “Well if he was aware of my background I don’t think he would let me go for it, I don’t have a very clear background”.

Four individuals reported that they had been deemed inappropriate for the Drug Court program and were therefore referred to CARDS as an alternative. For example,

I was going through the Drug Court program and when I got knocked back for that and I was a bit disappointed I mean it was a heavy program but I thought that’s what was on offer so I was a bit disappointed that I didn’t get it so when CARDS came up I thought that’s good I can still go for something that can aid me and assist me and it sort of became second option almost.

Well they apologised because they were putting me on another program and it didn’t happen and there was a bit of mix up so they put, the judge apologised for that and she said that ‘you know I think the CARDS program will be good for you’.

One individual assumed that making an effort to help himself was a factor, claiming “I had done so much work myself, I think that had an influence, I had done counselling to assist with my drug problem”. Another reported that input from their parent had an influence on the magistrate’s decision for referral, saying, “I think because mum said I was on drugs and stuff, to the judge, what mum said influenced the judge”.

When asked if individuals were under any pressure to accept the referral only two responded that they had felt pressured. One stated, “In one way there is a little bit of pressure, it was hard to talk to someone. Before you are getting sentenced there is a lot of stuff you want to talk about”, suggesting that the opportunity to ‘discuss’ the situation was not forthcoming. The other individual stated, “I didn’t have a choice I had to do it”.

Overall, almost two-thirds of those interviewed reported positively on the referral process and many of the remainder were undecided. Most participants felt that they had received enough information to make an informed decision regarding their participation on CARDS by the end of the assessment and generally those that had not were still willing to ‘have a go’. In practice, the referral worked smoothly for most participants. Reasons why individuals accepted a referral to CARDS varied. However most felt that they would benefit from some help or that the magistrate would look favourably on it. The most common reason given by

respondents as to why they thought they had been referred to CARDS was either because their offending history warranted it, or because they had been 'unsuitable' for Drug Court.

Completing the CARDS Assessment

Interviewees were asked to rate the CARDS assessment process on a scale of 1 to 5, 1 being very good and 5 being very bad. Three quarters of those interviewed rated the assessment process as either 'very good' or 'good'. Only one individual rated the process as 'bad' - on the basis that in their view it was "inappropriate" and unnecessary. The remainder were undecided. Many explained their rating on the basis of the assessors' approach and the extent to which they felt comfortable with the assessor.

I didn't feel at all intimidated I didn't feel left in the dark. Any questions I asked where answered to the best of their ability. If there was any questions they couldn't answer they did have people I could be referred to, to answer those questions.

You know she wasn't forceful in trying to get answers you know, you know she was pretty casual about everything.

I don't know whether it would be different with someone else or whatever but I dunno I really got along well with her.

Basically if I didn't feel comfortable I would have reserved a lot of my answers and information and probably held back and probably wouldn't be where I am today in a sense.

Almost nine in ten of those interviewed (n=26) were able to articulate reasons why the CARDS assessment had been necessary. These included the need to determine whether they had a drug problem, whether they fitted the scheme's criteria and whether they were committed to doing CARDS.

They had to find out if I, you know if I fit the criteria, whether I was someone with a drug problem. Or whether I was just using it as a loophole to get extra time out of court.

Just to see where I was with my drug problem, if it was getting better or worse.

I could have been pulling wool over the judges eyes. I could have been using it for a cop out.

A few of those interviewed reported that they did not fully understand why an assessment was necessary in their particular case. This was usually because the magistrate had already ordered that they undertake CARDS.

If it was someone else I'd understand, but mine it was a court order anyway so they can't assess me and say no this program's no good for you cause the judge has already ordered it.

Another individual reported not being able to recall the reason for the assessment due to being under the influence of drugs on the day.

Several individuals suggested that the assessment had given them an opportunity to learn more about the Scheme and to ask questions they may not have been able to ask during the court hearing.

Another thing I really appreciated as well is that I could ask questions as well about the program and the assessor didn't get annoyed about that she didn't just come for the assessment and that's it. I could actually ask more questions about what the program was about and sort of what if I said yes and what kind of repercussions would I expect if I don't follow through.

When asked if the assessment was what they had expected, over two thirds reported that it was. Most individuals anticipated that it would involve a series of quite personal questions. This said, more than two thirds of those interviewed were comfortable with the range and type of questions asked. Some individuals were well used to being questioned in relation to their drug history. One individual stated, "In jail I spoke with a drug counsellor and you know they, they ask you the same questions and really nothing's too private for me anymore". Another similarly suggested, "it wasn't anything out of the ordinary". In contrast, some individuals were uncomfortable about 'dredging up' things which were difficult to talk about, or thought that questions about their past were unnecessary.

I mean the only thing I don't like about them is that you just got to bring all shit from the past all the time you know. Just talk about stuff that you don't want to talk about cause they ask you a lot of questions about you know your past and your childhood. ... They bring up some pretty, you know yeah. Oh no it was alright, just sick of saying it. Sick of bringing it up.

It was a bit too in depth. It was going back about 7 years ago. I suppose they didn't need to know that about when I first tried marijuana or this or that. Courts and that are the most unpleasant place to try and think.

In contrast very few reported that the assessment was not what they expected, one individual suggesting, "I didn't expect her [the assessor] to be so nice, I thought it might have been a bit harder". Another said, "No. I thought it would be more along the lines of like pre-sentence report. They want to know um you know character references...family background".

For some individuals contemplating the assessment created a level of anxiety for them.

Yeah I was a bit worried at first cause I didn't know, like I said I didn't know how, what was involved in it at all. I wasn't sure what to expect really. Whether there was going to be like three people at a table sort of thing asking questions or what I dunno you know.

Asked whether they were comfortable with the assessor and the way the assessment was conducted, almost all of the individuals reported that they were and that the process had been straightforward. If a question was not clear individuals were comfortable enough to be able to ask for an explanation.

Yeah it was pretty straight forward I mean turn up at the court house so took about 40 minutes, 45 minutes. Yeah you know, I've been through similar before but not as a rehab program or ongoing you know like counselling.

the assessment lady, I didn't expect her to be so nice. Yes comfortable with the approach, usually pretty clear and if I didn't she would clarify it.

I think she wanted to know how I was living, my lifestyle and how I felt about things and stuff like that. I thought this was good as it was the first time somebody has asked me about these things. When I went there I didn't know what to expect but once I got there the first lady I had seen she was really good and I felt comfortable. I wasn't afraid to speak to say something. She was prepared to listen.

One individual reported the process as being similar to research surveys he'd completed.

Yeah. They used to do surveys at shopfront like clean needle exchange...I suppose they still do but every now and then you'd go in there and they'd say oh we'll give you twenty bucks if you do a survey thing.

Asked whether any difficulties were experienced in attending the assessment, only one individual stated that there had been. This was because the assessment location was a considerable distance from their home address, but *"it was the only place available at the time"*. Most had been able to attend the assessment at the time designated. Only one individual had difficulty attending, stating, *"The only difficulty I experienced was that my car had broken down on one occasion, I called to re-appoint, I got an appointment the next day"*.

Only one individual of those interviewed was recorded as Indigenous. While he was aware that transport could be made available to him he reported that no assistance had been required. Another individual reported that while he was of Indigenous descent, he had difficulties proving this to authorities and therefore assumed that he would not be eligible for assistance with transport. Notwithstanding that, he would have found this assistance useful.

Some individuals reported being motivated to undertake CARDS before the assessment.

I already had my foot in the door so to speak I had made it this far already rather than turn around and risk going backwards again I will see what's on offer and use what I can from it to better my life or to see what I can gain from the experience.

However, for many others the positive experience of the assessment either gave them motivation, or increased their motivation to attend CARDS treatment. For some it was a much needed 'sense of direction' as to how they might address their drug use.

They make you feel comfortable and you know they're really nice and you're going to want to make the effort. I mean if they're going to treat you like shit you're going to think you know stuff em like I don't want to do that.

Well for someone that uses drugs, it is very hard to find incentive and motivation. Now I convinced myself that I was going to benefit by going.

It makes you more focused on exactly what you want. Sometimes you may know that you want to fix the problem but you don't know the steps of how to fix it. This reminds you of the steps that you need to take to fix it so I found it quite good.

In summary, three-quarters of those interviewed rated the assessment process as 'good' or 'very good'. Almost nine in ten understood why an assessment was being conducted and for those who did not, their concerns were more likely to relate to their personal circumstances. That is, the magistrate had already ordered that they undertake CARDS, so they questioned the need for an assessment as to their suitability. For some individuals the assessment also provided an opportunity to ask questions and to clarify what CARDS involved. Two-thirds of those interviewed reported that the assessment was what they had expected. Those who were 'surprised' in some way very often commented on how well they had been treated by the assessor and that the assessor had seemed genuinely interested in them. Almost all were comfortable with the assessment process and few had any difficulties in attending. Some individuals were clear that they were already motivated to address their drug use prior to the CARDS assessment. However, the discussion during the assessment may have increased their motivation and given them a sense of direction. For others, some sense of motivation to address their drug use came about during the assessment.

Treatment process

Twenty six of the individuals interviewed had undertaken treatment at one of eight different DASSA locations and the remaining three had attended treatment at Offenders Aid and Rehabilitation Services, South Australia (OARS).

Three quarters of those interviewed reported that they had experienced no difficulties travelling to the treatment location. Generally this was either because they lived in close proximity to the clinic or they were able to access transport. Of those who used public transport to get to appointments, several commented that having the clinic right next to public transport had been useful. Only one individual reported difficulty in locating the clinic at the first treatment session.

It was just a bit hard to find the first time, you have to walk everywhere ...I didn't know The Parks, I didn't know where to go, I just had to go around asking a few people 'where's this'?

Of the one-quarter who reported having experienced difficulty in attending, the reasons given included: the scheduled time and location, the travelling distance, work commitments, their general level of functioning or not having money for bus fares.

Depending on what's going on like sometimes I'd have the money, you can't really afford running around on buses etc. It makes it a bit hard sometimes.

Money yep, but I tried to I make my appointment so it's near a pay day

Scheduling appointments around work commitments was reported to be difficult because only one clinic opened outside 'normal' working hours. For example, one individual lived closest to The Parks clinic, but was required to attend appointments at Elizabeth.

Elizabeth. Well yeah it was difficult because I would finish work late - sometimes at five and so I'd be pretty much, ... I found this getting out there within a certain time and that was fairly difficult. So if there was another like an office or something closer I would have found it would have been a lot easier.

Asked if they had completed all four treatment sessions within the three month time-span, over three quarters of those interviewed reported that they had. Of these, over half 'missed' or rescheduled at least one appointment. The reasons for this were varied. Four individuals

cited work commitments as being the cause for non-attendance. Two individuals were in hospital and could not attend, one booked into a drug rehabilitation program so missed the first appointment and another had difficulties with arranging care for a child. One individual had forgotten about the appointment and explained the difficulties with drug use and remembering to attend, saying,

I'm not the most responsible person in life like you know I've, I always miss appointments and don't go to stuff and lately like I've been trying to you know be responsible and go to everything yeah. Just forgetting like completely like you know I'd be walking down the street with my friend and like then I'd instantly remember shit it's 3.30 I was meant to be at [the CARDS appointment] like half an hour ago you know, just completely forget like I think that's probably got a lot to do with drugs as well you know like.

The process of rescheduling a missed appointment was viewed as straightforward. On the occasions that individuals had telephoned the clinic and reported they could not attend an appointment, another was made without difficulty.

I panicked that I was late yeah but she assured me that she could just make another appointment.

It didn't cause any problems rescheduling. ... Yeah I rang them up and let them know and they're like 'ok we'll reschedule for the next Friday'.

Rearrange appointments - Yeah easy I just rung . I'm not sure that was good because I knew I could call her, but I think she was like that anyway like, yep just moved it to the next week and went and saw her the next week.

Some individuals saw the onus as being more on the clinician to follow-up as to why they did not attend a scheduled appointment. One third of those interviewed reported that on at least one occasion an appointment had been rescheduled by the clinician due to either illness or holidays. Appointments were generally rescheduled via a telephone call and only one individual reported that the rescheduled appointment time was inconvenient.

Individuals were asked about what had motivated them to complete the treatment sessions. Over half reported that the motivation had come from them wanting to change their drug use and the consequences it had for them.

I was just sick of bloody stabbing myself with a needle really and I just wanted to get off of it and this was going to help me so I did it.

I knew I had to do it, I knew that like, that drugs were an issue and a problem for me and I knew I had to do it somehow.

I guess, just got to that point where the drugs just couldn't do one good thing for me.

Just wanted to do it for myself and because I was getting pretty deep into shit so. Pretty deep like just with drug taking speed, methamphetamines, ecstasy yeah. ... I got it on credit so, like I'd get it off of them and not pay for it for another week or two. I wanted to sort myself out.

Another significant source of motivation was a fear of losing the support of family and friends or their standing in the community.

I wish I could go back. That is if I go back and start doing crime again to try to support my habit and I'll go in jail, I'm on my own, I would have no more support. It feels like, if my parents friends, they find out ... it would just look bad, you know what I mean, it would just look bad because all their sons and that have got jobs and own houses and married, that's how it is in that culture.

*My daughter and grand-daughter, she's pregnant, made me determined. If I fu**ed up I'd be kicking them in the teeth.*

One in five individuals reported that being charged with their current offence, or the likelihood that they would go to jail as a result of the current charge, was a motivating factor to complete CARDS treatment.

I had to do it because the legal system was involved and my arse was in a sling if I didn't do it.

I just got charged with another charge ... and I was kind of like scared I was going to go to jail you know so I like I just don't want to go to jail you know like people have told me stuff about jail and like I'm scared do you know what I mean.

Only one third of individuals reported that the health treatment received was what they expected. A number of these individuals (n=5) had previous experience with counsellors and were familiar with the approach. Interestingly these individuals were most likely to describe the experience as 'nothing new' and to report that it was "just telling me what their services involved. What to do and what not to do."

For individuals who reported that the treatment was not what was expected responses were varied, with many suggesting that the experience was better than they had expected,

Yeah, I got to say pretty much what I wanted really. It's probably better than what I thought. I thought it would be more like she had set questions and set things she had to do. But it was just a discussion and we took it from there.

It was a bit lighter than I expected. It was still good and it was good in other ways. [Clinician] was really good at it and she would pick up good points and like helping you establish it. It was something I didn't expect but then I didn't get in-depth, we dealt with some of the issues like pain management and stuff but didn't really go in-depth with that.

Yes, it actually went better than expected. I had never seen a counsellor or had someone to talk to about drugs and things like that. It was good. I just thought somebody wouldn't know anything like about it. I would go in there and she would try and tell me how to do things but yeah, she actually understood and knew what was going on

A few of those who did not know what to expect had contrasting views. One individual regarded the treatment as 'limited',

I thought it would be a bit more to it really. I guess that's why I'm still seeing... going to go ahead and see ...cause I didn't get enough out of it for me. I thought it would be more involved than it was.

When asked if they had felt comfortable with the clinician, over three quarters of individuals responded positively. When asked to elaborate on this and explain things that stood out as most beneficial, many referred to the way that the clinician interacted with them in a helpful or non-judgemental way.

It was very comfortable. They spoke to you like they knew what you were going through. They understood. Almost instantly. I felt comfortable. There was no intimidation, no judgement. I knew that they were there to be helpful.

You know the lady was really nice and you know she was helpful. Probably just her trying to help me like um we'd go through sort of my problems and that and then she made some phone calls for me or you know get back to me on them like you know so she'd help me answer my questions or whatever you know so like it was handy like it helped yeah. She like followed up things for me kind of thing.

I didn't know her from a bar of soap and I got along well with her too so yeah. Yeah but, just how to relate with her and I dunno she just seemed to say things I could understand them you know what I mean like yeah I dunno she was sort of was on my level. Which made it a lot easier to think like

As the quote below illustrates, the ongoing contact between the client and clinician was important in motivating some individuals to continue to desist from using drugs.

Certain situations arise and I would go and carry out the nasty act and feel guilty for it afterwards. I was wanting to get through each week and go back with a happy report. I have had this many urges to pick up and use again but I haven't because there's something, I can't exactly pinpoint what it was during the course of the interviews but I felt the need basically each week to get up there and meet the appointment.

Others, such as the individual below, reported that they had received 'a wake-up call' from the clinician.

You know, she just makes you wake up ... that you're not the only person ... really, taking drugs, just selfish, you are having a good time and no one else around you ... Yeah, all the people that care about you, like ... something and you can't see that, you know, she makes you see things that you didn't see before, like people around me. I didn't think about it, I was thinking drugs and nothing else, making a bit of money, that's all the stuff.

Over half (n=17) of those interviewed were satisfied with the treatment aspect of CARDS. Interviewees were asked to describe those aspects of treatment that they found most beneficial. For some, simply the opportunity to talk about their life was the most beneficial aspect.

being able to sit down and talk openly without feeling intimidated or threatened.

We pretty much just talked about stuff actually. Because you know they, they're caring people, they do actually want to help you ... so you know that's got to be good.

Probably just the part that was, we were talking about the drugs and that like you know how long I've been using for...and what I'm doing to try get myself off of it. Yeah, like a huge relief off the chest mate. Because I couldn't exactly tell my parents you know because I didn't want them to know so it actually felt good to bloody tell someone.

I had never seen a counsellor or had someone to talk to about drugs and things like that. It was good.

Counselling. Yeah I can admit I felt a bit of like weight off my chest I guess. Yeah like cause everyone else I talk to like my mum and that wouldn't really listen just think it's all in my head and you know oh you can give it up like this and yeah pretty much. ... she would understand what I was saying and she'd tell me a way around it and how to deal with that problem.

Others reported they had benefited most from learning distraction techniques for when the urge to take drugs arises, or gained information or support during specific phases of reducing their drug use.

The stuff she gave me like little things to go and stick on my wall. I still got one sitting on my wall now like things to do instead of going to get drugs or whatever.

*My worker was *****, she was excellent. I was in physical pain from the detox, cramping, crying, couldn't sleep, was a mess. I was at home alone. On home D. I thought everyone thought I was exaggerating, but ***** never doubted anything I told her. She said it was all normal. Apart from the mandated appointments, I chose to have additional ones and telephone conversations. Without her I wouldn't have got through it at all. She provided listening and support, explaining what to expect, reassuring me that I wasn't abnormal. ... My withdrawal lasted months. She suggested that I go and get valium at certain stages which I did.*

The advice that she gave me was good like the medication I was on. I told her the medication I was on and she suggested [seeing my doctor to vary my prescriptions]

Just over a third of individuals (n=9) reported being dissatisfied with the treatment phase of CARDS. Reasons for this included that in their view they had not really received 'counselling', the sessions being too short or too few, or the sessions not addressing the real issues for them.

There was no real offering there was just like, what's wrong with you? Here's my name, here's your name, what's wrong, what have you done, what did you do to get done? A whole lot of crap. Then by that time the hour was already finished. So you go and come back four weeks later. Then she either forgot to bring her

book so you've got to go through the same shit again. Now your on to your third appointment or fourth you go over the same shit that was missed out on the past three times so you move through and then you've got half an hour to talk about the shit that's left and by that time your appointment time is up and they should be talking about how important clinics are and signing papers. Yes, that was the feeling. Until I come through the whole thing then I realise it was just a kick in the ass it was just another thing. I come out of it with nothing

I tell them what he wanted to hear because they aren't asking no real questions to what are the real concerns in your life, there's no concern, they don't care it's in their pocket at the end of the day.

She just said I wasn't cooperating. It was just pretty boring really. Asked the same questions and sat there looking at one another.

I dunno I would have just felt a bit yeah like it was short, short lived sort of you know when it's all finished you still feel like something's missing like you didn't complete it.

It's an hour session. I suppose overall at the onset of the interviews you say your hellos and how things have been going. Then you sort of gradually get into the end of the session and you find yourself wound into getting it out into the open, it's the time already. It's time to cease and pick it up again where we left off next week. ... To open up some of them old scars and begin talking about them issues as such and then to find that 'I would like to sit and talk more with you but I have other clients to see we are going to have to cut it short can we pick it up again next week'. I felt that it probably was a little shortcoming in that respect on an emotional level.

Two individuals reported that they had been uncomfortable with the questions asked by the clinician or their apparent lack of understanding.

*Maybe say more into things like what you're doing, where you're living and eat. There's these people that say have you a 'stable home' and well as 'stable as its going to be' well if that's an answer then that's not really an answer. Turn around and go 'ok what's not stable about it' 'well I live with a bunch of f**king rejects that don't pay the rent, don't eat etc'. You could list it for days, but you don't get that far, and you know there's no real achievement in talking about shit. Maybe ... not reading off a piece of paper of what you should do to avoid drugs you know its all the same shit and everybody knows it. You know they need to understand what your're going through and then talk to you as if they got some answers and so they can point you in the right direction instead of having no answer and expecting you to tell them. ... I don't know like she was offering me a quit smoking course but then like 3 weeks later she would be going through her folder and say 'oh that's right' and never got around to saying here's the date if you want to rock up, never chases up. No follow up.*

Although the situation was unavoidable, one individual related their dissatisfaction to the counsellor being changed half-way through the treatment, and mentioned the importance of continuity for CARDS clients saying,

Half way through the program, I got a different counsellor. The other one left the job. So I had two appointments with one counsellor and the third and fourth appointment with the other. I feel that this program would be improved by maintaining that continuity and consistency with the worker.

Two disgruntled individuals suggested 'in their experience' that the treatment was not counselling,

It isn't counselling, I've had counselling. That wasn't counselling. No, not at all they're just questions. Just questions. ... I've had a lot of drug counselling at that clinic.

It isn't counselling. No, not at all they're just questions. I expected a fair bit more counselling. They're just a survey so the government can get their statistics.

None of the clients interviewed reported difficulties with the treatment process which were related to their cultural background and needs, or their level of literacy. Only one of the 29 individuals interviewed reported issues specifically related to their mental health status. This related to the location of a mental health clinic,

I wasn't aware that we do not have a mental health (clinic) down in the Northern Area. I have to travel as far as Adelaide, Enfield to undergo any psychiatric treatment.

However this individual went on to note that as a result of CARDS he had been referred "to the Mental Health Board for psychiatric assessment".

I have never been properly diagnosed with anything. It's just been suggested that I've got these personal traits and emotional problems.

Over three quarters (n=22) of the individuals interviewed reported that completing CARDS treatment has assisted with addressing their drug use and criminal behaviour in some way. A high proportion of these (n=18) reported having reduced their drug use and related criminal activity.

Now towards the end of the program I found my use to be less. [Was this due to CARDS?] Not entirely. But I would say that I did benefit and receive assistance from them yes. I am in a position where I am now in control of it, it's no longer controlling me.

I'm still using now but just not as much. So yeah I did cut down a lot even when I was on the program. Sort of getting my life on track again. My criminal activity was related to drug use. All my criminal activity yeah.

CARDS and myself a bit of both really. Yeah I was taking a lot of sleeping tablets. Yeah during the day you know, not to sleep, taking them to block out things. Yeah so yeah it helped me in that way. I mean I haven't had a pill since the CARDS program. Nope, no use now not at all

I'd have to say definitely. I mean...I don't use anything, nothing at all. I don't drink, I don't do cigarettes. Nah, I haven't had any for like probably close to two and half, three months even I dunno um, I had it in the house for probably six weeks without touching it, I give it to the neighbour. My criminal activity has always been possess this or that use this or that.

I haven't done crime. I don't need to support my drug habit...no more so yeah bloody I just straight and narrow now just bloody want to get off the drugs and yeah. Only using subitex now.

My life has turned around unbelievably. This program motivated that change absolutely. Use was extreme - over an ounce a week of pure speed (\$5,000) a week. I found the first month incredibly hard cause I was doing on my own without any sort of professional help - it was only my determination. Without the personal support, I don't think I would have been able to get through the program.

Oh well I haven't done crime I don't need to support my drug habit...no more so yeah, just straight and narrow now just bloody want to get off the drugs.

I can't see how I would have given up had I not done that, but you know it's not a problem now

One individual went as far to suggest that CARDS had saved his life, stating “[It] has had a great effect, I didn't want to survive.”

When asked whether individuals expect that CARDS will assist them with setting long term goals, more than two-thirds of individuals (n=19 of 27) reported that they were confident it would. A selection of responses were,

Yeah. Because they were like important stuff that's good to like get through life with. you know what I mean like how I said about she printed me out like um like positive thinking and how to not be negative and that and like that that's good stuff you know like to have, stick with through life you know.

Yeah, it's definitely going to help me down the track.

Maybe a bit more structure back into my life.

CARDS will assist me in my long term goals, there is nothing better than someone listening to your problems, very comforting - somebody wanted to help, accept me for who I am, not judgemental.

They convinced me to believe that goals can be achieved. Before I lived day by day. They made me see that goals are achievable. They gave me the confidence to follow them.

Three individuals reported that they had not set any goals. One individual 'hoped' that it would help and another suggested that, while CARDS had not helped them to set goals, it had provided motivation.

A minority (n=3) of individuals suggested that CARDS did not assist them as they were already motivated to give up. Two individuals did not respond to the question.

When asked to grade the health treatment process on a scale of 1 to 5, 1 being very good and 5 being very bad, almost three quarters of individuals graded it as very good or good. Five individuals declined to grade the treatment sessions. Only two individuals graded the treatment unfavourably.

I reckon it could have been better like they could have been a bit more forward in some of their questioning, bloody could have helped a bit more like yeah

Another said,

Nothing helped me in the session, no. Honestly, no. There wasn't anything. There was no health treatment to me. It's just the program didn't really apply to me. I think I'm being kind by saying four really.

Overall, the majority of those interviewed experienced few difficulties in getting to CARDS treatment sessions or in completing the required number of sessions within a three month period. This said, over half of those interviewed missed and/or rescheduled appointments on one or more occasions. A desire to change their drug use was the most frequently reported motivating factor in treatment. However, concerns about the loss of family or friends, or that their current offence would lead to them going to jail, also motivated individuals to complete the treatment. The majority felt comfortable with the clinician and more than half were satisfied with the treatment received. The most significant benefits gained from the treatment were reported as 'having someone to talk to', learning specific techniques to control the urge to use drugs or gaining support and information at specific points in reducing or ceasing their drug use. One third of those interviewed were dissatisfied with some aspect of the treatment. This was most often because they did not regard the treatment as 'counselling', there were too few sessions, or the sessions were too short, or the treatment had not addressed the real issues for that individual. Three quarters of those interviewed reported that CARDS had helped to address their drug use or criminal behaviour in some way.

Final Court Appearance

The majority of those interviewed were required to attend a court hearing to have their charges finalised after they had completed CARDS treatment. The following information relates directly to these individuals experiences.

Of the twenty nine individuals, three quarters (n=22) reported that a guilty plea had been entered for the charge related to CARDS entry. Five individuals were not aware of the plea entered and two others did not enter a plea prior to CARDS participation.

Asked whether the court appearance took place as expected, just over half (n=15) reported that the court outcome was better than they had expected. Most of these reported that the penalty received was less than they had expected.

A lot better than I expected. ... I was thinking I am getting locked up. Magistrates report was a lot better than I expected. It was dressed up really nice.

I expected to go down. I was, if I did go I was looking at you know at least a year.

It went better than I expected and that was mainly due to me getting rid of my previous lawyer and hiring a barrister. ... The barrister was excellent really

wanted to help and knew my case inside out. If it wasn't for the barrister I would have gone to jail.

Look I did think that I was going to be done for everything you know. Yeah like I was screwed. Oh I was pretty, I was pretty bloody nervous yeah.

I was embarrassed, humble - judge was complimentary.

Two individuals reported that they had been told what to expect prior to the final court hearing.

Outcome was I was convicted of the offence but no further penalty imposed, it was stipulated, prior to CARDS, that successful completion would mean no further penalty imposed.

Because it was an old charge and I'd done this, I completed this program, that I was pretty much guaranteed a suspended sentence.

Three individuals were less certain about the outcome in court and admitted to not knowing what to expect. For example:

No, I didn't know what was going to happen. When I went to court and so forth I just thought I was going on a holiday. I was quite frightened. No. Only my lawyer got it and told me that the report was very good and he was very pleased with it.

I wasn't sure how it was going to go I was pretty worried. Actually I got a good sentence.

One individual did not have a court appearance as CARDS was attached as a condition of a bond. One individual's court hearing had been adjourned and was therefore not finalised at the time of the interview, and one individual could not recall their final court appearance.

A copy of an individual's treatment report was shown to some CARDS participants but not others. Just over a third (n=10) of the 29 individuals had seen a copy prior to the court hearing. In comparison, over half of the individuals (n=15) had not seen a copy although six of these were told what was in the report by their lawyer and the remainder found out about the report when in court, except for the individual who could not recall the court hearing.

The majority (n=19) of the 29 individuals tended to agree with the content of the treatment report. Eight individuals felt unable to comment on the report content and two disagreed with the content. One of these believed that they were "over praised". The other did not elaborate as to why they disagreed with the content.

Individuals were asked whether they thought completing CARDS had an influence on the magistrate's decision regarding sentencing. Of the 26 individuals who responded to this question, over three quarters (n=22) thought that it would have an influence on the magistrate's decision. Examples of comments justifying this view were plentiful:

He said I see you've completed the program and he took all that, he took that into account. Yeah definitely the CARDS had a big impact on it hey. Yeah it is good that was a lot of help.

It definitely did influence the magistrate, pretty important and will have an effect on my future and I am keeping in touch with [treatment worker]. This magistrate was really impressed with what I have done and said so in the court.

He had a bit of a smile on his face. He could actually see I was doing something. Seemed like he took a bit of interest and gave me a chance.

He said I'm going to reward you for the good work you have done, with a good behaviour bond. Even the judge's summing up the way he praised me - felt special.

*Well I saw the judge and he read the letter and he was looking at me ... he told me quite honest I thought you weren't going to last three days. He was heaps happy and the prosecutor was happy as well, so the prosecutor didn't deny anything, he was like agreeing with my lawyer and the judge and we'll keep **** on Home D, see how he is in three months, if he does good in three months can walk. The CARDS treatment had an impact on the sentence.*

Well the Judge was very happy with me, she did say that it was a very good report and I can see that you've been trying because I've got another report from the AV meetings I go to as well on top of that. I see this bloke's trying he is going off his own back to these other meetings. She said I can see you are actually trying. I think that's why the judge gave me a suspended sentence because she could see I am trying to better myself and trying to get rid of this out of my head.

Only one person was not convinced that the completion of CARDS would be an influence on the magistrate, saying, "they said it will or might not".

Overall View of CARDS

Those individuals interviewed were asked to grade the CARD Scheme overall on a scale of 1 to 5, 1 being very good and 5 being very bad. Of the 23 individuals who provided a response, more than eight in ten (n=19) graded it as 'good' or 'very good'. Some of the reasons given were:

I just found it very helpful. Easy to get on with the lady that interviewed me all the time just yeah ... found myself thinking of not taking tablets when I was offered them you know I'd think about OARS and what she'd said and not take them.

Just that I could talk it out, you know, bloody get it all off me chest and yeah just give me an incentive to keep going in the right direction really.

So friendly make you feel good. I have referred the Scheme to some friends.

More than I expected, highly recommend the program.

My personal opinion is it was great to finally sit down in a non-judgmental sort of environment and I guess be able to speak openly and honestly about why I used and what led to my drug use and not be judged on it. Yeah, basically it went at my own pace. I was happy with the end results.

One individual who graded it a 2 stated that, from their perspective, a limitation of the Scheme was the lack of information provided. Another, who rated the Scheme a 3, reported that they felt "it wasn't relevant" to their needs.

Influences on Drug Use and Crime

Interviewees were asked about the main influence on their involvement with drugs and crime. Of the 25 individuals who responded to the question, seven reported that peer pressure was a key factor.

Peers, majority of male role models in my family are affiliated with bike clubs. And I, growing up around that sort of environment I wanted to mimic them and be just like them and that included living the lifestyle and tattoo, bikes you know going parties, staying up all night, but being young and naive you're not aware of what you're really getting yourself into and the prolonged damage it can cause.

I was using bongos and that when I was twelve so you know then I started going to my friends and snorting speed on the weekend and you know taking E's and that and then that would become sort of like taking it on the week days and then you know you just start shooting up and then you know it was just, you're just hooked to drugs sort of thing I was getting like \$250 on the dole a fortnight or something and probably using just like \$100 worth a day.

It was just pressure from friends ... after a few times, after what, I kept saying no but after they kept pressuring me and that I had it, I tried it. I got forced to try it. I didn't even smoke marijuana. I just went straight into the heavy stuff because at the start you get it for free man, to become a user and how are you supposed to get money, you've got no money, so you do crime.

Yeah my friends did it and that, so yeah. Not everyone that uses it is a criminal. I used it for motivation to commit crimes.

I went to jail for 12 months on the day or the day after I turned 18 and I got out on my 19th. My mate was already into it and don't ask me how because he wasn't before I left and then before you know it, the first day I got out I got drunk, and yeah, first time.

Six individuals related their involvement in drug use to a combination of factors which included, experimentation, boredom or enjoying the effects of drug use,

Mainly just like the feeling of being really smashed out of my head ... With heroin you're just like you know casual as you know, relaxed and more mellow but that's all that I really liked about, just the fact that I could have that, go home relax and like not worry about bloody anything.

I mean hey I can't blame anyone else. It wasn't peer pressure or shit like that it was just me. Oh yeah, I was always driving cause I was out you know like speeding you know.

I would have started heroin and pills and all that at 16. For kicks, boredom.

I was working at ... and it just got out of hand and I didn't even want to go to work anymore, I just wanted to take drugs. So I stopped going to work ... walked out, just left my tools and everything. I just, I don't know, started taking meth and then you stay up all night and come in to work in the morning and be so tired so take more meth.

I was initially involved in drugs but not heavily, it helped me escape from problems, like a release.

For some individuals family issues were an influence in drug use and related crime activity.

Originally yeah I think it was all just a rebel thing against my parents whatever because we'd moved ... over here, like mum had left my dad and we got here and my mum told me that it was all my fault. That we'd left my father and I broke the whole family up and all that sort of thing I think it was just a more of a coping strategy.

I guess main influence that led to it was family issues; I guess the environment in where we live. ... What is done in this part of society so to speak. I've seen every person I knew was associated with one sense or another using drugs, selling drugs or manufacturing them. Some days I felt almost obliged to partake in the use. The influence was there, you look around you and you know that person over there and that person over there and at least nine out of ten people at some point or another if not daily were using drugs.

Heroin not really, that was pretty much when my girlfriend and daughter left I reckon. That's pretty much what I remember. I don't know. My brothers were doing it, so. Yeah, pretty much with my brother as well. ... I was young when I was breaking into my school and all that so I can't really say, but it would have escalated for sure because of drugs.

I didn't get into it until I was 40 years old. That was going through a divorce, two nervous breakdowns and losing my house, my family and my business. When you haven't got any money and to get the heroin you hang out. I would go out and do anything to get that money to buy my drugs.

For a minority (n=2) the influence was medically related.

I was initially blocking out pain, it was medical, then I was given drugs in jail, Corpromazine and Prozac, helped me to sleep. But then circumstances went bad, went to jail for driving disqualified, I just used the car to get away from things but got caught, then used to inject crazy when I got out.

I just used it as a block really to block all the negative things and using it as a pain killer. I used to like smoking Marijuana and smoking something a bit stronger. Yes, [committed crime] I needed money to support the habit.

One individual related the influence for drug use and criminal activity to not being able to deal with authority figures and suggested,

You know, like I put it down to, it might be a throw off, but I put all my troubles down to authority. From not just cops, I mean like I went to catholic boarding school for like four years and that's when my trouble started you know, I just had something with authority. I just didn't like being told what to do and things change once you do something like that for 30 years. Using drugs - I guess it just takes you away from reality I mean, the little problems in life other people you just, even those you, you know you don't have any problems if you lead that lifestyle the only problem you have is getting the money for drugs which is where the crime comes in or you got to sell it you know

Interviewees were also asked apart from being involved in CARDS treatment, did any other things in their life have an important effect on their drug use or criminal behaviour? Over half reported that family members or friends played an important role and highlighted the importance of a support network.

My daughter and grand-daughter, she's pregnant, made me determined.

A lot of family support. Oh yeah, like, I wasn't going to be here by myself. Even if I had the chance, I had no chance like anyway to sneak off or do anything or buy drugs because wherever I went my Mum and Dad or sisters or my brother, so I had a lot of family support and now I've got that trust back, like today I got dropped off here by my Dad and usually he waits for me, but he dropped me off.

Support from family, my mother, support from friends. I have a friend who I'm going to visit after we've finished here now and he also has a substance abuse problem. We share an awful lot in common. Now he is trying to give the stuff up.

Yes, close friends helped me out and my girlfriend. They were very positive.

Probably the main thing my family and myself. Yeah. One of my brothers is a bit more distant now because he is pretty much sick and tired of it. Its been pretty much near a year that I have been doing pretty good working and doing what I can.

My family know about the whole case and everything so that's good as well. There is always someone there to support you and also keep you in check.

Three individuals specifically described their motivation to reconcile with their children as having an important effect.

My son's grandparents got custody of him but I've just won custody back I just got to get a house now. Yeah it's the only way I could do it.

I had a very good relationship with my son, I never got along with my daughter from the day she was born you know we always clashed but I know she loves me and I love her. My son and I really close I would see him all the time. Then I didn't see him any more and I can't get a hold of him and he won't speak to me when I ring him anymore or answer my calls.

Partners were cited by approximately one-fifth of individuals (n=6) as having an important influence on their involvement in drug use and criminal activity.

Yeah well the support I get from my partner that helped in working. Changing the way I did things like on the weekends and that like going out. I wouldn't sit around and stuff you know and the same as her to help her come off it, we'd go to the markets.

The mother of my children, I guess I'm doing a bit of it for her as well.

Boyfriend was a dealer but has given up after ultimatum so assisting in some way.

Me and my boyfriend do it together you know yeah, ... Yeah you're both trying to help each other and instead of doing it by yourself, yeah that makes a big difference really.

A few individuals listed workers involved with the criminal justice process as having an important effect. One individual suggested their Home Detention Officer was important, saying,

Without the personal support, I don't think I would have been able to get through the program. My home D officer was supportive of the program. He was supportive of me full stop. Within those rules he was pretty lenient. He could see the improvements and increased my freedom. 2 - 3 times a week. I had the bracelet on as well. He was very supportive of the program and what I was trying to do and achieve as well.

Another explained that being on Home Detention assisted, as it kept them with the family,

Home detention helped me, home with the family, kids, combining home detention and CARDS is really good

Suggested Improvements to CARDS

Interviewees were asked whether there was anything they would change about the CARD Scheme and why. One third reported that no changes were necessary as they had benefited from CARDS in its current format.

No actually, I would not. ... it was beneficial to me and I appreciated that you know, having that help.

I can't see anything because it's all been good for me, it's all been positive so it works the way it's working. In my situation it's working.

No. Because it's, it's alright if you're not, as long as you're not ordered to do it. You're assessed and that for the program first so as long as you're not ordered to do it.

The most frequently suggested change, made by approximately one third of those interviewed, was to increase the number, frequency and/or duration of treatment sessions or to provide them with some support in between the treatment sessions.

I think there should be a lot more frequent appointments, once a week. I found that the first time around, because of the situation I was in I would go and see the clinician then two weeks before going back, I tended to lapse a bit, weekly is better. Even if they could 'phone us to see how things are.

I guess the appointments didn't really go long enough something like we'd just get into it. Didn't really go long enough. Like I guess we'd really starting to get into it and then by the time you start getting into it stopped. The longest probably an hour. And the least probably twenty minutes. Now that I've done it I would say weekly appointments.

Pretty much when I went there during the week I would think about things that I wanted to ask so I pretty much knew, but still an hour would have been alright but make it longer and the same four sessions. I reckon a few more sessions would have been all right.

I'd rather have gone once a week than bloody once every two weeks or once a month or something yeah. I reckon it's better to go like every week once a week, I mean I reckon it's better that way.

I thought the sessions were a bit short. Yeah, the hour was good but it used to go really quickly.

A couple of individuals felt that a follow up session would be valuable and explained,

Maybe after the initial, like the last interview you have maybe they could do like a month follow up interview to see how you're going ... like just so you can make sure that you are staying on the right track or whatever.

After the court appearance and that what would have been good was maybe a final session or something afterwards. Yeah, just like one final session would have been excellent. Something like that so that you could talk to them and say you know how things are. She could say well you know which direction you're going and stuff like that now and because it sort of ends the way it does, it's you know very abrupt.

One individual suggested that contact with a clinician would be better just before a weekend, a time when support was most needed, stating:

I found that certain dates like when it would come to the weekend because whenever you come to the weekend its Friday, it's pay day and you've got the weekend and it's usually a bad time you know what I mean that's when I found that it would help having the counselling that night.

Another noted the importance of having someone available after hours who understood their case.

I needed someone to talk to at 2.30 am and I called the number and a stranger came on. I was desperate and she said "ring this number". If someone needs help they need someone they know.

Others described the treatment as being lenient and suggested that it should include drug testing or home detention.

I was expecting like with CARDS being court related drug related offences I was expecting to be tested upon every appointment. It would have been better because there is too much trust. It is, I mean the individual puts their hand up in court and says yep I broke into somewhere and ripped it off. I have a drug problem that's why I did it. The courts turn around and say right you've got to go to this office on four separate occasions. ... I mean they make it too lenient. When I was told that um if I was having a day where I was stoned or depressed or just couldn't be fucked coming to the appointment, don't hesitate to ring up and reschedule. I felt that was a lack of support. There is no pressure. Not having any incentive to get off your arse and clean your act up, you're never going to achieve it.

Combining home detention and CARDS is really good.

The program is only going to work with someone who is going to give up gear. It is not a really strict supervised program (like drug court) for a long term user who is trying to give up.

Recommendation 13

It is recommended that consideration be given to the existing treatment regime offered to CARDS participants, taking account of the feedback provided by former participants.

As previously mentioned, a 'weakness' noted by several individuals was the lack of information either about the CARD Scheme, or about other services available to individuals with drug issues.

Firstly finding out about CARDS should be better you know, like they got it off a sign at the court which is that big and on the computer there that you can go and have a look on but that's bloody shit you know like, it's like a dot you know four lines of shit ... and that's it. You know there's nothing there's nobody there, I mean they could have a little office with it with a counsellor you know she can tell this is what's going to happen and rah rah rah.

just as much information about it so they know what they're getting into like getting involved in, just a bit more information.

probably good if they just done a bit more as in like you know like put out a list of joints that you can go to you know? Like the Waranilla or private doctors that you can go to just like a list of doctors that you can ring.

Although indirectly related to CARDS, one particular individual would have appreciated greater assistance with the legal process itself, suggesting:

Perhaps if there was an information pack regarding the legalities because its really hard when you go through that process. If I could have had more information about where to find out more, what to ask and how to determine. Its really hard to find someone and really difficult to know what questions to ask them. I don't know what I need to be doing to help me out. All that kind of stuff.

One individual extolling the positive aspects of CARDS suggested greater awareness for magistrates, stating, and “*Make judges more aware of CARDS to help more people.*”

Summary

The majority of those interviewed were not aware of the CARD Scheme at the point of their first court hearing. Most reported that CARDS was first mentioned by the magistrate or their lawyer during the court hearing. Almost two-thirds reported that they had received enough information to make a decision to accept a referral to CARDS. The sources of information were varied and included: magistrates, lawyers, drug court counsellors and pamphlets. The vast majority were satisfied with the referral process, rating it as ‘very good’ or ‘good’.

Three-quarters of those interviewed rated the assessment process as ‘good’ or ‘very good’. Almost nine in ten understood why an assessment was being conducted, and of those who did not, their concerns were more likely to relate to their personal circumstances. That is, the magistrate had already ordered that they undertake CARDS, so they questioned the need for an assessment as to their suitability. For some individuals the assessment also provided an opportunity to ask questions and to clarify what CARDS involved. Two-thirds of those interviewed reported that the assessment was what they had expected. Those who were ‘surprised’ in some way very often commented on how well they had been treated by the assessor and that the assessor had seemed genuinely interested in them. Almost all were comfortable with the assessment process and few had any difficulties in attending. Some individuals were clear that they were already motivated to address their drug use prior to the CARDS assessment. However the discussion during the assessment may have increased their motivation or given them a sense of direction. For others, some sense of motivation to address their drug use came about during the assessment.

Those interviewed had received treatment at one of eight different DASSA locations or at Offenders Aid and Rehabilitation Services (OARS). Overall, the majority of those interviewed experienced few difficulties in getting to CARDS treatment sessions or in completing the required number of sessions within a three month period. This said, over half of those interviewed missed and/or rescheduled appointments on one or more occasions. A desire to change their drug use was the most frequently reported motivating factor in treatment. However, concerns about the loss of family or friends, or that their current offence would lead to them going to jail, also motivated individuals to complete the treatment. The majority felt comfortable with the clinician and more than half were satisfied with the treatment received. The most significant benefits gained from the treatment were reported as ‘having someone to talk to’, learning specific techniques to control the urge to use drugs, or gaining support and information at specific points in reducing or ceasing their drug use. Just over a third of individuals reported being dissatisfied with the treatment phase of CARDS. Reasons for this included that in their view they had not really received ‘counselling’, the sessions being too short or too few, or the sessions not addressing the real issues for them.

Only one third of individuals reported that the health treatment received was what they expected. For individuals who reported that the treatment was not what was expected responses were varied, with many suggesting that the experience was better than they had expected. When asked if they had felt comfortable with the clinician, over three quarters of

individuals responded positively, with many referring to the way that the clinician interacted with them as being helpful or non-judgemental. Over half of those interviewed were satisfied with the treatment aspect of CARDS. None of those interviewed reported any difficulties in the treatment process which were related to their cultural background and needs or their level of literacy, and only one individual interviewed reported any issues specifically related to their mental health needs.

Over three quarters of the individuals interviewed reported that completing CARDS treatment assisted with addressing their drug use and criminal behaviour in some way. A high proportion of these reported having reduced their drug use and related criminal activity. Just over half reported that the court outcome was better than they had expected. Most of these reported that the penalty received was less than they had expected.

Interviewees were also asked apart from being involved in CARDS treatment, whether any other things in their life had had an important effect on their drug use or crime behaviour. Over half reported that family members, partners or friends played an important role. A few individuals also listed workers involved with the criminal justice process as having an important effect.

Overall, more than eight in ten interviewees rated the CARD Scheme as 'good' or 'very good'. When asked whether there was anything they would change about the CARD Scheme, one third reported that no changes were necessary. The most frequently suggested change, made by approximately one third of those interviewed, was to increase the number, frequency and/or duration of treatment sessions, or to add a follow up session. Several individuals also noted the lack of information either about the CARD Scheme, or about other services available to individuals with drug issues.

PRE AND POST-TREATMENT QUESTIONNAIRE ANALYSIS

CARDS clients were asked to contribute to the evaluation by completing a questionnaire both after the initial assessment and after treatment had finished. The information requested was similar in both questionnaires and included 12 questions that form the SF-12 Physical and Mental Health Summary Scales (PCS and MCS). The survey included 20 other questions regarding the individual's social functioning¹⁵, criminal activity¹⁶ and involvement with CARDS. Whilst the vast majority of the pre and post survey were identical, there were some minor alterations to questions regarding aspects of CARDS participation in the post survey. A copy of both the pre and post-treatment questionnaires are available from OCSAR on request.

Seventy-two clients completed the pre-treatment questionnaire and 29 completed the post-treatment questionnaire. Only fourteen clients completed both questionnaires. This small number limits the analysis of information gathered. The pre-treatment questionnaire is given greater attention in the analysis below due to the greater response rate. Where possible, comparisons are made to the post-treatment questionnaire. However, it should be noted that those surveyed at post-treatment included only clients who completed CARDS, who may be different in some way from clients who did not complete CARDS. The pre-treatment questionnaire included both clients who completed and did not complete CARDS. Comparison of clients that completed both pre and post-treatment questionnaires is limited to their overall scores on the two scales that form the SF12.

Number and Gender of Questionnaire Respondents

Sixty-eight of the seventy-two clients who completed the pre-treatment questionnaire provided detail of their gender. Fifty-one (75.0%) were male and 17 (25.0%) were female. Of the 29 clients who completed the post-questionnaire, 24 provided detail of their gender. Fifteen (62.5%) were male and nine (37.5%) were female.

Social Functioning

Living Arrangements

Pre: When asked about their living arrangements in the pre-treatment questionnaire, 36 clients (50.7%) reported living in one place over the previous six months. One-quarter (25.4%, n=18) reported living in two places and less than one-quarter (23.9%, n=17) reported living in three places or more. This suggests that although half lived in one place, a significant number of clients may not have had stable living arrangements. One client did not respond to this question. Post: Of 29 respondents to the post-questionnaire, only three (10.3%) lived in three or more places in the last six months, six (20.7%) lived in two or more places, whilst 20 (69.0%) lived in just one location across this period. The reduction in those living in numerous locations and an increase in clients living in just one location may indicate a reduction in transience and increase in stability in clients' living arrangements. However, it may also be related to the post-treatment sample including only clients who successfully completed CARDS, such that successful completion may be assisted by more stable living arrangements.

¹⁵ The Social Functioning Scale of the Opiate Treatment Index (OTI) was used.

¹⁶ The Crime Scale of the Opiate Treatment Index (OTI) was used.

Employment Status

Pre: In the six months prior to CARDS involvement, nearly half (n=34, 48.6%) of the 70 clients responding to an employment question reported being unemployed 'all of the time'. Seven clients (10.0%) were unemployed 'most of the time', whilst a further three clients (4.3%) were unemployed 'half of the time'. Ten clients (14.3%) were unemployed only 'some of the time', whilst 16 clients (22.8%) were always employed during the previous six months. Of the 36 clients who indicated that they were employed at some point in the last six months, 24 indicated that they had not had any full-time work in this period, seven indicated having one full-time job and four indicated having two different full-time jobs. Post: In the six months prior to completing the post-CARDS questionnaire, over half (n=16, 55.2%) of the 29 respondents were unemployed all of the time. Only six clients (20.7%) were employed throughout this period. These rates of unemployment are similar to that in the pre-treatment questionnaire. Of the 13 clients with some level of employment in the previous six months, seven did not have any full time work, whilst six did.

Conflict With Others

Pre: Clients were asked questions regarding the extent to which they had conflict with relatives, partners or friends. To these questions either 69 or 70 valid responses were received. The largest portion of the 69 respondents reported 'never' having conflict or 'not applicable' (n=27, 39.1%). A similar number of clients reported only 'sometimes' or 'rarely' having conflict with relatives (n=26, 37.7%). A minority of clients (n=16, 23.2%) reported having conflict with relatives 'often' or 'very often'. When reporting conflict with partners, 19 (27.6%) of 69 clients reported conflict 'often' or 'very often', 21 (30.4%) individuals reported 'sometimes' or 'rarely' having conflict and a majority (n=29, 42.0%) reported 'never' or 'not applicable'. When reporting conflict with friends, no clients (of 70 valid responses) reported having conflict 'very often'. Eleven individuals (15.7%) reported such conflict to 'often' occur, 29 (41.4%) individuals reported conflict 'sometimes' or 'rarely' and 30 (42.9%) individuals reported such conflict to 'never' occur or to not be applicable. Post: Clients generally reported limited conflict with relatives, partners and friends in the post-treatment questionnaire and there were no discernable differences to the rates of conflict reported in the pre-treatment questionnaire.

Pre: Clients were asked to estimate how many close friends they have. Of 69 valid responses, 26 (37.7%) individuals reported having one or two close friends whilst 30 (43.5%) reported three or more. Thirteen (18.8%) reported having no close friends. Whilst this may be negative for these individuals, data from client interviews also revealed that some clients had expressed the importance of severing ties with friends and associates in order to assist them in stopping using drugs. Post: A large portion of 28 clients responding to this set of questions in the post-treatment questionnaire indicated having three or more close friends (n=17, 60.7%). This is a greater proportion than that discovered for clients at pre-treatment. A lower proportion had one or two friends (n=7, 25%) than in the pre-treatment questionnaire. This difference may not relate to the program and could also reflect those who completed the CARDS requirements having a greater number of close friends.

Support Received from Friends

Pre: Of 69 clients providing valid responses, a significant majority (n=46, 66.7%) were 'reasonably ok', 'satisfied' or 'very satisfied' with the support that they received from friends. Only a minority (n= 23, 33.3%) reported not being satisfied or 'not applicable'. Thirty-two (45.7%) of 70 responding individuals reported that they saw friends 'very often' or 'often'. Twenty-six (37.1%) individuals reported seeing friends 'sometimes' or 'rarely' and 12 (17.2%) individuals reported 'never' seeing friends or the question to not be applicable. Post: Very similar proportions of satisfaction with the support of friends were reported by clients at pre and post-treatment.

Length of Association with Friends

Pre: Clients were asked how many of the people that they currently 'hang around' with they have known for more than six months and how often they see their friends. Of 70 clients who responded, 23 (32.9%) individuals reported having known all of the friends they 'hang around' with for at least six months, 20 (28.5%) reported knowing half or more than half and 24 (34.3%) reported knowing less than half or none six months prior. The remaining three clients (4.3%) indicated that this question was not applicable to them. Most clients reported seeing these friends 'sometimes' (n=17, 24.3%), 'often' (n=18, 25.7%) or 'very often' (n=14, 20.0%). Fewer reported seeing friends 'rarely' (n=9, 12.9%) or 'never'/not applicable (n=12, 17.1%). Post: At post-treatment clients reported a similar extent to which they knew the individuals they 'hung around with' in the previous six months. Some differences were found in the extent to which they claimed to have contact with their friends from pre to post-treatment completion of the survey. Only three (10.3%) of 29 respondents indicated seeing their friends very often, down from 20% at pre-treatment. Some increases were found in clients seeing friends sometimes, up to 37.9% (n=11). Other response options remained relatively steady. It is difficult to interpret too much from these results, but it is possible that some clients who successfully completed CARDS made changes to the peers they associate with, hence the reduction in how much contact with friends they had. However, no direct question was asked to gauge this.

Living with a Heroin User

Pre: Clients were asked whether they had lived with anyone in the last six months who used heroin. The majority of 70 respondents to this question (n=56, 80.0%) indicated that they had not lived with a heroin user. Ten individuals (14.3%) reported living some of the time in the last six months with a person who used heroin, whilst four individuals (5.7%) reported living with a heroin user 'all of the time'. Post: A higher proportion of post-treatment survey respondents (n=25, 89.3%) than pre-treatment respondents indicated that they had not lived at any time in the previous six months with a heroin user. This slight improvement is encouraging but may not relate to CARDS involvement.

Associating with Drug Users

Pre: A majority of 70 individuals (n=45, 64.3%) reported that they 'hang around' with people who use drugs. Significantly, 11 (15.7%) individuals reported that all the people they 'hang around' with are users. A further 16 (22.9%) reported that of those they 'hang around' with, more than half or about half use drugs. Eighteen clients (25.7%) indicated that less than half of the people they 'hang around' with use drugs, whilst 25 (35.7%) individuals reported that they do not 'hang around' with any drug users. Post: The extent to which clients at post-treatment 'hang around' with other drug users reduced from the pre-treatment questionnaire response. Prior to treatment, 64.3% indicated 'hanging around' with drug users, but at post-treatment this was just 42.9% (n=12). Again, this difference may not be the result of CARDS involvement and could reflect that the post-treatment questionnaire was only asked of clients who successfully completed CARDS. Regardless, the reduction in association with drug users is encouraging.

Health

Clients were asked a range of questions regarding their health and whether their level of health limits them in any way. This included questions regarding both physical and mental health. Together the questions regarding health formed the SF12. Firstly, a summary of responses to each of these questions at pre and post-treatment are provided, with some comparison between the two. Following this, analysis of the SF12 results as a whole are provided, along with a comparison of pre versus post treatment SF12 scores for the small number of clients who completed both questionnaires.

Responses to Health Related Questions

Pre: When asked to describe their level of general health, the most frequent response by the 72 respondents was 'good' (n=31, 43.1%), followed by 'fair' (n=19, 26.4%). Fourteen clients (19.4%) rated their general health as 'very good', whilst only four (5.6%) rated their general health as either 'excellent' or 'poor'. Post: There were no notable differences in the ratings of general health by clients from pre to post-treatment. Again, the highest proportion of the 29 respondents rated their general health as good (n=13, 44.8%).

Pre: Generally, clients reported that their health did not limit either moderate or strenuous physical activity. Of 72 clients, 47 (65.3%) were 'not limited at all' with respect to moderate physical activity. Seventeen (23.6%) were only 'limited a little', whilst eight (11.1%) were 'limited a lot'. For strenuous physical activity, again few clients were 'limited a lot' (n=11, 15.3%). A similar number of clients were either limited 'only a little' (n=31, 43.7%) or 'not limited at all' (n=30, 41.7%). Post: For moderate physical activity, only one client of 29 (3.4%) indicated being 'limited a lot' by their physical health as opposed to 11.1% of clients at pre-treatment. The proportion of those 'not limited at all' also rose from 65.3% to 75.8% (n=22). For strenuous physical activity, a slight increase in those clients 'not limited at all' was reported (rising from 41.7% to 53.5%, or 15 of 28 valid responses). This occurred at the expense of those 'limited only a little' (n=9, 32.1%). These results for moderate and strenuous physical activity may indicate some improvement post-treatment but may also relate to factors other than CARDS involvement, particularly differences in CARDS completers, of which all post-treatment respondents were, and clients who did not complete CARDS.

Pre: Clients were asked whether their physical health had limited their activities during the four weeks prior to undertaking the survey. Of 67 clients responding to this question, they were relatively evenly split between those whose activity was limited in some way (n=34, 50.7%) and those whose activity was not limited (n=33, 49.3%). Post: Whilst clients were relatively evenly split at pre-treatment (approximately 50:50) regarding the extent to which their physical health limited their activities in the previous four weeks, at post-treatment only seven of 29 respondents (24.1%) indicated being restricted, with 22 not restricted (75.9%). This improvement is encouraging but the frequently mentioned caveats discussed in relation to other improvements should still be remembered.

Pre: Most clients (n=44, 62.0%) indicated that they accomplished less in physical activities due to their physical health than they would have liked during the previous four weeks. Twenty-seven clients (38.0%) did not achieve less than they would have liked. The remaining survey respondent did not answer this question. Post: In stark contrast, a minority of clients at post-treatment reported accomplishing less in physical activities due to their physical health than they would have liked in the previous four weeks (n=9, 31%).

Pre: When asked the extent to which pain had interfered with normal daily activities during the past four weeks, clients most commonly responded 'not at all' (n=24, 33.3%) or just 'a little bit' (n=16, 22.2%). Fifteen clients reported pain to have impacted on them 'moderately' (20.8%) in the last four weeks, whilst 13 clients reported 'quite a bit' of impact from pain. Only three clients (4.2%) reported an extreme impact from pain, whilst the final client did not respond to this question. Post: No interference of pain with daily activities was reported by around one-fifth of clients (n=6, 20.7%), down from one-third at pre-treatment. Just 'a little bit' of interference was reported by 18 clients (62.1%), up from only 22.2% at pre-treatment. Interestingly, those reporting the impact of pain to be 'extreme', 'quite a bit' or 'moderate' numbered only five of the 29 respondents (17.2%), down greatly from the 43.1% of clients (n=31) reporting such pain in the pre-treatment questionnaire.

Pre: Clients reported on their level of energy in the past four weeks. The majority of clients indicated that they had a lot of energy 'a good bit of the time' (n=21, 29.6%) or 'some of the time' (n=19, 26.8%). Fourteen clients had a lot of energy either 'all' or 'most of the time' (19.7%), whilst a similar number had a lot of energy only 'a little' or 'none of the time' (n=17, 23.9%). One client did not respond to this question. Post: Energy levels across the previous four weeks were found to be higher at the post-treatment than pre-treatment questionnaire. Around half of the 29 respondents (n=15, 51.7%) at post-treatment reported energy levels to be high 'all', 'most' or 'a good bit of the time'. This contrasts to the pre-treatment finding,

where only 20 of 71 respondents (28.2%) reported such levels of energy. A closer proportion of clients at pre (n=29, 40.8%) and post-treatment (n=14, 48.3%) reported energy levels to be high only 'some' or 'a little bit of the time'. Worth noting is that no clients at post-treatment reported having high energy 'none of the time', unlike the 13 clients (18.3%) who reported this at pre-treatment.

Pre: With respect to clients' mental health and emotional well-being, they were asked a series of questions regarding how they felt they had been during the past four weeks. Fifty-three of 72 clients (73.6%) indicated that they had accomplished less than they would have liked due to emotional issues. This is a higher proportion than the 62.0% of clients that accomplished less due to physical health issues. Post: In contrast, at post-treatment, only 48.3% of 29 clients (n=14) reported accomplishing less than desired due to emotional issues in the four weeks prior.

Pre: Two-thirds of clients (n=48, 66.7%) reported that in the four weeks prior to treatment they did not do things as carefully as they usually do. Post: In contrast to respondents at pre-treatment, respondents to the post-treatment questionnaire reported doing things with less care than usual approximately one-third of the time (n=8 of 28 responses, 28.5%).

Pre: During the last four weeks prior to treatment most clients reported feeling calm and at peace only 'some' or a 'little bit of the time' (n=47, 66.2%). Less than a quarter (n=17, 23.9%) reported feeling calm and at peace 'all', 'most' or 'a good bit of the time'. Seven clients (9.9%) felt calm and at peace 'none of the time', whilst one client did not respond to this question. Post: Respondents to the post-treatment questionnaire reported greater feelings of calm and peace in the four weeks prior, with 18 (62.1%) feeling at peace 'all', 'most' or 'a good bit of the time'. This contrasted starkly to the less than one-quarter (23.9%) of clients reporting this level of calm and peace in the four weeks prior to treatment. Only 11 clients (37.9%) reported feeling calm and at peace only 'some' or 'a little bit of the time'.

Pre: Clients ranged in the extent to which they experienced feelings of sadness and depression in the four weeks prior to the survey. Whilst few clients felt sad or depressed 'all' (n=3, 4.2%) or 'none of the time' (n=7, 9.9%), a large portion felt this way either 'most' or a 'good bit of the time' (n=32, 45.1%), and a sizeable group also felt this way 'some' or 'a little bit of the time' (n=29, 40.8%). One client did not provide a response. Post: Clients surveyed at post-treatment reported lower levels of sadness and depression in the four weeks prior to the questionnaire. None indicated sadness and depression all of the time, whilst a reduced proportion felt this way either 'most' or 'a good bit of the time' (n=7, 24.2%). The proportion of clients suggesting they felt this way either 'some' or 'a little of the time' remained relatively steady (n=13, 44.8%), whilst a higher proportion compared to pre-treatment, reported feeling sad and depressed 'none of the time' (n=9, 31.0%).

Pre: The final health-related question required clients to indicate how much of the time their physical health and emotional problems had interfered with their social activities. The most common response was 'some of the time' (n=20, 28.2%), followed by 'most of the time' (n=17, 23.9%). A further 11 clients (15.5%) indicated that physical and emotional health problems impacted on them 'all of the time'. Therefore, around two-thirds (n=48, 67.6%) of clients reported such interference at least some of the time or more. A minority indicated only being impacted by these problems a little (n=8, 11.3%) or 'none of the time' (n=15, 21.1%). One client did not provide a response. Post: At post-treatment a much lesser proportion indicated interference with social activities from physical and emotional problems. Only 14 clients (48.3%) indicated that this occurred at least some of the time, lower than the two-thirds (n=48) indicating this at pre-treatment.

Comparison of CARDS Sample SF12 Scores to SA Population Norms

The SF12 includes 12 questions and two scales, the PCS (Physical Component Summary) and the MCS (Mental Component Summary). The responses from these questions are used to calculate the total score for the PCS and MCS, in order to provide summary measures of health status. Each scale can range between zero and 100, with increasing values indicating

better health.¹⁷ These scales were used in both the pre and post-treatment questionnaires. Recently, South Australian data from the 2003 July Health Monitor (a “user pays” telephone surveying/interviewing system) and the South Australian component of the 2000 Collaborative Health and Wellbeing Study were used to derive population norms for these scales.¹⁸

Table 7 below presents the mean population norms found in the South Australian study for both male and females, along with the mean score in the CARDS sample group for both male and female clients. Four clients of the 72 respondents to the pre-treatment questionnaire were excluded from this analysis due to their gender not being recorded.

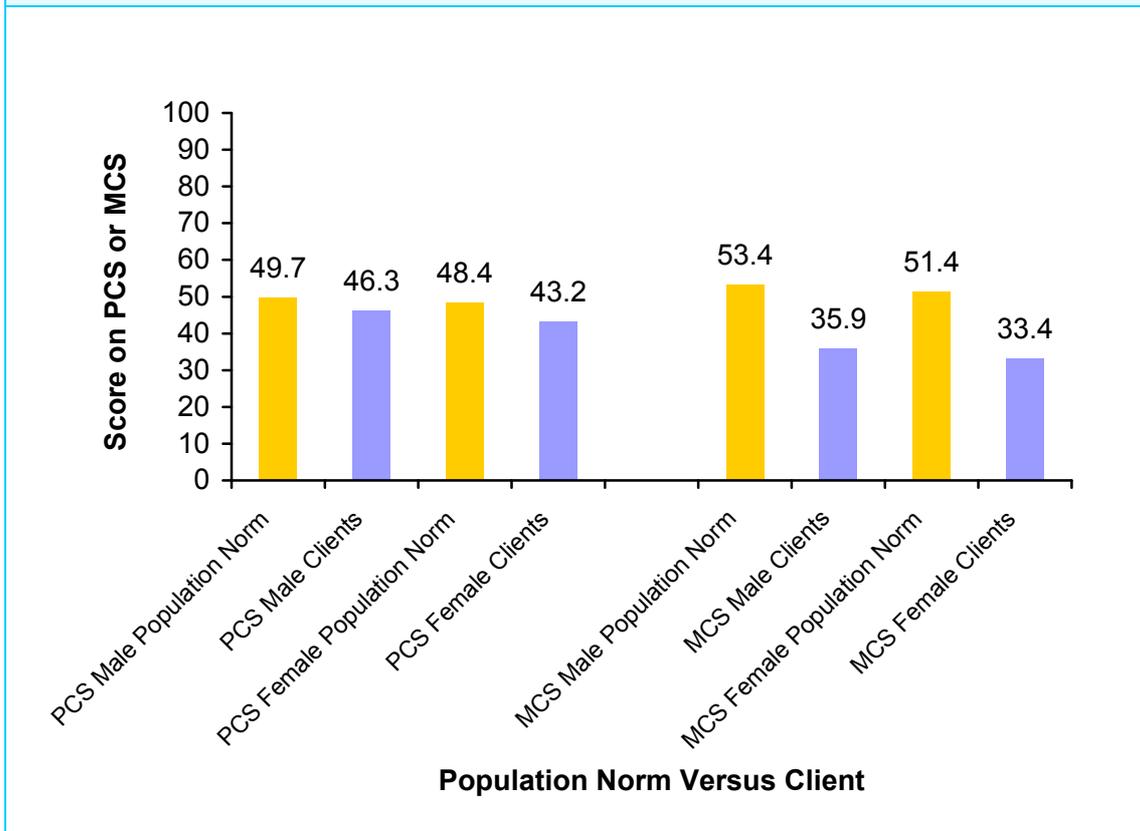
Table 7 SF12 South Australian Population Scores and Mean Scores for CARDS Clients at Pre-Treatment Questionnaire			
Scale	N	Mean	Standard Deviation
PCS			
- Overall Population norm	2013	48.9	10.2
- Overall male population norm	979	49.7	9.6
- Overall female population norm	1034	48.4	10.7
- CARDS sample males and females	68	45.5	9.8
- CARDS sample males	50	46.3	10.2
- CARDS sample females	18	43.2	8.4
MCS			
- Overall Population norm	2013	52.4	8.8
- Overall male population norm	979	53.4	7.8
- Overall female population norm	1034	51.4	9.5
- CARDS sample males and females	68	35.2	10.7
- CARDS sample males	50	35.9	10.6
- CARDS sample females	18	33.4	11.1

These population and CARDS sample means are also presented in Figure 6.

¹⁷ Avery, Jodie; Dal Grande, Eleonora; and Taylor, Anne (2004) Quality of Life in South Australia as Measured by the SF12 Health Status Questionnaire: Population Norms for 2003: Trends from 1997-2003. Population Research and Outcome Studies Unit, Department of Human Services, Adelaide.

¹⁸ Ibid.

Figure 6 SF12 South Australian Population Scores and Mean Scores for CARDS Clients at Pre-Treatment Questionnaire



As can be seen from Table 7, the CARDS sample displayed poorer health according to both the PCS (physical health) and MCS (mental health), than the best known representation of the overall South Australian population. For the PCS, the mean score for the CARDS sample was 45.5, below the overall population mean of 48.9. Of 68 CARDS clients, 41 had PCS scores above that of the population norm. A Wilcoxon Matched-Pairs Signed Rank Test was performed which indicated this difference between mean scores was significant ($Z = -2.88$, $p = .004$) indicating that the CARDS sample had poorer physical health than the general population.¹⁹ In this case, the fixed value used was the population norms for males and females respectively. These were compared to the actual scores on the scale by male and female CARDS clients.

In the overall population, a significant difference on the PCS was found between males and females, with females displaying significantly lower physical health.²⁰ In our CARDS sample, there was no significant difference between male and female scores on the PCS,²¹ although males recorded a higher mean score than females.

For the MCS, the mean score for the CARDS sample was 35.2, considerably below the overall population mean of 52.4. Sixty of the 68 clients in the CARDS sample scored lower on this scale, indicating poorer mental health, than the overall population norm. A Wilcoxon Matched-Pairs Signed Rank Test revealed that this difference between mean scores was significant, $Z = -6.87$, $p < .001$.

¹⁹ Whilst this test is designed for matched pairs data rather than a single sample, it can be used with a fixed value for one half of the pair to test a single sample against a fixed value. (SPSSX Forum hosted by the University of Georgia and available at <http://www.listserv.uga.edu/archives/spssx-l.html>. This particular post accessed at <http://www.listserv.uga.edu/cgi-bin/wa?A2=ind9605&L=spssx-l&P=R9351> on 10/11/2006 included advice from a Senior Support Statistician at SPSS.)

²⁰ Avery et al (2004) op cit.

²¹ $Z = -1.33$, $p = .182$

In the overall population a significant difference was found between males and females on the MCS, with males showing greater mental health. And again in the CARDS sample, no significant difference was found between male and female clients on this scale.²² It should be noted that the difference between mean scores on both the PCS and MCS scales differed more between males and females in the CARDS sample than it did between males and females in the population norms. It is likely that the small sample size reduced the chance of identifying a significant difference between male and female clients in the CARDS sample, despite these differences in means.

The sample size at the post-treatment questionnaire was considerably lower with only 28 completing these components of the post-treatment survey. Of these, only 22 had a recorded gender. The same comparisons to the population norms for both males and females were undertaken for this group as was undertaken with the pre-treatment questionnaire. For the PCS, the 22 clients had a mean scale score of 46.3, compared to the population norm of 48.9. The Wilcoxon Matched-Pairs Signed Rank Test revealed that this difference was not significant ($Z = -0.63$, $p = .527$). For the MCS, the 22 clients had a mean scale score of 44.2, compared to the population norm of 52.4. This difference was found to be significant ($Z = -3.10$, $p = .002$), indicating poorer mental health for CARDS clients compared to the general population. No significant differences were found between male and female clients on either the PCS or MCS, but the small sample size may have been a major reason for this.

Comparison of Pre and Post-Treatment Client Scores on the SF12 Scales

Finally, in the analyses of client SF12 responses, comparison was undertaken for the 14 clients who completed both the pre and post-treatment questionnaire. With such a small sample, the ability to detect changes is limited. For the PCS, of these 14 clients, six recorded a higher score at post-treatment than pre treatment, whilst eight recorded a lower score. For the MCS, nine of the 14 clients recorded a more positive score at post-treatment, whilst five clients recorded a reduced score. For both the PCS and MCS, the change in client scores from the pre to post-treatment questionnaire was not found to be significant.

Criminal Activity

In relation to criminal activity, CARDS clients were asked about the frequency with which they had committed specific crimes, including property crime, selling drugs, fraud and violent crime, over the previous month. Approximately 10 clients did not validly answer or refused to answer each of these questions. The description below regarding criminal activity in relation to certain types of crime was extremely low in all categories. Data provided in the section "Contact with the Criminal Justice System" provides us with detail for criminal events for which clients have been apprehended prior to and following CARDS involvement, rather than that self-reported by clients.

Property Crime

Pre: Of 62 respondents, 10 (16.1%) reported committing a property crime in the last month, whilst the vast majority ($n=52$, 83.9%) reported that they did not commit such crime. For the 10 clients who reported committing a property crime in the last month, two reported committing daily property crimes, five at least one or more a week, and three less than one a week. Post: At post treatment, only two of 29 clients reported committing a property crime (6.8%) in the last month. This is well below the 16.1% who admitted to such crimes in the month prior to the pre-treatment questionnaire.

Sale of Drugs and Fraud Offences

Pre: Similarly, of 64 respondents, only 10 (15.6%) reported selling drugs, whilst the vast majority ($n=54$, 84.4%) reported no drug dealing. For those clients who reported committing such offences, the occurrence rate ranged from daily to less than once a week. Only two of 63 (3.2%) respondents reported committing a fraud in the previous month and both reported

²² $Z = -1.17$, $p = .243$

this to have occurred less than once a week in the last month. A majority (n=61, 96.8%) reported no fraudulent activity. Post: Five of 29 clients (17%) reported selling drugs, a similar proportion to the pre-treatment questionnaire, whilst no clients at post-treatment reported having committed fraud.

Violent Crime

Pre: Of 62 respondents, only three (4.8%) reported committing a violent crime in the previous month. Of these, two reported this to have occurred less than once a week, whilst the other client reported such offending more than once a week. A majority (n=59, 95.2%) reported no violent criminal activity in the previous month. Post: no post-treatment clients reported having committed a violent crime in the previous month.

Explanation for Crime Committed Just Prior to CARDS Referral

Factors or circumstances leading to an individual committing the crime that resulted in a referral to CARDS were quite diverse. A number of clients gave more than one reason and therefore totals will be greater than the number of individuals. Of the 65 individuals who provided a response to this question, the majority (n=32, 49.2%) reported being drunk or high on drugs when committing the crime which led to referral. Twenty-four individuals (36.9%) reported that they committed the crime to support their drug habit, and 12 individuals (18.5%) reported committing the crime because they were unemployed and needed money. Eight individuals (12.3%) reported committing the crime as they needed money to support their family or themselves. The remaining individuals gave a range of different reasons. Only three suggested that they were under pressure from peers and two others admitted that they committed the crime 'for kicks'. Overall, it appears that a majority of clients made the decision to commit the crime alone, although nearly half were under the influence of alcohol or other drugs at the time of the offence.

Involvement with CARDS

Clients were asked about their involvement in CARDS only at the pre-treatment stage. Individuals were asked to report the source of the CARDS information received. Sixty-seven clients responded to this question, with clients invited to report more than one source of information where relevant. Therefore, totals for each information source are greater than the number of respondents. The most common information source was a solicitor, with 32 clients receiving information from this source. This was closely followed by magistrates or representatives of the courts who provided information to 27 clients. The CARDS pamphlet was cited as a source of information by 23 clients, whilst the CARDS assessor was specifically referred to by 11 clients. Friends provided specific information to three clients, whilst other sources listed once each were a cell-mate in jail, Centrelink, DCS, the Drug Court program, a police prosecutor and word of mouth.

Feedback regarding how helpful the information was in order to understand the CARD Scheme was mainly positive. Of 65 respondents to this question, 49 (75.4%) reported the information received to be 'extremely' or 'quite' helpful. Twelve individuals (18.5%) reported the information received to be 'moderately' or 'a little' helpful and only four individuals (6.1%) reported that it was not helpful.

Clients provided reasons for choosing to be part of the CARD Scheme. In some cases more than one reason was provided per client. The most common reason provided by the 62 responding clients was that it may benefit them from talking to someone about their drug problem (n=56, 90.3%). Eleven (17.7%) clients reported that it may help to reduce their sentence and three reported that it was due to the magistrate's recommendation that they chose to take part. Only two clients reported that they were involved because they thought they did not have a choice.

Drug Use Following Treatment

In the post-treatment questionnaire clients were asked if they had continued drug use following the treatment. Of 28 respondents, 17 (60.1%) stated that they continued to use drugs after their treatment episode, whilst 11 (39.9%) stated that they did not. Of the 17 who continued usage, 15 indicated that they had reduced their usage, whilst the remaining two did not provide an answer. Of those who had continued usage, most commonly used were amphetamines (n=12) and cannabis (n=11). Used by three or less clients each were hallucinogens, heroin, ecstasy, fantasy and morphine.

CONTACT WITH THE CRIMINAL JUSTICE SYSTEM

Introduction

This section provides an overview and analysis of the contact that CARDS clients have had with the criminal justice system. This includes the extent and nature of their prior offending before involvement with the Scheme, the range and type of charges that they entered the Scheme on, and the extent and nature of their offending following involvement in the Scheme. The section will be separated into two main parts as outlined below:

Firstly, an analysis will be provided of the major charge and overall charges that clients presented to court with when referred to CARDS (see “An Overview of Offences at Entry to the Scheme”).

Secondly, an analysis is undertaken of clients’ offending histories prior to, during and following their involvement in CARDS (see “Pre and Post Offending of CARDS Clients”). Particularly critical here is a comparison of client offending for the six months prior to their involvement in CARDS and the six months following this involvement. Where possible, differentiation is provided between those clients who completed the Scheme’s requirements and those clients who did not. Some analysis is also provided concerning which types of clients were the most likely to complete the Scheme’s requirements, based on the extent of their prior offending and the seriousness of their major offence at entry to CARDS.

An Overview of Offences at Entry to the Scheme

This section provides an analysis of the major charge and overall charges laid against clients, for which they were referred to CARDS.

It includes a sample of 74 individuals referred to and accepted onto the Scheme from its inception and who had ended their CARDS involvement by approximately October 2005. It includes clients who both successfully completed the CARDS requirements, and those who did not. The analysis for pre and post offending utilises a larger sample of 99 clients who commenced CARDS involvement by the end of December, 2005. The discrepancy in these sample sizes is due to this analysis of offences at entry to the Scheme relying on an earlier data extract. Given the general descriptive nature of the offences at entry to the Scheme, it was chosen not to repeat this activity as further data became available.

This section will firstly provide brief, general demographic details of those individuals for whom analysis is to be undertaken. It will then summarise and analyse the range and type of major charges that the client presented with at their entry to CARDS, along with the overall number and combination of charges that each client presented with. It also provides an overview of the penalties received for these offences for both CARDS completers and non-completers. Differences on the basis of age, gender or Indigenous status are also highlighted.

Demographic Profile of Study Sample

Age, Gender and Indigenous Status

This study sample comprises 74 CARDS clients, with 56 being male and 18 females. Table 8 provides a breakdown of the age and gender of the sample.

Age	Male	Female	Total	
	No.	No.	No.	%
18-24	10	8	18	24.3
25-29	12	5	17	23.0
30-34	18	-	18	24.3
35-39	9	3	12	16.2
40-44	3	1	4	5.4
45-49	3	1	4	5.4
50+	1	-	1	1.4
Total	56	18	74	100.0

Males in this sample considerably outnumber females by approximately three to one. The majority of offenders in this sample were aged below 40 years (n=65, 87.8%). Only eight were indicated by Courts Administration Authority data to be Indigenous. This included five Indigenous males aged under 40 and three Indigenous females aged under 30.

Major Charges on Entering CARDS

Range and Type of Major Charges Presented by Clients

The major charge for which each of the respondents in this CARDS sample appeared before the court was categorised according to its JANCO offence code,²³ resulting in nine possible categorisations. Within this, further categorisation is provided within the categories of offences against the person and what is referred to here as acquisitory crimes, being crimes such as larceny, serious criminal trespass and fraud that target the acquisition of property illegally. The major charge that clients presented to court with when accepted onto CARDS are presented below. These are provided according to gender (Table 9) and age range (Table 10).

Major Offence	Male	Female	Overall Total
Offences against the person			
- major assault	1	-	1
- minor assault	2	-	2
Robbery	-	1	1

²³ The JANCO classification system is an adaptation of the Australian Bureau of Statistics' ANCO (Australian National Classification of Offences, 1985. Catalogue No. 1234.0) classification system. Offences are grouped into nine categories which cover twelve major offence types. In some instances, additional lower levels of JANCO are used to distinguish particular subgroups of offences or to provide information on the characteristics of the victim. For further information see Castle, C & Sampson, L (2005) *JANCO Classification System*. Office of Crime Statistics and Research, Department of Justice, Government of South Australia, Adelaide.

Table 9 Major Charge on Entry to CARDS for Male and Female Clients			
Major Offence	Male	Female	Overall Total
Acquisitory crimes			
- serious criminal trespass	16	3	19
- Fraud and misappropriation	2	2	4
- Larceny and receiving	15	7	22
Damage property	2	-	2
Offences against good order	12	2	14
Drug offences	2	1	3
Driving and motor vehicle offences	4	2	6
Other regulatory offences	-	-	-
No-offence matters	-	-	-
Total	56	18	74

As can be seen from Table 9, both males and females in this sample were most likely to enter CARDS on a major charge related to property crime (excluding property damage) that is acquisitory in nature (n = 45), particularly larceny and receiving and serious criminal trespass. This group of offences outweighs the next most common major charge, namely offences against good order (n = 14), by approximately three to one. It appears that the Scheme is much more likely to “take on” defendants where the major charge is an acquisitory crime. This may relate to both referral processes and acceptance processes. Such defendants represent 45 of the 74 clients (56.9%) in this sample. This is well above the 19.2% of defendants with acquisitory crimes as the major charge in South Australia in 2005.²⁴

Not surprisingly, given the eligibility criteria of CARDS which generally will not accept violent offenders, offences against the person amongst the sample are rare, with only three clients, all males, having an offence in this category as their major charge, only one of which was a major assault. This represents a proportion of around 4% of the sample which is well below the state average across all offences for 2005, where 11.9% of major charges were for offences against the person (excluding sexual offences).²⁵ Driving and motor vehicle offences were also underrepresented as the major offence in this CARDS sample (8.1%) in comparison to the frequency of this as the overall major charge for defendants in South Australian courts in 2005 (30.7%).

Only three individuals (4.5%) in this sample had a drug offence as the major charge. This is slightly below the proportion of defendants with this as the major charge in South Australian courts in 2005 (5.8%). Such a small number of drug offences for clients of an initiative focused on their drug use is surprising at first glance. However, this may have been strongly influenced by the police practice of diverting minor drug offences. Also, consultations with magistrates, as referred to elsewhere in this report, have revealed a tendency for magistrates to refer defendants for whom they believe that drug use contributed to the offending, particularly where money was sought to potentially fund illicit drug use. This in turn explains the very high proportion of offenders on CARDS whose major offence is acquisitory in nature.

Of the eight Indigenous clients in this sample, two each committed larceny and receiving, serious criminal trespass or offences against good order as their major charge, whilst the

²⁴ Office of Crime Statistics and Research (2006). *Crime and Justice in South Australia 2005: Adult Courts and Corrections*. Department of Justice, South Australia.

²⁵ Ibid.

remaining two had a robbery and a driving and motor vehicle offence as their major charge. With such a small number of Indigenous offenders it is not possible to identify any particular patterns in terms of the type of major offence they presented with on entry to CARDS.

The age range of each CARDS client in this sample and their major charge is provided in Table 10.

Major Offence	18-24	25-29	30-39	40+	Total
Offences against the person					
- major assault	-			1	1
- minor assault	-	1	1	-	2
Robbery	1	-	-	-	1
Acquisitory crimes					
- serious criminal trespass	3	3	11	2	19
- Fraud and misappropriation	2	1	1	-	4
- Larceny and receiving	4	6	8	4	22
Damage property	1	1	-	-	2
Offences against good order	6	4	4	-	14
Drug offences	1	-	-	2	3
Driving and motor vehicle offences	-	1	5	-	6
Other regulatory offences	-	-	-	-	-
Non-offence matters	-	--	-	-	-
Total	18	17	30	9	74

Of note is the concentration of offences against good order amongst younger clients (aged 29 and below). Overall, the sample is too small to uncover further differences in major charges across age groups relative to their respective proportion in the sample.

Seriousness of Major Charge

The seriousness of the major charge presented by clients was analysed via the use of a seriousness ranking based on the ABS National Offence Index (NOI). The NOI ranks all offence classifications contained within the Australian Standard Offence Classification (ASOC) system in order of seriousness. The index starts with the most serious offence of murder, which is given an index value of one, and then continues down through 159 ranked offences.²⁶ The seriousness index used here (JNOI) reverses the NOI such that 159 ranks as the most serious offence and 1 as the least serious.

All major charges were grouped into three 'seriousness' categories:

²⁶ Skrzypiec, G. (2005). *Offending at 16 to 20 Years of Age: Identifying Youth for Intensive Intervention*. Office of Crime Statistics and Research, Department of Justice, Government of South Australia, Adelaide.

- Scores ranging from 1-64 consisted of 'minor offences'. Charges in this category included driving and registration offences, shop lifting, possession of illicit drugs and selling or trading illicit drugs (cannabis only).
- Scores ranging from 65-96 consisted of 'moderately serious' offences. Charges in this category included property damage, negligent driving, receiving proceeds of crime, other larceny, theft of a motor vehicle and fraud.
- Scores ranging from 97-159 consisted of the most 'serious' offences. Charges in this category included *aggravated and non-aggravated serious criminal trespass, robbery and assaults*.

Table 11 below provides an overview of the number of defendants with a major charge that falls into each seriousness category.

Table 11 Seriousness Category of Major Charge for CARDS Sample		
Category of Major Offence	Number of Defendants	Percentage of Sample
Minor Offence	31	41.9
Moderately Serious Offence	27	36.5
Serious Offence	16	21.6
Total	74	100.0

The major charges for the 74 clients in this sample were mainly of minor or moderate seriousness according to the seriousness index utilised. However, the 16 clients whose major charge is rated as serious on this scale indicates that CARDS is available to a broad range of offenders. There were no notable differences in the seriousness of the major charge for clients in this sample according to their age, gender or Indigenous status.

It should be noted that the analysis here only refers to the major charge the CARDS defendant presented with when referred to CARDS. It does not highlight whether these individuals had at some previous point been charged with a more serious offence than that for which they were accepted onto the Scheme.

All Charges on Entering CARDS

The Overall Number of Charges Laid Against Clients at Point of Entry

In order to provide an overview of the overall charges that defendants on the Scheme presented to the court with beyond the major listed charge, it was necessary to analyse the number, type and combination of charges that defendants presented with.

The 74 CARDS clients in this sample were charged with a total of 325 offences, an average of 4.4 charges per person. The majority of these people presented to court with only one or two charges (38 offenders, 51.4%). At the other extreme, seven clients presented with over 10 charges, including one with 35 charges. The median number of charges was two per person. Table 12 provides an overview of the number of charges for which the client was before the court.

Number of Charges	Number of Participants	Percentage
1	20	27.0
2	18	24.3
3	6	8.1
4	6	8.1
5	11	14.9
6-10	6	8.1
11-15	3	4.1
16-20	3	4.1
Over 20	1	1.3
Total	74	100

No noteworthy differences were identified in the pattern or number of charges for which the client was before the court, across either age range, gender or Indigenous status.

The types of charges that defendants presented to the court with is provided in Table 13 below, categorised according to their highest level JANCO code, and again with extra detail for acquisitory crimes and offences against the person. Also provided is a breakdown on the basis of gender.

Major Offence	Male (n = 55)	Female (n = 19)	Overall Total (n = 74)
Offences against the person			
- major assault	3	-	3
- minor assault	4	4	8
Robbery	-	1	1
Acquisitory crimes			
- serious criminal trespass	40	8	48
- Fraud and misappropriation	12	48	60
- Larceny and receiving	41	24	65
Damage property	8	-	8
Offences against good order	53	15	68
Drug offences	4	2	6
Driving and motor vehicle offences	45	6	51

Table 13 All Charges on Entry to CARDS for Male and Female Clients			
Major Offence	Male (n = 55)	Female (n = 19)	Overall Total (n = 74)
Other regulatory offences	6	-	6
Non-offence matters	1	-	1
Total	217	108	325

It should be noted that this data can be deceptive due to some clients being charged with numerous offences of the same type, such as one female with 34 fraud charges.

In comparison to their frequency as a major charge, most different in terms of frequency amongst secondary charges was driving and motor vehicle offences. Only three defendants in the sample had this as their major charge but 51 overall charges were laid against clients for this offence category, highlighting its frequency as a secondary rather than major charge.

Number of Drug Charges

Of the 325 charges across 74 clients, only six charges were for drug related offences. These included three charges for possession or use of an illicit drug, and one charge each for selling or trading cannabis, production or manufacture of an illicit drug and an unspecified drug related offence.

These six drug-related charges occurred across five individuals and was the major charge for three of these. With such small numbers it was not possible to identify any trends based on the age range, gender or Indigenous status of the client.

Combinations of Offences Within Clients

Of the 74 individuals in this sample, 55 presented with more than one charge when accepted onto CARDS. Eighteen of these represented additional charges of the same category only. Ten of these were for acquisitory crimes (five larceny and receiving, three serious criminal trespass and two fraud and misappropriation). The remaining eight clients with multiple offences in the one offence category included four with multiple offences against good order, three with multiple driving and motor vehicle offences and one with multiple drug offences.

Thirty-seven clients, exactly half the sample, presented with at least two different categories of charges. Most common was the combination of acquisitory offences and offences against good order, with 22 clients having both of these charges. Across these 22 clients, with some clients having more than one type of acquisitory offence, 17 had an offence of larceny and receiving, 12 had an offence of serious criminal trespass, and four had an offence of fraud or misappropriation combined with at least one offence against good order. The next most common combination of charges to appear together in defendants was offences against good order and driving and motor vehicle offences, with nine pairings. This was followed by acquisitory crimes and driving and motor vehicle offences, with seven pairings. Across these seven individuals, six involved larceny and receiving, of which four included a charge for larceny and/or illegal use of a motor vehicle. Four of these individuals also had a charge related to serious criminal trespass. There were no noticeable differences in combinations of charges that clients presented with based on their age, gender or Indigenous status.

Penalties for CARDS clients

Table 14 below provides an overview of the penalties received by clients as a result of the offences for which they entered CARDS. It separates first, second and third penalties received. The table distinguishes between those clients who successfully completed the Scheme and those who did not, which may influence sentencing outcomes. However, it

should be noted that the type and seriousness of the offence(s) that clients committed would have been considered by the courts, along with their prior offending histories, so caution must be used in considering these outcomes according to the clients' completion of CARDS or otherwise.

Table 14 Penalty Received by Clients for the Charge CARDS Entered Upon										
successfully completed	Fine	No penalty	Other order	Driver's license disqualification	Bond without supervision	Bond with supervision	Community service order	Suspended imprisonment	Imprisonment/detention/ home detention	Total
Penalty 1 for offence that clients entered CARDS upon										
No	-	10	1	1	1	-	-	14	4	31
Yes	-	6	2	2	5	8	1	17	2	43
Total	-	16	3	3	6	8	1	31	6	74
Penalty 2 for offence that clients entered CARDS upon										
No	1	16	-	-	4	9	1	-	-	31
Yes	2	19	4	1	6	11	-	-	-	43
Total	3	35	4	1	10	20	1	-	-	74
Penalty 3 for offence that clients entered CARDS upon										
No	-	20	4	6	1	-	-	-	-	31
Yes	-	32	7	4	-	-	-	-	-	43
Total	-	52	11	10	1	-	-	-	-	74

It can be seen that clients who successfully completed CARDS were much more likely to receive a bond with or without supervision than clients who did not successfully complete CARDS. Interestingly, a higher proportion of non-completers received no penalty at all (n=10, 32.3%) than CARDS completers (n=6, 14.0%). Whilst numbers are very small, CARDS non-completers (n=4, 12.9%) were more likely to be sentenced to some form of detention than CARDS completers (n=2, 4.7%).

Pre and Post Offending of CARDS Clients

This section firstly provides an overview of the offending history of CARDS clients prior to their entry, during and following their involvement in the Scheme. It then provides a comparison of offending prior to and post involvement with CARDS, along with an analysis of which types of clients are most likely to complete the Scheme's requirements, based on the extent of their prior offending and the seriousness of their major offence at entry to CARDS. Prior to this, a demographic profile is provided of the individuals used in this analysis, along with some program-related data concerning the nature of their involvement in the Scheme.

Demographic Profile of the Client Group

Client Group

This part of the analysis includes all individuals referred and accepted onto CARDS from its inception and who had ended their CARDS involvement by December 31st 2005 at the latest. This end date was selected to allow for the analysis of six months of client offending as at June 30th 2006 for all CARDS clients following their CARDS involvement. In all, 101 clients had completed their involvement by December 31st 2005. This included both clients who fulfilled the Scheme's requirements ("Completers") and those who did not ("Non-Completers"). Of these 101 clients, two clients have been excluded from analysis due to there being no recorded criminal events for these individuals in South Australia during our main period of interest (six months pre-CARDS and six months post). Both these clients had committed Commonwealth social security fraud offences, which do not generate a South Australian apprehension report.

Age, Gender and Indigenous Status

Of the 99 CARDS clients analysed, 75 were male and 24 female. Table 15 provides a breakdown of the age and gender mix of the sample.

Age	Male	Female	Total	
	No.	No.	No.	%
18-24	14	9	23	23.2
25-29	14	6	20	20.2
30-34	26	2	28	28.3
35-39	12	3	15	15.2
40-44	6	1	7	7.1
45-49	3	2	5	5.0
50+	1	-	1	1.0
Total	76	23	99	100.0

As with overall defendants before South Australian courts, males in this sample considerably outnumber females. In South Australia, the ratio is four and a half males to every female defendant,²⁷ whilst this CARDS sample has a ratio of approximately three males to each female. Whilst there are considerably fewer female respondents, they appear to be more highly concentrated in the 18-24 and 25-29 year old age groups (n=15, 65.2%) when compared to males (n=28, 36.8%). This is unlike the South Australian average for 18 to 29 year olds which comprised approximately 50% of all offenders for both males (51.1%) and females (46.9%) in Magistrates Courts in 2005.²⁸

The majority of offenders in this sample were aged below 40 years (n=86, 86.9%). This is higher than the proportion of all defendants aged below 40 years appearing before South Australian Magistrates Courts in 2005 for major offence committed (78.0%).²⁹

²⁷ Office of Crime Statistics and Research (2006). *Crime and Justice in South Australia 2005: Adult Courts and Corrections*, Department of Justice, South Australia.

²⁸ Ibid.

²⁹ Ibid.

Of the 99 individuals in this sample, only twelve were indicated by Courts Administration Authority data to be Indigenous. A further individual who was not identified as Indigenous based on this data, was identified in our dataset as Indigenous due to their appearance in the Port Adelaide Nunga Court. This brought the number of Indigenous people identified in this sample to 13, nine of which were male and four female.

Program-related Profile of the Client Group

Pre-Sentence vs Post Sentence Entry to CARDS

The vast majority of the sample entered CARDS at the pre-sentencing stage as a condition of bail (n=82, 82.8%) or via case adjournment (n=4, 4.1%). The remaining eight entered CARDS post sentencing via a bond (n=13, 13.1%). Given the small number of clients entering CARDS via bond or adjournment, it was not possible to identify any discernible differences between the method of entry to CARDS according to age, gender, Indigenous status or offence type.

CARDS Site

Of the 99 participants who had ceased their involvement with CARDS (either completing or failing to complete) by the end of 2005, numbers were relatively evenly split between Adelaide (n=46) and Port Adelaide Magistrates Courts (n=44). A further five clients were involved in the Nunga Court at Port Adelaide, whilst three were referred to CARDS via the Murray Bridge Magistrates Court and one via the Mt Barker Magistrates Court.

Completion

Of the 99 participants, 57 completed the requirements of the Scheme, whilst 42 did not. A full analysis of which sub-groups (i.e. gender, Indigenous status etc.) were more likely to complete the requirements of the Scheme is provided later in this report.

Offending History of the Client Group

This section provides an overview of the offending history of CARDS clients prior to their involvement in CARDS (which includes the criminal event upon which they entered CARDS), during their involvement and following their involvement. It primarily focuses on the number of criminal events³⁰ which clients were apprehended for across particular periods, namely all events recorded for clients:

- in the five years prior to CARDS involvement;
- in the six months prior to CARDS involvement;
- during involvement in CARDS (this period will vary according to the amount of time the client spent on the Scheme); and
- in the six months since their involvement in CARDS was completed or ceased.

The majority of detailed analysis will compare offending in the six months prior to and post CARDS involvement.

Client Offending in the Five Years Prior to CARDS

In order to provide detail regarding the criminal histories of clients on CARDS, their offending for the five years prior to CARDS involvement was analysed. Unlike offending data for the six months prior to CARDS involvement, this data will not be used for any comparison of pre or

³⁰ A criminal event refers to one or more offences that occurred on the same day for which the individual was apprehended.

post offending, but will be used in later analysis regarding which clients are more likely to complete the Scheme's requirements.

In the five years prior to involvement in CARDS, the clients had an average of 16.2 criminal events each (median 12). This equates to approximately three events per year. This includes criminal events committed both as juveniles and as adults. Males (mean 16.1) and females (mean 16.7) in the client group had a similar number of events in the five years prior to CARDS involvement. The number of prior offences in this period was highest in those aged 18 to 24 (mean 20.5, median 17), which may reflect the prevalence of offending in juvenile years. Clients aged 40 and over (mean 12.8, median 8) had the lowest mean number of offences across the five years prior to CARDS involvement. For those aged 24 to 29, 30 to 34 and 35 to 39, the mean offences in the five year period ranged between 13.9 and 16.6. Differences in mean offences between most other groups were generally quite small. Whilst CARDS completers (mean 15.1) had fewer events than CARDS non-completers (mean 17.8), this difference was not significant.

The main group of 99 clients varied in the number of events in the five years prior to CARDS involvement. Four clients had only one recorded event, this being the event that brought them onto CARDS, whilst two clients had over 50 events each. The majority had 10 or less events (n=45, 45.5%), whilst 20 clients each had either 11 to 20 or 21 to 30 events (20.2% each). Fourteen clients (14.2%) had over 30 events. The number of events, categorised by range, for CARDS completers and non-completers is provided in Table 16.

Offences	Completed CARDS	Did not complete CARDS	Total
1 to 10 offences	32	13	45
11 to 20 offences	8	12	20
21 to 30 offences	9	11	20
Over 30 offences	8	6	14
Total	57	42	99

In the five years prior to CARDS involvement, the most common offence category these offenders were charged with was acquisitory crimes. These comprised the major charge in 640 of the 1,606 recorded criminal events across all clients (39.9%). Within this larger category, over half of the events were for larceny and receiving (n=447), a further 146 were for serious criminal trespass, whilst 47 were for fraud and misappropriation. Beyond such acquisitory crimes, also prevalent were driving and motor vehicle offences (n=426, 26.5%) and offences against good order (n = 337, 21.0%). Drug offences comprised just 3.2% of all events (n=52) and were committed by 28 of the 99 participants. The largest portion of these events (n=20) were for the possession and/or use of amphetamines, whilst selling or trading amphetamines also featured (n=9), but not production or manufacture of amphetamines. Cannabis-related offences also featured, with possession and/or use (n=5), selling or trading (n=9) and production or manufacture (n=7) represented. Table 17 provides an overview of these events across the five years prior to involvement in CARDS, with a distinction made between the criminal events of males and females, along with CARDS completers and non-completers.

Table 17 Client Criminal Events in the Five Years Prior to CARDS Involvement

Criminal Event	Completed (n=57)		Not Completed (n=42)		Total (n=99)
	Male (n=44)	Female (n=13)	Male (n=32)	Female (n=10)	
Offences against the person					
- major assault	15	-	4	-	19
- minor assault	22	-	21	4	47
- other assault	6	1	10	3	20
- sexual assault	-	-	1	-	1
Robbery	3	1	7	5	16
Acquisitory crimes					
- serious criminal trespass	68	9	61	8	146
- Fraud and misappropriation	17	18	7	5	47
- Larceny and receiving	137	81	168	61	447
Damage property	3	2	8	3	16
Offences against good order	119	57	112	49	337
Drug offences	19	5	22	6	52
Driving and motor vehicle offences	220	40	142	24	426
Other regulatory offences	2	1	8	-	11
Non-offence matters	10	1	9	1	21
Total	641	216	580	169	1606

Client Offending in the Six Months Prior to CARDS

In the six months prior to their involvement in CARDS, the 99 clients had an average of 2.55 criminal events each. This six-month period did not always include the charge upon which they entered CARDS, which may have occurred more than six months prior, particularly if adjourned through the courts. Males had slightly more events (mean 2.6) than females (mean 2.3), whilst Indigenous (mean 2.6) and non-Indigenous clients (mean 2.5) had a similar number of mean events. With respect to age, the mean events in the six months prior to CARDS involvement was similar for 18 to 24 year olds (mean 3.1, n=23), 30 to 34 year olds (3.1, n=28) and 35 to 39 year olds (mean 2.9, n=15). Mean events were considerably lower in this period for both 25 to 29 year olds (mean 1.8, n=20) and those aged 40 and over (mean 1.1, n=15).

The biggest difference between groups was that between clients who successfully completed CARDS (mean 2.3 events) and those who did not (mean 2.9 events), although this difference between groups was not statistically significant.

The 99 clients varied in the number of events in the six months prior to CARDS involvement from 23 who had no recorded event, to two clients who had 10 events. No recorded event

occurred where the event that led to the CARDS referral occurred more than six months prior to acceptance onto CARDS and where the client had not otherwise offended in the six-month period. The majority had one or no events (n=46, 46.5%), whilst a further 34 had two to four events (34.3%). Nineteen clients (19.2%) had five or more events. This is detailed in Table 18 below, which also distinguishes CARDS completers and non-completers.

Offences	Completed CARDS	Did not complete CARDS	Total
0 to 1 offence	30	16	46
2 to 4 offences	17	17	34
5 to 10 offences	10	9	19
Total	57	42	99

Nearly half of the events recorded for this client group in the six months preceding CARDS were acquisitory crimes, which made up 114 of the 252 events across the group (45.2%). Of these, most common were larceny and receiving (n=79), followed by serious criminal trespass (n=32). Also prevalent were offences against good order (n=71, 28.1%) and driving and motor vehicle offences (n=43, 17.0%). Only three defendants had a drug offence as an event in this period, two for the possession or use of amphetamines and one for production or manufacture of cannabis. Table 19 below provides an overview of these recorded events, with a distinction made between criminal events for males and females, along with CARDS completers and non-completers.

Major Offence	Completed (n=57)		Not Completed (n=42)		Total (n=99)
	Male (n=44)	Female (n=13)	Male (n=32)	Female (n=10)	
Offences against the person					
- major assault	2	-	1	-	3
- minor assault	4	-	3	-	7
- other assault	-	-	1	-	1
- sexual assault	-	-	-	-	-
Robbery	-	-	-	1	1
Acquisitory crimes					
- serious criminal trespass	13	1	16	2	32
- Fraud and misappropriation	2	-	-	1	3
- Larceny and receiving	27	14	26	12	79
Damage property	-	-	3	1	4
Offences against good order	34	9	20	8	71

Major Offence	Completed (n=57)		Not Completed (n=42)		Total (n=99)
	Male (n=44)	Female (n=13)	Male (n=32)	Female (n=10)	
Drug offences	1	1	-	1	3
Driving and motor vehicle offences	19	2	20	2	43
Other regulatory offences	-	-	5	-	5
Non-offence matters	1	-	-	-	1
Total	103	27	95	28	253

Client Offending During Involvement in the Scheme

Of the 99 clients analysed, 60 were not charged with a criminal event whilst on the Scheme. Of these, 41 completed the requirements of CARDS, whilst 19 did not. A further 23 only had one criminal event recorded in this period (11 were completers, 12 were non-completers). Of the 16 clients with two or more events recorded whilst they were listed on CARDS, 11 ultimately did not complete CARDS, whilst five did.

The number of weeks that each client was listed as being on the Scheme was recorded along with the number of events these clients were charged for during this period. Those who successfully completed the Scheme averaged just .05 events per week, or one event for every 20 weeks spent on the Scheme as a whole. This contrasted starkly to those who did not complete the Scheme who had .14 events per week, or one event for every seven weeks whilst on the Scheme. A Mann-Whitney U test revealed this difference to be significant ($Z = -3.01, p = .003$).

In total, the 99 clients were charged with 93 events whilst on the Scheme. Seventy-six of these 93 events were committed by 30 male clients, whilst the remaining 17 offences were committed by nine female clients. The most common offence types with 26 events each, were larceny and receiving and motor vehicle and driving offences, closely followed by 25 events involving an offence against good order. Only two criminal events during CARDS involvement committed by two discrete participants were drug offences, both selling or trading amphetamines.

Client Offending in the Six Months Post CARDS Involvement

The 99 clients had an average of 1.69 events each in the six months following their involvement in CARDS. This compares favourably with the average 2.55 offences that clients had in the six months prior to CARDS involvement (This is analysed in detail in the upcoming comparison of pre and post offending - see below). Males had slightly less (mean 1.6) events than females (mean 1.8), whilst Indigenous (mean 2.1) CARDS clients had more events than non-Indigenous clients (mean 1.6). Those aged 18 to 24 (mean 1.8, n=23) and 30 to 34 (mean 1.9, n=28) had the highest number of post-CARDS offences, whilst those aged 25 to 29 had the least (mean 1.3, n=20).

The biggest difference in post offending levels was between clients who successfully completed CARDS (mean 1.4) and those who did not (mean 2.0), although this difference was not statistically significant.

The 99 clients ranged in their number of criminal events in the six months following CARDS involvement from 46 who had no recorded event, 24 who had one or two events, 22 who had three to five events and seven who had six to 10 events. This is detailed in Table 20 below, which also distinguishes CARDS completers and non-completers.

Offences	Completed CARDS	Did not complete CARDS	Total
No events	33	13	46
1 or 2 offences	10	14	24
3 to 5 offences	10	12	22
6 to 10 offences	4	3	7
Total	57	42	99

The most common offence category for events committed by this client group in the six months following their CARDS involvement was acquisitory crimes (n=59, 35.3%), closely followed by offences against good order (n=54, 32.3%) and driving and motor vehicle offences (n=34, 20.4%). Within acquisitory crimes, 48 of these involved larceny and receiving, 10 involved serious criminal trespass, and one involved fraud and misappropriation. Only three defendants had a criminal event involving a drug offence as the major charge in this period. These events involved selling or trading amphetamines, producing or manufacturing amphetamines and possessing or using heroin.

Comparison of Offending Prior to and Post CARDS Involvement

The number of events charged against CARDS clients in the six months prior to their entering the Scheme was compared to the number of events they were charged with following their involvement in CARDS. Analysis was undertaken via a Wilcoxon Matched Pairs Signed Ranks test for the group as a whole, along with subsequent analysis of particular groups within the overall group based on gender, Indigenous status, age, CARDS site, completion of CARDS, whether the client had previously undertaken any drug treatment and whether the client had a drug offence in the five years prior to involvement in CARDS.

The result for the overall CARDS group, which is our best indicator as to the potential effect of CARDS on offending levels, is encouraging. In the six months prior to involvement in CARDS the clients had an average of 2.55 criminal events each. This had reduced to only 1.69 events each in the six months following their involvement in CARDS. The Wilcoxon Matched Pairs Signed-Ranks test indicated that this difference was significant ($Z = -3.10, p = .002$). This result and the results of analyses undertaken with the sub-groups mentioned within this group are provided in Table 21 below.

Table 21 Comparison of Client Mean Criminal Events Six Months Pre and Post CARDS Involvement

Paired Sample	Criminal Events 6 months pre CARDS	Criminal Events 6 months post CARDS	Wilcoxon Matched-Pairs Signed-Ranks test result	Significant p < .05
Whole Group	2.55	1.69	Z = -3.10, p = .002	Yes
Gender				
- male	2.61	1.63	Z = -2.87, p = .004	Yes
- female	2.35	1.83	Z = -1.14, p = .253	No
Indigenous status				
- non-Indigenous	2.54	1.62	Z = -3.04, p = .002	Yes
- Indigenous	2.62	2.08	Z = -0.76, p = .446	No
Age				
- 30 and under	2.50	1.42	Z = -2.90, p = .004	Yes
- 31 and over	2.59	1.92	Z = -1.62, p = .106	No
CARDS site				
- Adelaide	2.59	1.65	Z = -1.95, p = .051	No
- Port Adelaide	2.31	1.57	Z = -2.22, p = .026	Yes
Completion				
- completers	2.26	1.44	Z = -2.36, p = .018	Yes
- non-completers	2.93	2.00	Z = -2.01, p = .044	Yes
Previous treatment				
- previously treated	2.48	1.73	Z = -1.92, p = .055	No
- not previously treated	2.64	1.59	Z = -2.65, p = .008	Yes
Drug offence in 5 years prior				
- at least one	2.89	1.96	Z = -1.79, p = .073	No
- none	2.41	1.56	Z = -2.57, p = .010	Yes

As can be seen from Table 21, the overall group and all sub groups have experienced a reduction in the number of criminal events charged against them in the six months post CARDS involvement in comparison to the six months prior to CARDS involvement. Along with the significant result stated for the overall group, significant reductions in criminal events were found for males, non-Indigenous clients, those aged 30 or under, clients from Port Adelaide Magistrates Court (Adelaide Magistrates Court clients still improved), clients who completed and did not successfully complete CARDS, clients who had not received previous treatment for their drug and alcohol usage and clients who had not had a drug offence in the previous five years.

Whilst both female and Indigenous clients experienced a reduction in number of criminal events, this was smaller than other sub groups. Combined with their smaller group sizes, this reduced the possibility for identifying a statistically significant difference in their number of pre and post CARDS criminal events.

For analysis based on age, the median age of the group was considered (31years) and the sample was distinguished between those aged 30 and under, and those aged 31 and over. This revealed that for those aged 30 and under, the number of events pre versus post CARDS reduced by a significant amount, whereas for those aged 31 and over, it did not. This may indicate that involvement in the Scheme is more beneficial to younger rather than older offenders.

The court through which clients were referred to CARDS was considered with Port Adelaide Nunga Court clients being included with Port Adelaide Magistrates Court clients. This was compared to Adelaide Magistrates Court clients. Both groups experienced improvement, although only for Port Adelaide clients as a whole was this found to be statistically significant. As a group, Adelaide clients were on the cusp of being identified as significantly improved.

Most encouraging is the fact that both clients who completed and did not complete CARDS experienced reductions in their post CARDS criminal events. This suggests that the Scheme may provide benefit regardless of whether or not it is completed by the client. It is also possible that a reduction in offending may have occurred irrespective of CARDS involvement and is not related to this Scheme. Without a control or matched comparison group, it is not possible to make any firm conclusion in this regard. Nonetheless, the result, revealing a reduction in offending, is in the direction that would be desired by those responsible for the Scheme.

The Scheme appeared to have more benefit, in terms of reduced number of criminal events, for clients who had not previously received drug treatment than those who had, although clients who had previously experienced drug treatment were on the cusp of a significant reduction in events following CARDS involvement.

The number of events for which the client group as a whole appeared before the court both six months prior to and post CARDS involvement were compared on the basis of their JANCO offence category as used in this report. Detail is provided in Table 22. The table also distinguishes CARDS completers and non-completers.

Table 22 Comparison of Offence Categories for Client Criminal Events Six Months Pre and Post CARDS Involvement

Major Offence	Six Months Pre-CARDS			Six Months Post-CARDS		
	Comp.	Not Comp.	Total	Comp.	Not Comp.	Total
	(n=57)	(n=42)	(n=99)	(n=57)	(n=42)	(n=99)
Offences against the person						
- major assault	2	1	3	-	1	1
- minor assault	4	3	7	1	3	4
- other assault	0	1	1	2	1	3
- sexual assault	-	-	-	-	1	1
Robbery	-	1	1	1	1	2
Acquisitory crimes						
- serious crim. trespass	14	18	32	7	3	10
-Fraud and misapprop.	2	1	3	1	-	1
- Larceny and receiving	41	38	79	19	29	48
Damage property	0	4	4	2	2	4
Offences against good order	43	28	71	28	26	54
Drug offences	2	1	3	2	1	3
Driving & motor vehicle offences	21	22	43	17	17	34
Other regulatory offences	0	5	5	2	-	2
Non-offence matters	1	0	1	-	-	-
Total	130	123	253	82	85	167

The respective total columns (Table 22 above) for six-month pre and post CARDS involvement present a reduction in overall criminal events across the entire sample from 253 to 167. Most noteworthy is the reduction pre-versus-post CARDS in events of serious criminal trespass from 32 to 10, and in events involving larceny or receiving, reduced from 79 to 48 events. Offences against good order reduced in those clients that completed CARDS from 43 to 28 events, but reduced only marginally from 28 to 26 events in non-completers. Neither group experienced any notable change in driving and motor vehicle related offences.

A final point of comparison was made between the level of seriousness of client criminal events in the six months prior to and six months post CARDS involvement. This analysis included only those offenders who had a criminal event in either the six months before or after CARDS, of which there were 86. Table 23 shows which events committed by clients fell within the category of minor, moderately serious or serious offences. One event for one client in the six months prior to CARDS was deemed a non-offence, and has not been included in Table 23 below, resulting in 252 total events rather than the 253 events revealed in Table 22.

Table 23 Seriousness of Offence across Client Group six months Pre versus six months Post CARDS				
Pre vs Post CARDS	Six Months Pre-CARDS	Percentage	Six Months Post-CARDS	Percentage
Minor Offences	151	59.9%	121	72.4%
Moderately Serious Offences	53	21.0%	23	13.8%
Serious Offences	48	19.1%	23	13.8%
Total Offences	252	100%	167	100%

Along with the already demonstrated reduction in overall criminal events for the client group in the period following CARDS involvement, of note here is the differing proportion of the level of seriousness of these events when comparing pre and post CARDS involvement. Events across each seriousness level reduced by between 25 and 30 events pre-versus-post CARDS involvement. However, given the lower numbers of moderately serious and serious events compared to minor events, this represents a much greater proportional reduction in moderately serious and serious events pre versus post CARDS. The corresponding increase in the overall proportion of events that are classified as minor in seriousness (from 59.9% to 72.4%) highlights that the offending profile has tended towards less serious events post CARDS involvement. Along with the reduction in overall criminal events, this reduction in seriousness is encouraging.

A Wilcoxon Matched Pairs Signed Ranks test was undertaken to measure whether the reductions for each level of seriousness were significantly different between six-month pre and six-month post CARDS involvement. The reduction in both serious criminal events and moderately serious criminal events were found to be significant (serious events: $Z = -2.72, p = .007$; moderately serious events: $Z = -2.64, p = .008$). Given the lesser proportional reduction in minor criminal events, the reduction in these more minor events was not found to be significant.

Differences in Likelihood to Complete CARDS Requirements

Chi-Square analysis was undertaken comparing the likelihood of CARDS completion between clients based on their extent of prior offending, whether or not they had a prior drug offence in the five years prior to CARDS involvement and the seriousness of their major offence at entry to CARDS.

On the basis of prior offending levels, a significant difference was found in the likelihood of clients to complete CARDS according to the number of recorded criminal events they experienced in the five years prior to CARDS involvement ($\chi^2(2, N = 99) = 6.21, p < .05$). For this analysis, prior events were divided into the following categories: 1 to 10 events, 11 to 25 events and over 25 events. This significant result was most strongly contributed to by the greater likelihood of those with 10 or less events in the previous five years successfully completing (n=32, 71.1%), compared to those clients with either 11 to 25 events (n=15, 45.5%) or more than 25 events (n=10, 47.6%). Put simply, those with less offending in the last five years were more likely to successfully complete the requirements of CARDS. No significant difference was found in the likelihood to complete CARDS on the basis of offending levels across the six months prior to CARDS involvement.³¹

³¹ This analysis utilised the following offending ranges: 1 or zero events, two to four events and five or more events. The non-significant chi-square result was $\chi^2(2, N = 99) = 2.089, p = .352$.

Of the 99 clients analysed, 28 had a drug offence in the five years prior to CARDS involvement, whilst 71 did not. No significant difference was found in the likelihood of these two groups in completing the requirements of the Scheme.³²

No significant differences were found in the likelihood of clients completing CARDS based on the seriousness of their major offence at entry to the Scheme.³³ However, small numbers in the group entering the Scheme on more serious offences may have reduced the chances of a significant result. Only six of 16 clients (37.5%) entering the Scheme on a serious major charge completed CARDS. This was considerably less than (although not significantly) the successful completion rates amongst those clients with major charges categorised as moderately serious (63.0%) and minor (64.5%).

³² $\chi^2(1, N = 99) = 0.917, p = .232$.

³³ The non-significant chi-square result was $\chi^2(2, N = 74) = 3.576, p = .167$. This analysis utilised the sample of 74 clients which were analysed for charges at entry CARDS, rather than the more recent sample of 99 clients used in the pre versus post CARDS offending analysis.

PROGRESS TOWARD OBJECTIVES

The South Australian CARD Scheme was developed and implemented in order to fill a gap along the continuum of drug interventions available to individuals in contact with the criminal justice system. It was to do this by providing court based referral into drug assessment and treatment for individuals who have a treatable licit or illicit drug use problem, were facing charges in the Magistrates Court and who were suitable for release on bail or bond. The Scheme was to differ from the Drug Court - which deals with higher tariff offences in a specialist court setting, and the Police Drug Diversion Initiative which is confined to simple possession or use drug offences.

There was a high degree of planning and project management during the Scheme's development and implementation - and throughout the pilot period. The CARD Scheme was 'rolled out' as per schedule, or ahead of time, at each pilot site. These things were aided by:

- the employment of a dedicated CARDS Coordinator several months prior to implementation of the Scheme;
- broad representation on the Steering Group, combined with keen support and goodwill from many of its members;
- consultations with a broad range of stakeholders during the development and implementation phases;
- the development and distribution of thorough documentation (including flowcharts of CARDS processes, an operational manual etc);
- the provision of training and support to Magistrates Court and other staff;
- being able to recruit suitable staff as required;
- ongoing dialogue with respect to emerging issues; and
- an adequate lead time in which to undertake the preparatory work for the Scheme.

From a process perspective, cumulatively these things stood the Scheme in good stead to achieving its aims. Acknowledging this, and drawing on analyses contained in previous sections, the present section examines the extent to which each of the objectives of the CARD Scheme was achieved.

Ensure there is an option for court referral into drug assessment and treatment services available

At the end of the pilot period the CARD Scheme was available in each of the intended pilot sites (Port Adelaide, Adelaide and Murray Bridge Magistrates Courts). In addition, for reasons discussed earlier, the Scheme had also been 'rolled out' to the Mount Barker and Elizabeth Magistrates Courts and in late 2006 was also extended to the Christies Beach Magistrates Court. A CARDS assessor, able to undertake both Adult and Youth CARDS assessments, was based at four Magistrates Court sites³⁴ and services were provided to Holden Hill, Mount Barker and Murray Bridge as required. The aim of having an option for court referral into assessment was therefore achieved, in-so-far as the availability of personnel to conduct a CARDS Assessment.

The eligibility criteria for the Scheme specifically excluded defendants with a history of sexual or violent offences. Some stakeholders reported that Indigenous defendants were particularly likely to be excluded on this basis, due to relatively minor 'violent' offences. The Scheme was then modified to consider these defendants on a case-by-case basis. In doing so, it enabled a wider group of defendants to be referred for drug assessment.

³⁴ Namely Adelaide, Christies Beach, Elizabeth and Port Adelaide.

The option of referral is of limited value unless referrals actually take place. As discussed previously, there have been substantially fewer referrals to CARDS than were estimated during the planning of the Scheme. A fewer than anticipated number of referrals during the pilot period is a consistent evaluation finding across a number of South Australian criminal justice related initiatives.³⁵ This said, the number of referrals to CARDS did increase in the second year of the pilot and this trend appears to be continuing.

This report, along with previous briefing papers to the Steering Committee, have examined a range of reasons which may explain the lower than anticipated referrals. Principally among these is the willingness and ability of magistrates (and others involved in the court process) to identify and refer defendants who may be suitable for the Scheme. This appears to be related to the extent to which the individual magistrate is willing to accommodate (both in terms of time and process) the CARD Scheme in their court and whether or not, more broadly, they are 'comfortable' with a therapeutic jurisprudence approach. Putting aside the more recent additions of 'self-referral' and 'participation by invitation' (see below) - which in some respects moves CARDS outside of the court arena - magistrates are the 'gatekeepers' to defendant's accessing the Scheme. Findings from interviews with magistrates and others indicate that some have embraced the CARD Scheme and others have not. As a result, whether or not an option for referral to CARDS exists for any given defendant rests largely with the magistrate; that is, some defendants currently may have the option presented to them and others, perhaps with equivalent drug issues but appearing before another magistrate, will not. Finding ways to address this potential inequity and for magistrates to have a frank and constructive dialogue (and hopefully reach an agreed position) about the role of therapeutic jurisprudence in South Australian Magistrates Courts is highly integral to the future success of CARDS and any similar Scheme which may operate in a general Magistrates Court (as opposed to a Specialist Court).

Having initially been referred by a magistrate, the process from referral to assessment and a recommendation back to the court regarding the suitability of a defendant for the Scheme appears to be operating effectively. The original model suggested an adjournment of the court hearing for two weeks to enable the assessment to be conducted and a report returned to the court. The introduction of CARDS assessors being based at the courthouse, or being available to come to the courthouse at short notice, has significantly reduced this delay and in many instances the magistrate is able to hold the matter over in the list while an assessment is conducted and the assessor provides a verbal report to the court. This change reduces the number of court appearances and has been welcomed by magistrates. It also has the advantage of defendants not having to return for an assessment appointment and therefore improves the likelihood of the assessor 'catching them'. It does, however, have implications for (a) the assessors reported ability to conduct a thorough assessment and to build on a defendant's motivation to engage in treatment - given the lesser time available, and (b) the resources required to 'rollout' CARDS across the State and to service regional areas in particular.

The pathway from assessment to treatment appears to be operating effectively. The vast majority of treatment appointments are arranged via the CARDS Appointment Line. This process appears to operate efficiently and stakeholders report a high degree of satisfaction with the service.

In summary, the option for court referral into drug assessment and treatment was achieved at each of the pilot court sites and a number of others. This said, the numbers referred during the pilot was lower than anticipated, but appears to be increasing over time. The likelihood of individual defendants being referred to CARDS rests heavily on the ability of magistrates, prosecutors and lawyers to identify suitable defendants and the willingness of magistrates to then refer. On this basis there seems merit in continuing a dialogue with magistrates about CARDS in order to promote and reinforce the place of the Scheme within the criminal justice system.

³⁵ This includes the Magistrate's Diversion Court Program, the Drug Court and the Police Drug Diversion Initiative.

Encourage drug users to seek treatment by capitalising on the reality that the drug using defendant has entered the criminal justice system as a result of being charged for drug related crime

The opportunity to encourage drug users to seek treatment by capitalising on the reality that they have entered the criminal justice system as a result of being charged for a drug related crime exists at several points in the CARD Scheme; the court process, the assessment process and the treatment. Each is discussed briefly below.

The original CARDS model offered the option of undertaking the Scheme as a condition of bail or bond. The rationale for this was that it may increase a defendant's motivation to comply with the Scheme if they could be sanctioned by a magistrate for non-compliance. In practice, of those who undertook CARDS as a condition of bail or bond, the bail option was used in the majority of cases. This said, over the course of the pilot there was an increasing trend away from imposing CARDS as a condition of bail or bond and instead magistrates were likely to suggest or invite the defendant to undertake CARDS - and on some occasions to extend their bail or adjourn the matter while this occurred. This option did not preclude magistrates taking CARDS participation into account at the point of sentencing, but was seen to have the advantage of not further criminalising (via a breach of bail or bond) individuals who failed to attempt or complete the Scheme. Some stakeholders have suggested that this provides lesser encouragement for defendants to seek treatment. From a statistical point of view it is difficult to determine whether or not this is accurate based on the data available to date.

CARDS participants expressed mixed views regarding the extent to which their current court matters motivated them to seek treatment for their drug use. Approximately one in five explicitly suggested that the likely court outcome was an important motivating factor - this group were likely to be facing a custodial sentence. Clients reported that some magistrates (or their lawyer) had explicitly indicated that successful completion of CARDS would 'help their case', while for others this was implied. Of the participants interviewed, approximately half thought that their participation on CARDS had positively influenced the penalty they received. Encouragement offered by the magistrate, lawyer, or other criminal justice agency staff at the point of referral to CARDS was important for some participants. Others reported that the encouragement by the magistrate to keep going with treatment at the sentencing hearing was important for them.

The vast majority of CARDS participants reported favourably on their experience of the CARDS assessment and their interaction with the CARDS assessor. From the participants' perspective the assessment process provided an opportunity to ask questions about the Scheme and ensure that they understood what was involved. While some individuals reported that they were already motivated to address their drug use prior to the CARDS assessment, others suggested that it gave them a sense of direction about how they could address their drug use or increased their motivation to do so. For some, their sense of motivation to address their drug use very much emerged during the assessment process.

The appointment booking process was reported to operate effectively and keeping the amount of time before the first treatment appointment to a minimum was also reported to help capitalise on the client's motivation to access treatment.

Participants' reports of CARDS treatment were mixed. The majority felt comfortable with the treatment provider (clinician) and found them to be non-judgemental, however this did not necessarily correspond to whether or not they found the treatment useful. Some clearly felt they had benefited from the treatment. Others, however, were dissatisfied with the treatment and related this to the type of interaction with the clinician (that is, the questions asked, whether a 'script' was followed or the extent to which the clinician appeared to understand their issues); the number of sessions offered; the frequency of sessions (including the length of time between sessions and the availability of support during this time); a perception amongst some clients that only four treatment sessions were available to them (and their view that the Scheme should include more appointments); and whether or not they were offered 'ongoing' treatment. Each of these factors appeared to impact on the extent to which treatment capitalised on the opportunity to intervene in the participants' drug use.

It appears that some clinicians continue to be reluctant to provide treatment to individuals referred by CARDS. The main reasons offered for this are (a) the perception that such clients are 'mandated' (as opposed to voluntary) clients and treatment is likely to be ineffective under these circumstances, and (b) that some defendants are unmotivated to engage in the treatment and only agree to CARDS because they believe it will benefit them in court. There are also some reservations with respect to whether CARDS participants should be offered priority access to treatment, the timeframe provided for treatment, the number of treatment sessions, and whether or not these clients should be offered further priority access treatment at the conclusion of CARDS - or whether they should join a waiting list (if one exists) for 'voluntary' clients. It appears important that these issues are resolved if the opportunity to provide treatment is to be capitalised on.

There is some agreement amongst stakeholders (and participants) that support beyond the four counselling sessions is required during and after CARDS participation, if defendants are to succeed in ceasing their use of illicit drugs and 'getting their life on track'. It is unclear what the scope of this support should be and who should provide it, however this warrants further consideration.

In light of the relatively low number of Indigenous defendants accessing the Drug Court and other diversionary schemes, those responsible for the development of CARDS placed particular emphasis on trying to ensure that this group would access the CARD Scheme. The proportion of Indigenous defendants referred and accepted on to CARDS far exceeded that of both the Police Drug Diversion Initiative and the Drug Court, however, the proportion who complete CARDS is significantly lower than amongst non-Indigenous defendants.

In summary, the CARD Scheme appears to be achieving its objective of capitalising on the opportunity to encourage drug users to seek treatment as a result of having entered the criminal justice system. There is scope to enhance this opportunity by resolving issues with respect to treatment and the lower than desirable completion rates amongst Indigenous participants. There is also merit in (a) ensuring that CARDS assessors use the opportunity of assessment to further motivate defendants to comply with treatment, (b) exploring other ways individuals might be supported to successfully comply with treatment, and (c) continuing the dialogue with magistrates about whether CARDS should be a condition of bail or bond or whether there are alternative ways that the court can encourage defendants to seek drug treatment.

Reduce the risk of further offending to support drug use and associated criminal activity and harm to themselves or others.

The relatively short period of time in which to track offending amongst CARDS completers (i.e. minimum of six months), combined with the low response rate to the post-treatment questionnaire, make it difficult at this point in time to definitively say that CARDS has reduced the risk of further offending to support drug use. This said, the available data show encouraging signs in regard to a reduction in contact with the criminal justice system amongst CARDS participants during and after their participation on the Scheme, along with some evidence of improved health and social functioning.³⁶ Notably, there appears to be a reduction in offending amongst both individuals who completed CARDS as well as those who did not. This suggests that the CARD Scheme may have benefits for individuals even if they do not complete all of the required treatment sessions.

The limited post-questionnaire suggested some improvement to physical and mental health, but on average CARDS participants still scored below that of the general South Australian population. The low physical and mental health scores (as measured by the SF-12) of CARDS participants in comparison to the South Australian population is of concern. This information supports views commonly held by service providers of the complex needs of drug

³⁶ Given that acceptance on to CARDS was not by random allocation and there was no control group it is not possible to determine whether or not there is a causal relationship between changes and CARDS participation. Therefore while we cannot categorically say that CARDS was responsible for participants reduction in offending and improvements to health and social functioning, we can say that it is likely to have contributed to the positive outcome.

dependant individuals and may indicate the range of services which could usefully be offered as part of CARDS treatment / support.

Conclusion

Overall, the evidence available indicates that the objectives of CARDS are being achieved. There have been some variations in the Scheme from the original model and some of these potentially have implications for the level of resources which may be required for a state-wide rollout of CARDS. The level of support for the Adult CARD Scheme amongst stakeholders and the outcomes for participants (to the extent that they are available) suggest that there is merit in continuing the Scheme and considering how it may be offered more broadly across the State, taking account of the recommendations contained within the report and comments made below regarding its future. The main issues to be addressed are the level of take up of CARDS, its appropriateness for Indigenous defendants (given the low completion rates amongst this group) and a subset of issues regarding the treatment regime. Each of these will need to be addressed in the context of the Scheme's continuation and any expansion.

Future of the Scheme

Throughout the pilot the CARDS team, CAA management and the Steering Committee have been responsive to issues as they have been identified, and worked pro-actively to resolve these. A number of adjustments have been made to the model as a result. Perhaps the most significant of these is the shift away from CARDS assessors being based at the Specialist Courts Unit within the CBD and travelling (usually to the courthouse) to undertake assessments as required. This enabled a small team of staff to cover many Magistrates Court sites. The shift to locating an assessor full-time at each courthouse, while seemingly increasing the number of referrals, has implications for the level of resources required, or the need for other models to be developed if the Scheme is to be rolled out across the state.

Any continuation or expansion of the Scheme ought to include the development of performance targets. Based on the evaluation findings it is suggested that such targets should include reference to;

- The expected role of CARDS assessors and a workload formula which ensures the Scheme is cost-effective
- The number of defendants referred, accepted and completing CARDS. These measures should include specific reference to Indigenous participants and may include reference to particular Magistrates Court sites.
- The level and type of treatment provided to CARDS participants (including specific reference to Indigenous participants) and the proportion of participants who continue to engage in treatment after their CARDS obligation is completed
- Participants' level of satisfaction with the Scheme
- The health and social outcomes for participants, along with their level of contact with the criminal justice system during and after CARDS

RECOMMENDATIONS

Recommendation 1

It is recommended that consideration be given to ways of increasing the retention and successful completion of CARDS by Indigenous defendants.

Recommendation 2

It is recommended that CARDS management consider ways to ensure the provision of training and written information is received by all relevant agency staff and that this take account of the needs of existing and newly appointed staff.

Recommendation 3

It is recommended that CARDS and DASSA management consider creating additional opportunities for staff from both agencies to discuss their respective concerns in relation to the implementation, rollout and procedures associated with CARDS. Included in this should be consideration of the respective roles and workload allocation for both CARDS assessors and DASSA clinicians.

Recommendation 4

It is recommended that the CARDS Steering Group and management continue to monitor the number of referrals to CARDS and to develop further strategies to identify suitable defendants and ensure their referral to CARDS. Consideration of such strategies may well require the involvement of magistrates and lawyers in their development and implementation.

Recommendation 5

It is recommended that discussions be held between the CARDS Steering Group, CARDS management and DCS management with respect to the ongoing role and resourcing of the Department for Correctional Services in relation to CARDS.

Recommendation 6

It is recommended that CARDS management give consideration to arrangements for ongoing database technical support and for the monitoring of CARDS data quality.

Recommendation 7

It is recommended that all appointments for CARDS continue to be booked through the CARDS Appointment Line.

Recommendation 8

Should CARDS expand its use of treatment providers beyond DASSA, it is recommended that steps be taken to ensure the standardisation of data collection across agencies and that consideration be given to ensuring these data are sufficient for ongoing monitoring and evaluation purposes.

Recommendation 9

It is recommended that consideration be given to ways to address the reluctance of some clinicians to working with CARDS clients and the appropriate distribution of this type of work.

Recommendation 10

It is recommended that an agreed position be reached to whether CARDS clients who elect to continue treatment beyond the four required sessions continue to use CARDS priority appointments or be treated as voluntary clients for DASSA purposes, and that all CARDS clients (with ongoing drug related issues) be proactively encouraged to continue treatment.

Recommendation 11

It is recommended that CARDS staff and management give consideration to ways of further increasing support for the Scheme amongst magistrates.

Recommendation 12

It is recommended that consideration be given to whether the option of 'inviting' a defendant to participate on CARDS should formally be included in the model, the implications of this change considered and monitored, and any changes in outcomes of the Scheme reported on.

Recommendation 13

It is recommended that consideration be given to the existing treatment regime offered to CARDS participants, taking account of the feedback provided by former participants.

Appendix A

Terms of Reference for CARDS Steering Committee

1. Identify issues and problems in the planning and implementation of CARDS, including
 - a. Recommend and endorse strategies for these to be addressed
 - b. Monitor the effectiveness of these strategies
2. Make recommendations about, and endorse CARDS Operational Policy and Procedures.
3. Contribute to effective communication at senior levels of Government and Non-Government agencies regarding the operation of CARDS.
4. Monitor and review the progress of the pilot program.
5. Contribute to the implementation plan for the state-wide roll-out of CARDS.
6. Ensure an appropriate evaluation process is established for CARDS.