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# **AN EVALUATION OF THE COMPULSORY DRUG TREATMENT PROGRAM (CDTP)**

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# EXECUTIVE SUMMARY

## BACKGROUND

In 2003, the NSW Bureau of Crime Statistics and Research (BOCSAR) was directed by the NSW Government to undertake a randomised controlled trial of the Compulsory Drug Treatment Program (CDTP). This proved impossible because the number of offenders eligible for the program was never large enough to conduct a meaningful randomised controlled trial. The number of offenders dealt with on the program was also too small to evaluate its effect on rates of re-offending. The evaluation was therefore limited to assessing the impact of the CDTP on the health and wellbeing of participants, measuring changes in perceived coercion, affective reactions, treatment readiness and therapeutic alliance, gauging participant satisfaction with various aspects of the program, and monitoring participants' drug use whilst on the program. While these measures do not encompass all aspects of program effectiveness, they do have an important bearing upon the legislative objectives governing the program, which are:

1. to provide a comprehensive program of compulsory treatment and rehabilitation under judicial supervision for drug dependent persons who repeatedly resort to criminal activity to support their dependency;
2. to effectively treat those persons for drug dependency, eliminating their illicit drug use while in the program and reducing the likelihood of relapse on release;
3. to promote the re-integration of those persons in the community; and
4. to prevent and reduce crime by reducing those persons' need to resort to criminal activity in support of their dependency

*(Crimes (Administration and Sentencing) Act 1999, Section 106B).*

## PROGRAM DESCRIPTION

The Compulsory Drug Treatment Correctional Centre (CDTCC) is a purpose-built facility erected for the CDTP. The CDTP began in August 2006 and operates as a five-stage post-sentencing program for males. Drug treatment and rehabilitation is provided in Stages 1-3 primarily from the CDTCC, followed by Stage 4 (parole) and Stage 5 (voluntary case management) in the community where appropriate. It was beyond the scope of the study to investigate the impact of Stages 4 and 5.

Stage 1 involves closed detention, and participants are kept in full-time custody at the CDTCC. This stage aims to stabilise participants and to address physical and mental health needs, while providing adult education, work readiness and skills programs, and therapeutic programs that target dynamic risk factors for drug-related offending.

Stage 2 involves semi-open detention, whereby participants are permitted to leave the CDTCC to attend employment, training and approved social activities. Stage 2 involves therapeutic programs to maintain positive behaviour change and other training to assist in effective re-integration into the community.

Stage 3 involves community custody, where participants reside outside of the CDTCC but under intensive supervision from CDTCC staff. Stage 3 aims to support community re-integration and to strengthen changes made in Stages 1 and 2. Participants should stay in each stage of the program for a period of at least six months. Following successful completion of Stage 3 of the program, offenders are released into the community once the period of the sentence has been completed.

## THE EVALUATION

The research involved a series of face-to-face interviews with CDTP participants. Baseline interviews were conducted with 95 participants at the commencement of their time on the program. Three follow-up interviews were conducted as close to the time that participants finished Stages 1, 2 and 3, as was practicable. By the time data collection ceased, 78 per cent of the baseline sample (74 participants) had completed Stage 1 and participated in one follow-up interview (end of Stage 1), and 41 per cent of the baseline sample (39 participants; for some measures information is missing for one participant so N = 38) had completed both Stages 1 and 2 and participated in two follow-up interviews (end of Stages 1 and 2). Of the baseline sample, 13.5 per cent (13 participants) had completed all three follow-up interviews (end of Stages 1, 2, and 3). Due to the small number of participants who had completed Stages 1, 2 and 3 and participated in all three follow-up interviews, changes from baseline through to the end of Stage 3 were not investigated.

The evaluation also included analysis of the regular urine samples provided by CDTP participants as a condition of the program. Corrective Services NSW provided these urinalysis results to BOCSAR so that drug use at each stage of the program could be assessed.

The drug test outcome of each unique test could take one of four values:

1. **Positive** urine test results in which non-prescribed drugs were detected, very dilute test results were detected indicating an attempt to mask drug use, or participants refused or failed to supply a sample;
2. **Dilute** urine test results were found which may indicate an attempt to mask drug use or may be due to other reasons (such as consuming lots of water because of hot weather);
3. **Inconclusive** urine tests in which tests were cancelled due to administrative or human errors and cases where a participant was not tested; and
4. **Non-prescribed drug free** urine test results where no drugs were detected or where only prescribed medications were detected.

## MAJOR FINDINGS

### HEALTH AND WELLBEING

Significant improvements were found for outcome measures of mental and physical health. For those 38 participants who completed an end of Stage 2 interview and completed the SF-12, mental health was significantly higher at the end of Stage 2 than at baseline. Physical health amongst this sample of participants improved from baseline to the end of Stage 2. There was also evidence that improvements in physical health occurred during the first month of being on the program.

### PERCEIVED COERCION, TREATMENT READINESS AND THERAPEUTIC ALLIANCE

Contrary to the compulsory nature of the CDTP, the vast majority of participants perceived that their admission to the CDTP was voluntary. Further evidence suggested that participants' negative affective reactions to being sentenced to the treatment program decreased significantly from sentencing to the baseline interview and did not significantly change thereafter. Treatment readiness appeared to peak at the end of Stage 1, although it was similar at baseline and the end of Stage 2. Additionally, working alliances with therapists did not appear to change significantly.

## **PROGRAM PERCEPTIONS**

Across the program, the vast majority of participants were 'sure' they wanted to attend the program, 'sure' that the CDTP would be helpful to them and satisfied with most aspects of the CDTP. The programmatic aspects that the majority of participants did not like were non-contact 'box' visits (visits where the offender and the visitor cannot make contact with one another) or the possibility of being regressed from a later stage to an earlier stage (e.g. for non-admitted drug use).

Interestingly, there was a downward trend in the proportion of participants who felt 'sure' that they needed help to keep from relapsing to drug use over the program, although this only reached significance between baseline and the end of Stage 2 (n = 39). A downward trend in the proportion of participants who felt 'sure' that they needed help to keep from taking part in further criminal acts or behaviour was also apparent; this trend was only significant from baseline to the end of Stage 2 (n = 39).

When asked for open-ended comments about the program, participants were largely positive about the program, although some participants made negative comments and suggestions for change regarding box visits, sanctions and employment.

## **DRUG USE**

Overall, the vast majority (95.7%) of drug tests conducted during the study were classified as 'non-prescribed drug free', with only small proportions classified as 'positive' (1.8%, n = 257 tests). Of the 257 positive tests, 82.5 per cent (n = 212) were due to the detection of non-prescribed drugs. However, the majority of the 108 participants with non-baseline drug tests (61.1%, n = 66) returned at least one positive test result. Of the 66 participants with at least one positive test, 39.4 per cent (n = 26) were due to very dilute urines or involved refusal or failure to supply samples. About a third (34.8%, n = 23) involved non-prescribed morphine and another third (33.3%, n = 22) involved cannabis.

A greater proportion of drug tests conducted in Stage 3 returned 'positive' results than in Stage 1 or Stage 2. In Stage 1, cannabis and buprenorphine were the most commonly detected non-prescribed drugs (36.3% and 16.5% respectively). In Stage 2, morphine (27.8%) was the most commonly detected drug, followed by failure or refusal to supply a sample or returning a very dilute sample (23.0%). In Stage 3, morphine (35.0%) and buprenorphine (30.0%) were the most commonly detected drugs.

## **CONCLUSION**

Due to the lack of a comparison group it is difficult to draw any firm conclusions about the effectiveness of the program. Nevertheless, there are some promising aspects to the program. Participants' health and wellbeing appeared to improve over time on the program. Although the program was coercive, the vast majority of participants felt that their participation in the CDTP was voluntary. Participants made positive comments about the program and consistently expressed their desire to be in the program regardless of what stage they were in. This is encouraging evidence that offenders in the program genuinely wanted to change their behaviour. These positive findings, however, have to be set against the fact that illegal and non-prescribed drug use was detected in at least one of the drug tests for the majority of participants, despite 'positive' tests accounting for only a very small proportion of all tests conducted.



# 1 INTRODUCTION

In 2003 the New South Wales Government proposed to establish a Compulsory Drug Treatment Correctional Centre (CDTCC) for males by the end of 2005 as a 'new way to break the drug-crime cycle.' The New South Wales Bureau of Crime Statistics and Research (BOSCAR) was directed to undertake an evaluation of the Compulsory Drug Treatment Program (CDTP) that was to be run at the CDTCC once it was established.

## 1.1 BACKGROUND

The CDTP is an initiative of the New South Wales (NSW) Government designed to divert recidivist, drug-dependent offenders away from the traditional criminal justice system. The CDTP is the first legally coerced prison-based program of its kind in Australia. It is targeted at people with long-term drug dependence who have committed multiple criminal offences to support their dependence over a long period. The program aims to prevent and reduce crime by 'breaking the drug-crime cycle' and re-routing offenders into compulsory treatment and rehabilitation. Treatment is primarily abstinence-based and involves judicial supervision, stabilisation, case management, group work and learning, linked to a growth in personal responsibility and social functioning (Birgden, 2008). The CDTP is run at the CDTCC, a purpose-built facility erected at the Parklea correctional complex. The CDTCC received its first participants at the end of August 2006.

The CDTP, which is governed by the *Compulsory Drug Treatment Correctional Centre Act 2004*,<sup>1</sup> has four program objectives:

1. to provide a comprehensive program of compulsory treatment and rehabilitation under judicial supervision for drug dependent persons who repeatedly resort to criminal activity to support their dependency;
2. to effectively treat those persons for drug dependency, eliminating their illicit drug use while in the program and reducing the likelihood of relapse on release;
3. to promote the re-integration of those persons in the community; and
4. to prevent and reduce crime by reducing those persons' need to resort to criminal activity in support of their dependency

(*Crimes (Administration and Sentencing) Act 1999*, Section 106B).

The CDTP operates as a five-stage post-sentencing program. Drug treatment and rehabilitation is provided in Stages 1-3 primarily from the CDTCC, followed by Stage 4 (parole) and Stage 5 (voluntary case management) in the community where appropriate. Stages 1-3 at the CDTCC last between 18 to 36 months. NSW Drug Court Judges are the only judicial officers who can make a Compulsory Drug Treatment Order (CDTO). Convicted offenders who might be eligible for the CDTP are referred to the Drug Court for an eligibility assessment.

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<sup>1</sup> The implementation of the *Compulsory Drug Treatment Correctional Centre Act 2004* resulted in amendments to the *Drug Court Act 1998*, the *Crimes (Sentencing Procedure) Act 1998*, and the *Crimes (Administration of Sentences) Act 1999* which together provided conditions for the compulsory treatment of drug-dependent offenders.

The eligibility criteria is:

1. A person is an eligible convicted offender if:
  - (a) the person is convicted of an offence, other than an offence referred to in subsection (2), and
  - (b) the person has been sentenced to a term of imprisonment for the offence to be served by way of full-time detention and the unexpired non-parole period in relation to that sentence is a period of at least 18 months but not more than 3 years, and
  - (c) the person, has in the 5-year period immediately before the person's sentencing, been convicted of at least 3 other offences that resulted in any of the following:
    - (i) a sentence of imprisonment (including a sentence of imprisonment suspended under section 12 of the *Crimes (Sentencing Procedure) Act 1999*),
    - (ii) the making of a community service order,
    - (iii) the entry into a good behaviour bond, and
  - (d) the person appears to have a long term dependency on the use of prohibited drugs (within the meaning of the *Drug Misuse and Trafficking Act 1985*) or other drugs prescribed by the regulations, and
  - (e) the facts in connections with the offence for which the person has been sentenced, together with the person's antecedents and any other information available, indicate that the offence was related to the person's long-term drug dependency and associated lifestyle, and
  - (f) the person satisfies such other criteria as are prescribed by the regulations.
2. A person is not an eligible convicted offender if the person has been convicted of the following:
  - (a) murder, attempted murder or manslaughter,
  - (b) sexual assault of adults or children or sexual offences involving children,
  - (c) any offence involving the use of a firearm,
  - (d) any offence that, in the opinion of the Drug Court, involves serious violence (such as malicious wounding or assault with intent to do grievous bodily harm, but not including common assault or assault occasioning actual bodily harm),
  - (e) an offence under section 23 (2), 24 (2), 25 (2), 26, 27 or 28 of the *Drug Misuse and Trafficking Act 1985* involving a commercial quantity or large commercial quantity of a prohibited plant or prohibited drug within the meaning of that Act,
  - (f) any offence prescribed by the regulations for the purposes of this section.
3. A person is not an eligible convicted offender if the person suffers from a mental condition (such as serious or violent mental illness or disorder) that could prevent or restrict the person's active participation in a drug treatment program

(*Drug Court Act 1998 No 150*, Section 5A).

If the offender is found to be an “eligible convicted offender” (*Drug Court Act 1998*, Section 5A), the CDTCC multi-disciplinary team conducts a suitability assessment. This assessment provides information to the Drug Court regarding the offender’s drug treatment history; the defendant’s history of violent offences in the community and violent acts in prison; the defendant’s likelihood of committing a domestic violence offence in the final stage of the program; the defendant’s level of motivation and attitude toward compulsory drug treatment; and whether the defendant may harm the program or any other person’s participation in the program.

Offenders who meet both the eligibility and the suitability criteria and who are accepted onto the program serve their sentence by way of a CDTO. The orders are compulsory because neither the Crown nor the offender can object to, or appeal, the imposition of a CDTO.

Participants who are accepted into the CDTP move through three stages of treatment (Birgden, 2008). Stage 1 involves closed detention, and participants are kept in full-time custody at the CDTCC. This stage aims to stabilise participants and to address physical and mental health needs, while providing adult education, work readiness and skills programs, and therapeutic programs that target dynamic risk factors for drug-related offending.

Stage 2 involves semi-open detention, whereby participants are permitted to leave the CDTCC to attend employment, training and approved social activities. Stage 2 involves therapeutic programs to maintain positive behaviour change and other training to assist in effective re-integration into the community.

Stage 3 involves community custody, where participants reside outside of the CDTCC but under intensive supervision from CDTCC staff. Stage 3 aims to support community re-integration and to strengthen changes made in Stages 1 and 2. Participants should stay in each stage of the program for a period of at least six months.

Following successful completion of Stage 3 of the program, offenders are released into the community if the period of the sentence has been completed. The Probation and Parole Board may also determine to release the offenders into the community earlier if the non-parole period has been completed. A post-release case manager is appointed to provide assistance to the released offender, providing a single point of contact, and act as a mentor for the next 12 months. The participant is also provided with referrals to community-based treatment and other services. However note that the current study was not commissioned to evaluate the program beyond participants’ release to parole.

Once a CDTO has been made and the participant has been admitted into the CDTCC, members of a multidisciplinary team, in collaboration with the participant, develop a Compulsory Drug Treatment Personal Plan. This Personal Plan imposes conditions on participants for treatment and rehabilitation, specifies the rewards for meeting these conditions, and identifies areas of dynamic risk and wellbeing needs (Birgden, 2008). Participants must meet the conditions of the Personal Plan in order to progress from one stage to the next. Non-compliance with the conditions of the Personal Plan can result in sanctions, such as more intensive supervision, increased case management, ‘regression’ to a prior stage, or revocation of a CDTO and removal from the program (Birgden, 2008). The Drug Court Judge is responsible for revoking a CDTO. However, the Commissioner can ‘immediately remove’ the participant from the CDTCC pending revocation (that removal has to be considered by the Judge within 21 days).

The *Compulsory Drug Treatment Correctional Centre Act 2004* requires that a review of the CDTCC be conducted during the first four years of the program’s operation (*Crimes (Administration and Sentencing) Act 1999*, Section 106Z). The present report aims to inform this review process by describing an evaluation of the impact of the CDTP on participants’ changes in health and wellbeing, perceived coercion, affective reactions, treatment readiness and therapeutic alliance; drug use whilst on the program; as well as describing participants’ attitudes towards the program. These results will be discussed in terms of their bearing upon the four aforementioned legislative program objectives.

Before discussing the aims and methods in more detail, prior research bearing on the effectiveness of programs such as the CDTP will be outlined. However note that while our literature search attempted to identify studies that evaluated the effect of treatment on health and wellbeing, very few good quality studies were identified. As such, a number of studies focussing on the impact of drug treatment programs on recidivism are included in the review, as well as those investigating the impact on rates of relapse to drug use and to a lesser extent, health and wellbeing.

## **1.2 PREVIOUS RESEARCH**

The CDTCC, as previously mentioned, is the location of the first legally coerced prison-based program of its kind in Australia. There is very little prior research to draw upon that could inform the likely effect of this program, as we were only able to find two similar international programs in operation. However the relevant research will be examined. Furthermore, the CDTCC does have similarities to other voluntary and coerced drug treatment programs and these are also reviewed below. Relevant evidence for the effectiveness of three categories of treatment program is described: (1) voluntary, prison-based drug treatment, (2) community-based, legally coerced drug treatment, and (3) prison-based, legally coerced drug treatment. A review is not undertaken of research on community-based, voluntary drug treatment programs because of their limited relevance to the population under study here.

### **VOLUNTARY, PRISON-BASED DRUG TREATMENT**

While a broad range of drug treatment programs operates in custodial settings, one of the most common settings is the Therapeutic Community (TC). TCs have been evaluated previously in a number of contexts. In general, TCs are drug-free residential settings with treatment stages focusing on re-socialisation, intensive therapy, behaviour modification and gradually increasing responsibilities (Belenko & Peugh, 1998; National Institute on Drug Abuse, 2002). The CDTP shares many of the characteristics of traditional TCs, in that it focuses on behaviour modification in a residential setting and takes a staged approach to behaviour change.

Specific evaluations of prison-based TCs demonstrate encouraging results (e.g. Welsh, 2007). One example is the Key-Crest program that operates in the state of Delaware, U.S. The Key-Crest program has three phases: in-prison treatment (Key), transitional treatment through a residential work release centre, and aftercare for parolees (Crest). Inciardi, Martin, Butzin, Hooper, and Harrison (1997) conducted a randomised trial of the Key-Crest program and found strong treatment effects, particularly among those who had received both primary and secondary treatment (Key-Crest). Both the Crest and Key-Crest groups did significantly better on measures of re-arrest and drug use relative to the no-intervention comparison group. For instance, after 18 months, only 23 per cent of the Key-Crest graduates were likely to have been re-arrested, compared with 54 per cent of the comparison group. Furthermore, only 28 per cent of Key-Crest graduates were using drugs compared with 65 per cent of the comparison group in the 30 days prior to the 18-month follow-up interview. The latter outcome measure was a composite based on self-report in the 30 days prior to the 18-month follow-up interview and urinalysis. However, the Key group (in-prison treatment without aftercare) was not statistically distinguishable from the comparison group on any of the outcome measures. This demonstrates the importance of combining primary treatment with structured aftercare.

Another in-prison TC evaluation conducted on the three-phased Amity Right Turn program in the state of California, also found evidence of strong treatment effects (Wexler, Melnick, Lowe, & Peters, 1999). Inmates who completed the prison and aftercare programs were less likely to be returned to prison than the control group, which was comprised of inmates who volunteered for treatment but who had too little

time remaining on their sentence to complete treatment. More specifically, among inmates in Amity who completed both treatment and aftercare, only eight per cent were re-incarcerated within a year. This compared with 39 per cent of those who completed treatment but not aftercare, 45 per cent of those who failed to complete treatment, and 50 per cent in a control group who received no treatment at all.

In their meta-analysis, Pearson and Lipton (1999) concluded that voluntary, corrections-based TCs were effective in reducing recidivism. Other US evaluations of voluntary prison-based drug treatment programs, such as Stayin' Out, Cornerstone and the Kyle program, found similar positive results (Belenko & Peugh, 1998). While a number of studies such as these have been criticised on the grounds that they are subject to selection biases (i.e. their voluntary nature sifts out those least likely to succeed), studies that have employed rigorous statistical methods to account for that selection bias also tend to find positive treatment effects (Pelissier et al., 2000). It appears that there is good evidence to support the effectiveness of voluntary prison-based drug treatment in reducing recidivism rates, particularly when combined with aftercare programs.

## **COMMUNITY-BASED, LEGALLY COERCED DRUG TREATMENT**

Legally coerced treatment refers to programs that operate within the criminal justice system as an alternative to the regular justice procedures. Offenders are typically offered a constrained choice between participating in the treatment option in exchange for a reduction in the severity of their sentence and accepting the traditional criminal justice path. Legally coerced treatment generally tends to be community-based because it aims to divert offenders away from the criminal justice system and into treatment. In Australia, diversion includes a range of program options that can occur at the pre-plea stage, the pre-conviction stage or as a post-conviction response to drug related offending (Bull, 2003).

There has been significant debate about the merits of legally coerced drug treatment. It has often been argued – usually by drug treatment providers – that for drug treatment to be successful, clients must enter voluntarily (VanderWaal, Taxman, & Gurka-Ndanyi, 2008). On the other hand, others have argued that offenders will not always choose to participate in treatment programs if they are voluntary. They argue that this creates a revolving courthouse door for some drug-dependent offenders; that is, when offenders are released with their substance dependence untreated, they continue to commit crimes to support their drug use (Warner & Kramer, 2009).

To date, most evaluations of drug treatment programs on legally coerced offenders have examined re-offending and relapse to drug use, although a small number have also investigated effects on offenders' health and wellbeing. Results on the effect of diversion programs on offenders' re-offending and relapse rates have been mixed and the research area has considerable methodological limitations. However, in an international review of the role of legal coercion in the treatment of offenders with heroin problems, Hall (1997) found some evidence to suggest that all major forms of community-based treatment for heroin dependence were effective in reducing heroin use and crime, irrespective of whether they are provided under "legal pressure."

Drug courts fall under the umbrella of community-based legally coerced treatment. For example in the United States, drug courts consist of court-supervised treatment programs that provide intensive judicial supervision and monitoring of offenders, using positive as well as negative reinforcement to encourage offender compliance, and hold offenders closely accountable for their own actions (Warren, 2008). A wide consensus has emerged regarding the effectiveness of drug courts. In a systematic review of drug court effects, Wilson, Mitchell, and Mackenzie (2006) found that drug courts significantly reduce recidivism among drug court participants in comparison to similar but non-participating offenders, with effect sizes ranging from 10 per cent to 70 per cent. In the majority of evaluation studies that have included a suitable

comparison condition, drug court clients achieved a significantly greater reduction in drug use, criminal recidivism and unemployment compared to individuals on standard probation or intensive supervision programs (Belenko, 2002). Indeed Marlowe, DeMatteo, and Festinger (2003) suggested that drug courts appeared to outperform all other strategies that have been attempted for drug-involved offenders.

In NSW, two examples of contemporary community-based and legally coerced treatment programs are the Magistrates' Early Referral into Treatment (MERIT) program and the NSW Drug Court program. MERIT operates in the lower (local) courts at the pre-plea stage for suspected offenders who have demonstrable illicit drug problems. Defendants who elect to take part in MERIT have their matters adjourned for three months while they engage in drug treatment services. In turn, Magistrates can take program performance into account in sentencing. There is some evidence to suggest that measures of health and wellbeing improve while on the MERIT program (NSW Health, 2007) and strong evidence to suggest that MERIT reduces rates of recidivism, particularly among those who complete the program (Lulham, 2009).

The NSW Drug Court, which is separate from the CDTP, operates at the post-conviction stage, whereby eligible and suitable offenders who have been given a prison sentence can have the sentence suspended if they comply with the requirements of an intensive drug treatment order. The program involves intensive judicial oversight, drug treatment and regular urine screening to ensure compliance with the treatment order. An early evaluation of the program found improvements in health and social functioning as participants moved through the program (Freeman, 2002). A randomised trial of the impact of the NSW Drug Court Program on rates of re-offending also found reduced levels of offending among program participants (Lind et al., 2002). Furthermore, a more recent re-evaluation of the NSW Drug Court Program, in light of changes to the Drug Court Program, also found that Drug Court participants were less likely to be reconvicted (Weatherburn, Jones, Snowball, & Hua, 2008).

## **PRISON-BASED, LEGALLY COERCED DRUG TREATMENT**

As mentioned earlier, two known prison-based, legally coerced drug treatment programs operate internationally and none other than the NSW program operates in Australia. Comparable international programs to the CDTP are the court-ordered treatment of drug-dependent offenders (Strafrechtelijke Opvang Verslaafden or SOV) in the Netherlands and the detention and compulsory treatment of drug-dependent offenders in Hong Kong.

The CDTP was modelled on the Dutch program. Court-ordered treatment of drug-dependent offenders was introduced into the Dutch criminal justice system in 2001. It is aimed at deterring criminal behaviour, reducing crime rates and improving the manageability of addiction problems (Koeter & Bakker, 2007). The SOV treatment program involves three stages: (i) placement in a secure residential environment for six months to cease drug use and improve physical health, (ii) placement in a semi-open facility for six to nine months to allow leave for employment, training and education, and (iii) placement in a follow-up facility outside of the secure and semi-secure institution for the remainder of the order to facilitate and concentrate on reintegration into the community (Koeter & Bakker, 2007).

In a study on the effectiveness of the SOV, the Amsterdam Institute of Addiction Research (AIAR) compared SOV participants to those in two quasi-compulsory community-based treatment programs and to offenders in regular detention. SOV participants performed significantly better than offenders in the regular detention group in terms of subsequent offending, addiction and social functioning. SOV participants showed comparable results to offenders in both quasi-compulsory treatment control groups (Koeter & Bakker, 2007). The authors concluded that there was some evidence that the SOV program was effective.

Recent legislative changes integrated the SOV program into another Dutch program, the ISD program (Inrichting Voor Stelselmatige Daders). The ISD program was originally introduced in October 2004. The ISD program targets a wider variety of systematic offenders by including people who are not drug-dependent, females and offenders with psychiatric problems. The legislative changes allow a wider spectrum of systematic offenders to be detained for a longer period in order to prevent and reduce crime and promote reintegration into the community.

Compulsory drug addiction treatment in Hong Kong, governed by the Drug Addiction Treatment Centres Ordinance, was introduced in 2009. A person sentenced to detention under the ordinance can be detained for a period between 2 to 12 months. The program encompasses three phases: the restoration of physical health, eliminating drug dependence and assistance in readjusting to the community after release. To date, no research into the effectiveness of this program has been conducted.

### **1.3 THE CURRENT STUDY**

The New South Wales Bureau of Crime Statistics and Research (BOCSAR) was directed by the NSW government to undertake an evaluation. It was requested that the evaluation take the form of a randomised controlled trial (the most rigorous form of evaluation). The key imperative in a randomised controlled trial is the creation of a control group that is identical in all relevant respects to the 'treatment' group but for the fact of treatment. Although randomised controlled trials are not common in criminal justice program evaluation, they are possible where the number of persons deemed eligible for a program exceeds the program capacity. In such circumstances, a random ballot can be held to determine who among those eligible is placed on the program. The remainder can then be placed in the treatment group. An approach of this sort was adopted by BOCSAR in its evaluation of the NSW Drug Court (Lind et al., 2002).

It was initially hoped to adopt a similar approach in the evaluation of the CDTP. Unfortunately, the number of offenders deemed eligible for the CDTP never exceeded the capacity of the program and it was therefore impossible to conduct a randomised trial. The small number of offenders deemed eligible for the CDTP also made it impossible to investigate the effectiveness of the program in reducing re-offending. The evaluation was therefore forced to examine other program outcomes by methods that are less than ideal. We will return to this issue at the end of this report. As noted earlier, the objectives of the CDTP were:

1. to provide a comprehensive program of compulsory treatment and rehabilitation under judicial supervision for drug dependent persons who repeatedly resort to criminal activity to support their dependency;
2. to effectively treat those persons for drug dependency, eliminating their illicit drug use while in the program and reducing the likelihood of relapse on release;
3. to promote the re-integration of those persons in the community; and
4. to prevent and reduce crime by reducing those persons' need to resort to criminal activity in support of their dependency

*(Crimes (Administration and Sentencing) Act 1999, Section 106B).*

In light of these objectives, the current evaluation focuses on improvements in the health, wellbeing and drug use of participants placed on the program. Analyses of participants' views of the CDTP were also undertaken. The lack of access to key items of information on inmates in the general prisoner population, however, made it impossible to construct a comparison group of offenders, similar to those placed on the CDTP, with which the CDTP participants could be compared. The present evaluation is, for the most part, a simple pre-post test of changes in the cohort of offenders placed on the CDTP. The implications of this are discussed at the end of this report.

The specific aims of the current study then, were to assess:

- a. whether indicators of CDTP participants' health and wellbeing changed as they progressed through the program;
- b. whether indicators of the participants' perceived coercion to be on the program, readiness to change and the degree to which they developed a good working relationship with their therapist changed as they progressed through the program;
- c. participants' views towards various aspects of the program; and
- d. participants' drug use throughout the program.

## 2 METHOD

### 2.1 DESIGN

This evaluation employed a prospective, repeated-measures, single-group study design. Structured interviews were conducted with the CDTP participants on four occasions: once at baseline (i.e. a short time after program entry) and once at the end of each of the three treatment stages. By taking repeated measures at the different stages of the program, the treatment group acted as their own controls. CDTP participants' drug use across stages was assessed using urinalysis data provided to BOCSAR by Corrective Services NSW.

### 2.2 SAMPLE

Between 1st August 2006 and 31st July 2009, 198 offenders were referred to the NSW Drug Court for eligibility and suitability assessments for entry to the CDTCC. The Drug Court Judges subsequently made 109 CDTOs. Of the 198 referrals, 45 per cent (n = 89) were deemed ineligible or unsuitable to be put on a CDTO.<sup>2</sup>

Of the 109 offenders who entered the program, three had their CDTOs revoked before they could be invited to take part in the study. Figure 1 shows the number of interviews conducted during the data collection period for the 106 offenders who were invited to participate. Of these 106 offenders, 95 agreed to participate in the study, a 90 per cent response rate. As Figure 1 shows, by the end of the data collection period, 95 baseline interviews, 74 end of Stage 1 interviews, 39 end of Stage 2 interviews<sup>3</sup> and 13 end of Stage 3 interviews were conducted.

### 2.3 INTERVIEW PROCEDURE

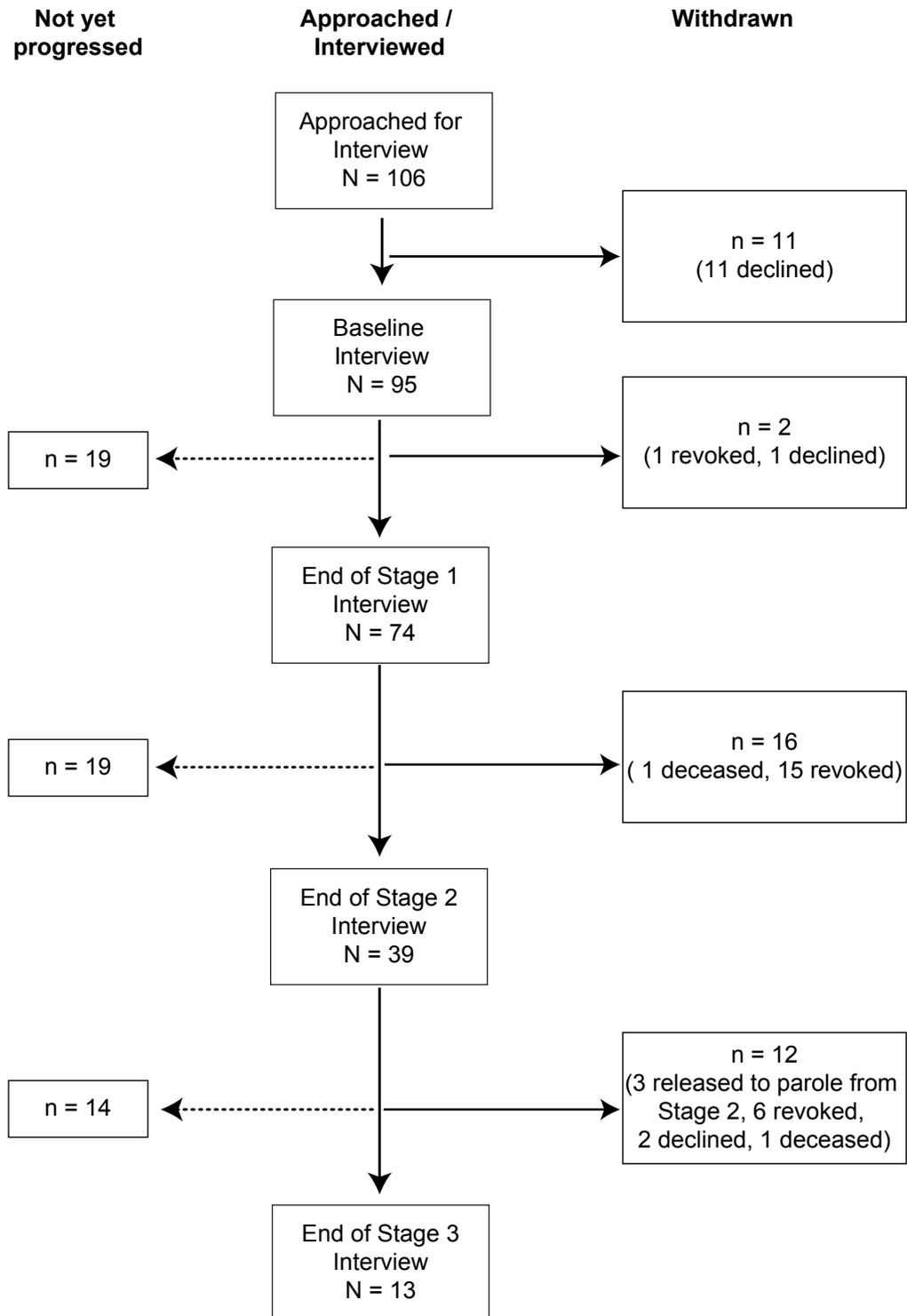
The primary measures analysed in the current evaluation were collected by way of face-to-face interviews with participants (see the Appendix for interview schedules). All baseline interviews were conducted at the CDTCC between August 2006 and August 2009 and took approximately 20 minutes to complete. Initially, the baseline interviews were conducted after the Drug Court had approved the participants' Personal Plans. There were significant unforeseen delays in approving Personal Plans for the first 12 months of the program. The mean delay between the CDTO and baseline interviews for the 33 interview participants who entered the program in its first 12 months of operation was 7.7 weeks (95% confidence interval around the mean = 6.6 to 8.8 weeks; range = 3.6 to 16.0 weeks).

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<sup>2</sup> Reasons for being deemed ineligible or unsuitable to be put on a CDTO were described in the background section of this report. Obtaining data for the 89 offenders who did not meet the eligibility and suitability criteria was beyond the scope of the current study.

<sup>3</sup> For some measures information was missing for one participant and N = 38.

**Figure 1. The number of CDTCC participants approached, interviewed and withdrawing from the evaluation (August 2006 - September 2009)**



To reduce the delay between program entry and baseline interviews, it was subsequently decided that baseline interviews would be conducted either when the participant's Personal Plan had been prepared or four weeks after his entry into the program, whichever came first. This significantly reduced the time between program entry and baseline interview. For the 32 interview participants who entered the program in its second 12-month period of operation, the average time between program entry and baseline interview was 4.7 weeks (95% confidence interval around the mean = 4.1 to 5.3 weeks; range = 3.1 to 11.0 weeks;  $t(63) = 5.06, p < .001$ ). Overall, the average time between program entry and baseline interview was 5.2 weeks (95% confidence interval around the mean = 4.6 to 5.8 weeks; range = 0.7 to 16.0 weeks).<sup>4</sup>

End of Stage 1 and end of Stage 2 interviews were conducted as close as possible to the date when the participant was expected to progress to the next stage. All interviews were conducted at the CDTCC between March 2007 and September 2009, and took between 20 to 30 minutes to complete. End of Stage 3 interviews were conducted as close as possible to the expected parole date. They were all conducted at either the CDTCC or the participant's place of work between April 2008 and September 2009 and took between 20 and 30 minutes to complete.

All participants were informed that their participation in the evaluation was voluntary and that the information they provided was completely confidential and would not affect their participation in the program. This information was reiterated at each of the follow-up interviews. Trained female interviewers, who were independent of the CDTCC, conducted all interviews.

## **2.4 MEASURES**

Three sources of data were utilised for the current evaluation: data from face-to-face interviews conducted specifically for this evaluation, data from offence records obtained from the Drug Court database, and drug use data obtained from routinely collected urinalysis screening tests. The following sections describe each of the measures.

### **OFFENDER DETAILS**

A number of demographic and offence-related characteristics were measured at the baseline interviews for descriptive purposes, including ethnicity, age, marital status, drug(s) of choice, and treatment history.

### **DRUG COURT DETAILS**

Information relating to the offence(s) for which participants were referred to the CDTP was extracted from the Drug Court database, as well as information on the sentences they received for those offences. Information was also obtained from the Drug Court database to ascertain movements between program stages including progressions (that is, moving to later stages of treatment) and regressions (that is, moving back to earlier stages of treatment).

### **PHYSICAL AND MENTAL HEALTH**

The Short Form-12 (SF-12) health survey (Ware, Kosinski, & Keller, 1996) was administered at baseline and again at the end of each of the three program stages to determine whether there were any changes in the participants' physical and mental health as they progressed through the program. The SF-12 is a 12-item instrument that provides a generic measure of health status. The SF-12 contains two summary scales, measuring eight dimensions of health and wellbeing. The Physical Component Summary (PCS) scale measures physical functioning, role limitations due to physical health problems, bodily pain, and

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<sup>4</sup> Aside from health and wellbeing measures, earlier interviews were not associated with any differences in responses.

general health (6 items). The Mental Component Summary (MCS) scale measures vitality (energy/fatigue), social functioning, role limitations due to emotional problems, and mental health (6 items). The SF-12 items were referenced to the four weeks prior to each interview. Summary scale scores were calculated using norm-based scoring based on US population norms (which have a mean of 50 and a standard deviation of 10 units).<sup>5</sup> Scores higher than 50 indicate greater physical and mental health than US population norms, while scores below 50 indicate health and wellbeing that is poorer than US population norms. The SF-12 has been shown to have good reliability and validity (Ware et al., 1996).

## **PERCEIVED COERCION, AFFECTIVE REACTIONS, TREATMENT READINESS AND THERAPEUTIC ALLIANCE**

### **Perceived coercion**

The Macarthur Perceived Coercion Scale (MPCS, adapted from Gardner et al., 1993) is a five-item self-report measure of perceived coercion to attend treatment. While the MPCS was originally designed for use in mental hospital admissions, it has been adapted for use in a variety of treatment settings. The MPCS assesses individual clients' perceptions of their *freedom* to participate in treatment, their *influence* and *control* over participation and their *choice* to participate in treatment. CDTP participants responded to each statement on a three-point scale (0 = yes, 1 = don't know, 2 = no). The five items were then aggregated, providing a total perceived coercion score ranging from zero to ten. Higher scores indicate greater perceived coercion to enter treatment. The MPCS was administered only at baseline because this type of perceived coercion was not expected to change over time. One item from the Program Interest Questionnaire (PIQ, Wanberg & Milkman, 1998) also assessed perceived coercion.

### **Affective reactions**

The Affective Reactions to Hospitalisation Scale (ARHS, adapted from Gardner et al., 1993) is a six-item scale that measures participants' affective reactions when being sentenced to the drug treatment program, and their affective reactions at the time of the baseline, Stages 1, 2 and 3 interviews. Participants were asked whether they felt/feel angry, sad, pleased, relieved, confused and frightened about being sentenced to, and participating in, the CDTP. Participants respond to each statement on a three-point scale (0 = no, 1 = don't know, 2 = yes). The two positive emotions were reverse scored and the six items summed to produce a total score ranging from zero to twelve. Higher scores reflect more negative reactions regarding participation in the CDTP. The ARHS was administered at baseline and at the end of Stage 1, 2 and 3 interviews. Two scores were generated from the baseline interviews – one relating to their affective reactions to how they retrospectively felt at sentencing and one relating to their affective reactions at the time of the baseline interview.

### **Treatment readiness**

The Serin Treatment Readiness Scale (STRS, adapted from Casey, Day, Howells, & Ward, 2007) assesses participants' problem recognition, perceptions of the benefits of treatment, treatment interest, distress, goals and behaviours, motivational consistency and treatment support. The STRS is an 11-item scale, although only nine of the 11 items were employed for this evaluation (the two items excluded were an assessment of whether participants had taken steps to enter drug treatment previously and participants' perception of whether they needed to learn new ways to respond to other people). Questions were answered on a five-point scale (range from 1 = strongly disagree to 5 = strongly agree). The items were summed to provide a total score of individual readiness for treatment (range 9-45). Higher scores reflect a higher level of treatment readiness.

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<sup>5</sup> The authors are unaware of Australian norm-based scoring of the SF-12, hence US norm-based scoring was used.

## Therapeutic alliance

The 12-item self-report client version of the Working Alliance Inventory Short-Form (WAI-C SF, Horvath & Greenberg, 1989; Tracey & Kokotovic, 1989) was employed to assess the CDTP participants' perceptions of the relationship between himself and his counsellor. The WAI-C SF has three four-item subscales, which measure the extent to which the client and counsellor:

- (a) Endorsed and valued mutually agreed upon outcomes of treatment (*goals*);
- (b) Agreed on how to achieve the goals of treatment (*tasks*); and
- (c) Developed a personal attachment based on mutual trust, acceptance and confidence (*bonds*).

Participants rated their agreement with each of the 12 items on a seven-point Likert-type scale ranging from one (does not correspond at all) to seven (corresponds exactly). Higher scores indicate a better working alliance between the participant and counsellor. The subscale scores can range from 4 to 28. The subscales were also summed to produce a total score measuring general alliance, with scores ranging from 12 to 84. Validity studies conducted in the U.S. show the WAI has good internal consistency and reliability (Hanson, Curry, & Bandolas, 2002; Tracey & Kokotovic, 1989). The WAI-C SF was administered at the end of Stage 1, 2 and 3 interviews but not at the baseline because participants had not, at that stage, had the opportunity to form a working alliance with their counsellor.

## PROGRAM PERCEPTIONS

Five items were adapted from the Program Interest Questionnaire (PIQ, Wanberg & Milkman, 1998) to assess participants' perceptions of, and satisfaction with, the CDTP. One of the PIQ items addresses perceived coercion while the remaining four items address participants' perceptions of whether the program will be helpful to them, their interest in participating in the program and whether they believe they need help to prevent relapse to drug use or re-offending. The PIQ used various response formats to elicit responses (e.g. yes/no or three-point scales). The PIQ was administered at baseline and at the end of Stage 1 and 2 interviews. Three items from the PIQ were also administered at the end of Stage 3 interview; the items excluded were those investigating how they currently felt about attending the program (these were considered to be invalid because the participant was just about to complete the program).

The remaining program perception items were designed specifically for this evaluation and included:

- Participants' understanding of their obligations while on the program, their perceptions of the difficulty of the program, the importance of being drug-free while on the program and their preference for being in a mainstream goal compared to the CDTCC (each rated on a 5-point scale, where 1 = strongly disagree and 5 = strongly agree).
- Thirteen items assessing whether participants liked various aspects of the CDTP, such as the support provided by staff, the education and employment opportunities and the abstinence-based nature of the program (each rated on a scale using a yes/no/don't know format).
- A free-response item asking participants whether they would like to make any additional comments about the program.

Several additional program perception questions were asked at some but not all interviews:

- Whether participants were receiving methadone treatment when they entered the CDTP and, if so, how they felt about being taken off methadone. These perceptions were measured on a five-point scale where 1 = very unhappy and 5 = very happy (included in the end of Stage 1 interview only).

- Five items assessing participant satisfaction with Stage 1, 2 or 3 of the program, their perceptions of how they would cope with life in the community after completing Stage 2 or 3 of the program and whether they found their Personal Plan helpful. Participants rated their agreement with these items on a five-point scale (1 = strongly disagree and 5 = strongly agree). These questions were included in all interviews except the baseline interview.
- Open-ended questions targeting participants' opinions on a range of specific areas.

### **Criminogenic Risk Factors**

A number of questions were included in the end of Stage 3 interviews that investigated criminogenic (or changeable) risk factors such as: education, employment, relationship conflict, accommodation, peer associations/social functioning and alcohol. In terms of education and employment, participants were asked how much time they spent involved in education and employment in Stage 3 and their degree of satisfaction with it. In terms of relationship conflict, participants were asked how often they had conflict with relatives, partners and friends/acquaintances and their degree of satisfaction with their personal relationships. In terms of peer relationships and social functioning, participants were asked how many close friends they had and their degree of satisfaction with the amount of support these friends give them in times of trouble. Participants were also asked how many of the people they "hang around with", that is, partners, friends or acquaintances, were involved in drugs or crime. In terms of accommodation, participants were asked in how many different places they had lived during Stage 3 and how satisfied they were with their housing arrangements. Finally, participants were asked whether they consumed alcohol during Stage 3.

### **DRUG USE**

CDTP participants were required to provide regular urine tests as a condition of the program. Samples were provided at least two times per week in Stage 1, and at least three times per week in Stages 2 and 3. Corrective Services NSW provided these urinalysis results to BOCSAR, so that drug use at each stage of the program could be assessed.<sup>6</sup>

Corrective Services NSW creates a unique record for each drug detected on a specific test demand date or, if no drugs were detected, one record for each person for each test demand date. Participant movements from stage to stage were monitored via the 'Event' field in the NSW Drug Court database so that the stage each participant was in at the time of each of their drug tests could be determined. There were 16439 unique drug test records. The 16439 records were aggregated to obtain one record for each test demand date for each participant, which resulted in 14638 unique tests.<sup>7</sup> Participants in the CDTP get a baseline drug test upon their entry into the program, that is, before they enter the centre proper. This baseline test is the first test conducted on each participant and this test was treated separately to other tests. As such, there were 109 baseline drug tests and there were 14529 non-baseline tests.

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<sup>6</sup> At the time data analysis was conducted, urinalysis data was available from 1st September 2006 until 30th September 2009 inclusive.

<sup>7</sup> If residual trace metabolites are present in the body between drug tests, then at the unique test level one incidence of drug use can show in two or more consecutive test results. At the person level this overestimation is accounted for as test outcomes are aggregated across unique tests.

The drug test outcome of each unique test could take one of four values:

1. **Positive** urine test results comprise any one of the following results on the test demand date: at least one non-prescribed drug was detected, a participant failed or refused to supply a urine sample or 'very dilute'<sup>8</sup> samples were provided. The details of the drug detected for each unique test outcome that was classified as *positive* was also extracted.
2. **Dilute** urine test results occur when urine creatinine is low.<sup>9</sup> Dilute tests are problematic as drug metabolites may be diluted to concentrations below the level of detection by standard methods. At the CDTCC, dilute urines are seen as a potential indicator or "red flag" for illicit drug use and a possible attempt to mask such use. When 'dilute' test results have been detected, the participant is questioned and, on most occasions to date, drug use has been admitted.<sup>10</sup> However, on their own, dilute urine test results are not sufficient evidence to charge a participant with drug use and are therefore reported as a separate category for the purposes of this research.
3. **Inconclusive** urine tests include tests that were cancelled due to administrative or human errors (e.g. if the wrong participant was selected or an error was made with the data entry) and cases where a participant was not tested. There are several reasons why a participant may not be tested, including 'temporary absence' from the Centre (e.g. if the participant was transferred to another prison prior to the test), if he was incapable of providing a sample (due to a medical or physical problem) or if he escaped or died prior to the test.
4. **Non-prescribed drug free** urine test results include samples where no drugs were detected or where only prescribed medications were detected.

The data for the 14529 non-baseline unique tests were aggregated to obtain one record for each participant (aggregated across each person's tests), resulting in data for the 108 unique persons.<sup>11</sup> The drug test outcome of each unique person based on the aggregation of unique tests could take one of four values:

1. **Positive**: at least one of the participant's unique test outcomes was positive;
2. **Dilute**: at least one of the participant's unique test outcomes was dilute and none were positive;
3. **Inconclusive**: at least one of the participant's unique test outcomes was inconclusive and none were positive or dilute; or
4. **Non-prescribed drug free**: all the participant's unique test outcomes were non-prescribed drug free.

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<sup>8</sup> Very dilute urines are deemed to be an overt attempt to mask drug use and are therefore viewed as 'positive' by the CDTCC (Personal communication, Timothy Burt, Superintendent, CDTCC).

<sup>9</sup> Dilute samples can indicate that a large volume of water has been consumed prior to passing the urine. Dilute samples can result from an attempt to disguise drug use, hot weather, other health conditions or the timing of drinking fluids before providing a urine sample.

<sup>10</sup> Personal communication, Timothy Burt, Superintendent, CDTCC.

<sup>11</sup> One participant only had drug test data for their baseline test.

## **2.5 ANALYSES**

### **INTERVIEW SURVEY**

The analyses were primarily descriptive, although statistical tests were employed to test whether there were any differences between groups or any significant changes over time on some of the measures. Two comparisons across time were considered in these analyses. The first comparison assessed changes in the various measures from baseline to the end of Stage 1 for the 74 participants who had both baseline and end of Stage 1 interviews. The second comparison assessed changes in the various measures from baseline to the end of Stage 2 for the 39 participants who had a baseline, end of Stage 1 and end of Stage 2 interview.<sup>12</sup> Both comparison groups included participants who had reached the end of the relevant stage and excluded those who had not completed that stage. Statistical analyses for participants who were interviewed at all four time points were not conducted due to the low number of participants who had reached the end of Stage 3 at the end of the study period (N = 13). Parametric tests were employed where appropriate and non-parametric tests were employed where the distributional assumptions underpinning parametric methods were not met.

### **DRUG USE**

Descriptive statistics for drug test data at both the unique test and at the unique person level were obtained. Chi-square tests of association were conducted to assess whether there were any differences in the proportion of positive tests across the program stages.

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<sup>12</sup> Recall, for some measures information was missing for one participant and N = 38.

## 3 RESULTS

The results section will firstly present the demographic data of the interview sample, including a brief investigation of how these participants progressed through the program (i.e. whether they were regressed and how many were revoked etc.). Analysis of health and wellbeing, perceived coercion, affective reactions, treatment readiness, therapeutic alliance and participants' perceptions over time on the program will follow. Participants' answers to specific and general open-ended questions will also be reported. Finally, an examination of participants' drug use whilst on the program will be described.

### 3.1 CHARACTERISTICS OF THE INTERVIEW SURVEY SAMPLE

#### DEMOGRAPHIC CHARACTERISTICS

At the time of the baseline interview, the average age of the 95 interview survey participants was 30.1 years (95% confidence interval of mean age: 28.6 to 31.5, age range: 20.2 to 58.1 years) and 18.9 per cent were either married or in a de facto relationship. Participants were primarily European/Caucasian (62.1%), 9.5 per cent identified their cultural background as Aboriginal or Torres-Strait Islander, 8.4 per cent as Middle Eastern and a further 5.3 per cent as Asian. The remaining 14.7 per cent identified one of a number of other cultural backgrounds including New Zealander and mixed cultural backgrounds.

#### ILLICIT DRUG(S) OF CHOICE

Table 1 shows the participants' nominated drugs of choice at the time of the baseline interview. The majority of participants (78.9%) identified heroin as one of their drugs of choice. Significant proportions also nominated cannabis (43.2%), cocaine (38.9%) and amphetamines/methamphetamine (37.9%). Smaller proportions nominated benzodiazepines, ecstasy and other opiates as their drugs of choice.

**Table 1. Participants reporting of their drug(s) of choice at the baseline interview (N = 95)**

	n <sup>a</sup>	%
Heroin	75	78.9
Cannabis	41	43.2
Cocaine	37	38.9
Amphetamines/Methamphetamine	36	37.9
Benzodiazepines	16	16.8
Ecstasy	9	9.5
Other opiates	7	7.4
Hallucinogens	1	1.1

<sup>a</sup> Each participant could choose multiple drugs of choice.

#### TREATMENT HISTORY

CDTP participants were asked whether they had attended a range of drug treatment programs before entry to the CDTP and, if so, how many times they had started each treatment program. Table 2 shows that the vast majority (83.2%) of participants had entered at least one form of drug treatment before their CDTO was made. The study participants had, on average, started any type of drug treatment at least eight times before entering the CDTP (the mean number of times any type of treatment was started was 6.7 when the outlier, the offender who reported starting treatment 130 times was excluded).

Multiple entries into the same type of treatment was common. For example, the mean number of times participants had entered self-help groups such as Narcotics Anonymous was 2.5 times (range = 0-100). Table 2 also shows that more than half of the participants had previously entered methadone maintenance treatment (52.6%).

As well as entering the same type of drug treatment multiple times, most participants reported trying more than one type of treatment with 30.5 per cent having tried between two and three different types of treatment, and 27.4 per cent having tried between four and six different types of treatment.

**Table 2: Participants drug treatment history at baseline interview (N = 95)**

	Number of times started treatment					
	n <sup>a</sup>	%	Mean	Median	Minimum	Maximum
Prescribed methadone	50	52.6	1.2	1	0	8
Inpatient or residential rehabilitation	39	41.1	0.9	0	0	5
Self-help groups (e.g. Narcotics Anonymous)	37	38.9	2.5	0	0	100
Outpatient counselling	30	31.6	1.1	0	0	20
Inpatient detoxification	25	26.3	1.0	0	0	20
Outpatient detoxification	21	22.1	0.8	0	0	20
Other treatment	12	12.6	0.4	0	0	20
Naltrexone	6	6.3	0.2	0	0	7
<b>Any treatment</b>	<b>79</b>	<b>83.2</b>	<b>8.0<sup>b</sup></b>	<b>3</b>	<b>0</b>	<b>130</b>

<sup>a</sup> Each participant could identify multiple treatment programs.

<sup>b</sup> The mean number of times any type of treatment was started was 6.7 when the outlier, the offender who reported starting treatment 130 times was excluded.

## REFERRED SENTENCES, CRIMINAL HISTORY AND CDTO NON-PAROLE PERIOD LENGTH

On average, the 95 participants of the CDTP who were administered a baseline interview had 3.5 sentences referred to the Drug Court to be considered for a CDTO (range: 1-16 sentences) and an average of five charges related to these sentences (range: 1-35 charges). Table 3 shows the most serious offence for which the participant was referred to the Drug Court.<sup>13</sup> The large majority of offenders were serving a sentence for break and enter or robbery (90.5%).

Seventy-eight percent of CDTP participants reported that they received their first criminal conviction before the age of 18 years. The average age reported at first conviction was 15.8 years (range: 9 to 36 years). However the recording of a conviction is a discretionary issue in the Children's Court and is often not recorded. As such, self-reported age at first conviction may not reflect actual age at first conviction.

<sup>13</sup> 'Most serious offence' was classified as the offence that carried the longest sentence, on the condition that the non-parole period for that sentence ended on the date that their CDTO was set to expire.

The length of the non-parole period for a CDTO was calculated by subtracting the minimum non-parole expiry date of the CDTO from the date the CDTO was made. The minimum non-parole expiry date of the CDTO and the date the CDTO was made were extracted from the NSW Drug Court database. The average length of the non-parole period for CDTOs during the study period was 20.5 months (range = 6-35 months). Thirty-eight per cent had orders that were less than 18 months,<sup>14</sup> 36 per cent had orders that were between 18 and 24 months inclusive, and 25 per cent had orders over 24 months long.

**Table 3. Most serious offence for which participants were referred to the CDTP (N = 95)**

Section of <i>Crimes Act 1900</i>	Most serious offence description	n	%
94/95	Robbery or stealing from the person/Robbery or stealing from the person in circumstances of aggravation	5	5.3
97(1)	Robbery etc or stopping a mail, being armed or in company	22	23.2
112(1)	Breaking etc into any house etc and committing serious indictable offence	28	29.5
112(2)	Aggravated breaking etc into any house etc and committing serious indictable offence	27	28.4
113	Breaking etc into any house etc with intent to commit serious indictable offence	4	4.2
	Other	9	9.5

### **PROGRESSION THROUGH THE PROGRAM FOR PARTICIPANTS NO LONGER ON THE PROGRAM AT THE TIME DATA COLLECTION ENDED**

This section considered data from the 109 participants who entered the CDTCC (not just the 95 who were interviewed). There were 54 participants who were no longer on the program at the time data collection ended. Those who were still on the program at the time data collection ended are excluded from the analysis in this section, as their progression through the program was ongoing (n = 55).

Participants can have their CDTO revoked for serious or repeated breaches of their order. These official participant movements were monitored via the 'Event' field in the NSW Drug Court database. Regressing, or moving back to a previous stage, is automatic whenever a participant relapses to non-admitted drug or alcohol use or engages in some other serious violation of the conditions of the Personal Plan.<sup>15</sup> Participants can be regressed from Stage 2 to Stage 1, or from Stage 3 to either Stage 1 or 2. Regressors were defined as those participants who regressed at least once during their time in the program. Non-regressors were those who at the time data collection ended had progressed through the program without an occasion of regression. The majority (59.3%) of participants no longer on the program were regressed at least once.

<sup>14</sup> CDTOs of less than 18 months can arise because of the need for eligibility and suitability assessments to be made before a CDTO can be made.

<sup>15</sup> The CDTP also has unofficial "regressions" such as increased supervision. No data was available on unofficial regression.

The exit characteristics of the 54 participants no longer on the program at the time data collection ended are shown in Table 4.

**Table 4. Exit type by program progression characteristics for participants no longer on the program at the time data collection ceased (N = 54)**

<b>Exit status</b>	<b>n</b>	<b>% of 54 participants no longer on the program</b>	<b>% within exit type</b>
<b>Released to Parole</b>	<b>26</b>	<b>48.1</b>	<b>100.0</b>
In Stage 2 at the time of parole	12	22.2	46.2
In Stage 3 at the time of parole	14	25.9	53.8
Ever progressed from Stage 1 to Stage 2	26	48.1	100.0
Ever progressed from Stage 2 to Stage 3	21	38.9	80.8
<b>Ever regressed</b>	<b>19</b>	<b>35.2</b>	<b>73.1</b>
Ever regressed from Stage 2	15	27.8	57.7
Ever regressed from Stage 3	10	18.5	38.5
<b>Revoked from Program</b>	<b>26</b>	<b>48.1</b>	<b>100.0</b>
In Stage 1 at the time of revocation	12	22.2	46.2
In Stage 2 at the time of revocation	10	18.5	38.5
In Stage 3 at the time of revocation	4	7.4	15.4
Ever progressed from Stage 1 to Stage 2	22	40.7	84.6
Ever progressed from Stage 2 to Stage 3	6	11.1	23.1
<b>Ever regressed</b>	<b>13</b>	<b>24.1</b>	<b>50.0</b>
Ever regressed from Stage 2	13	24.1	50.0
Ever regressed from Stage 3	2	3.7	7.7
<b>Died</b>	<b>2</b>	<b>3.7</b>	<b>100.0</b>
In Stage 2 at the time of death	1	1.9	50.0
In Stage 3 at the time of death	1	1.9	50.0
Ever regressed	0	0.0	0.0

## Paroled

Just under half (48.1%) of participants no longer on the program were released to parole. Among the paroled participants (n = 26):

- the majority (53.8%) were paroled from Stage 3;
- the majority had been regressed at least once (73.1%; 8 had been regressed only once, 9 had been regressed twice and 2 had been regressed three times); and
- most had progressed from Stage 2 to Stage 3 at least once (80.8%).

## Revoked

Just under half (48.1%) of participants no longer on the program were revoked from the program. Among those revoked (n = 26):

- the most common stage to be revoked from was Stage 1 (46.2%);
- the majority had progressed from Stage 1 to Stage 2 at least once (84.6%);
- almost one quarter (23.1%) had progressed from Stage 2 to Stage 3 at least once; and
- half had been regressed at least once (8 had been regressed only once, 4 had been regressed twice and 1 had been regressed three times).

## Died

Two participants died in the community while on the CDTP and both these participants had never been regressed in the program. One died while in Stage 2 of the program and the other while in Stage 3.

## 3.2 HEALTH AND WELLBEING

### DIFFERENCES IN HEALTH AND WELLBEING RELATED TO THE TIME BETWEEN PROGRAM ENTRY AND THE BASELINE INTERVIEW

Before assessing whether there were any changes in participants' health and wellbeing over time while on the program, the time between program entry and the baseline interview needs to be considered. Since there was a relatively long time between program entry and the baseline interview for some participants it is possible that any improvements in health and wellbeing may have already become manifest by the time the baseline interviews were conducted.

**Figure 2. Mean and standard errors for baseline SF-12 mental and physical health component summary scores, by the time between program entry and baseline interview (N = 95)**

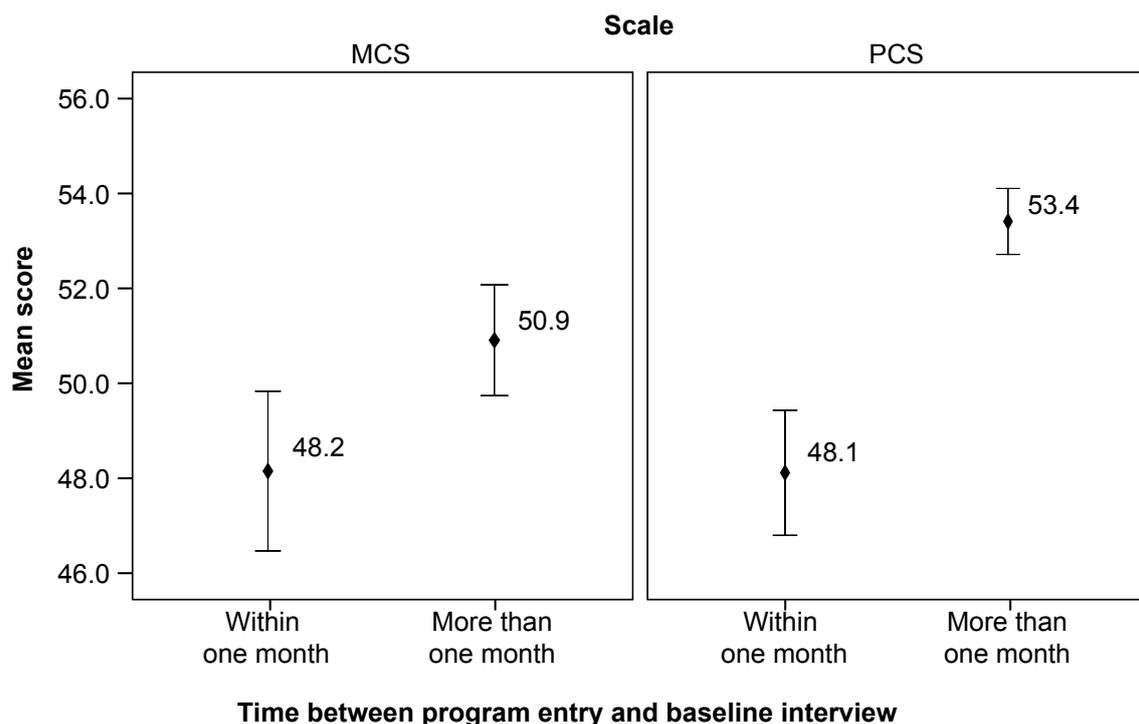


Figure 2 demonstrates support for this hypothesis. Figure 2 shows the means and standard errors for baseline SF-12 mental health component summary scores (MCS) and physical health component summary scores (PCS), by the time between program entry and baseline interview. Participants who were interviewed within one month of entering the CDTP ( $n = 48$ ) reported significantly lower physical wellbeing scores (PCS) than participants who were interviewed more than one month after entering the CDTP ( $n = 47$ ;  $t(93) = 3.54, p < .001$ ). However, mental health scores (MCS) were similar for those who were interviewed within one month and those who were not interviewed within one month ( $t(93) = 1.34, p = 0.182$ ).

### CHANGES IN HEALTH AND WELLBEING

Figure 3 shows the mean SF-12 mental (MCS) and physical (PCS) health component summary scores for the 74 participants who completed Stage 1. The mean baseline mental health score for this group was 49.5 at baseline and 51.4 at the end of Stage 1. A pair-wise  $t$ -test revealed that this difference was not statistically significant ( $t(73) = 1.62, p = .109$ ).

The mean physical health score for this group was 50.8 at baseline and 53.1 at the end of Stage 1. This difference was statistically significant ( $t(73) = 2.79, p = .007$ ), which suggests that, on average, physical health improved for those who are still in the program at the end of Stage 1.

**Figure 3. Mean and standard errors for SF-12 mental and physical health component summary scores by interview stage, for those who completed Stage 1 (N = 74)**

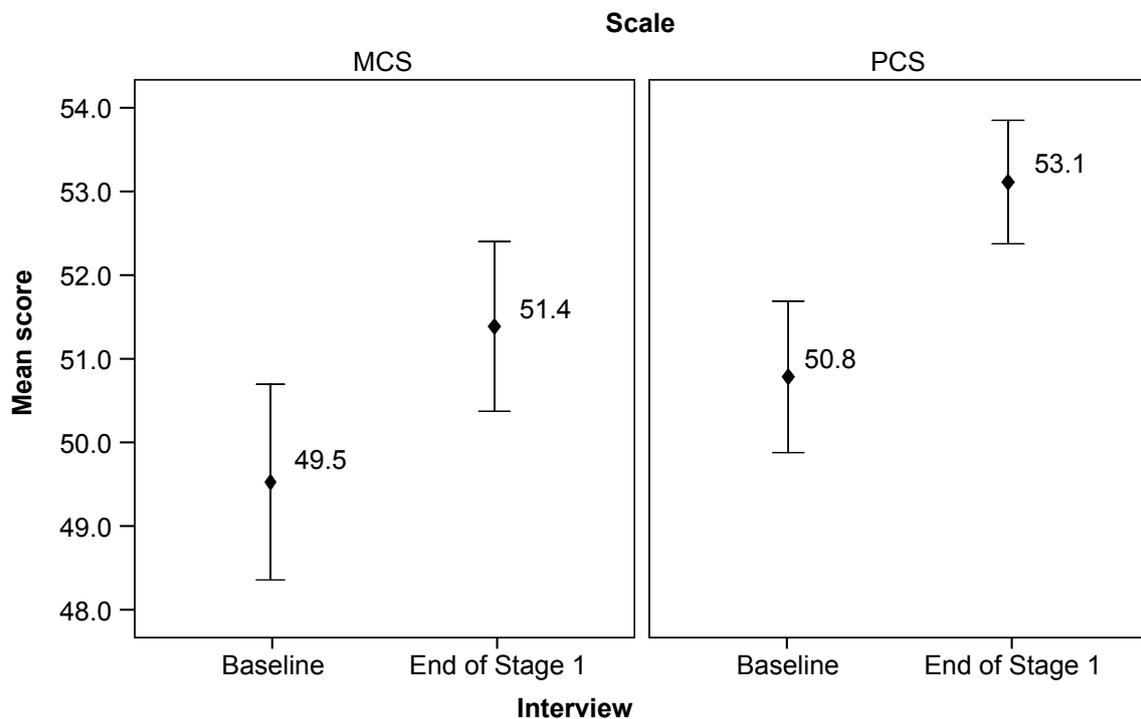
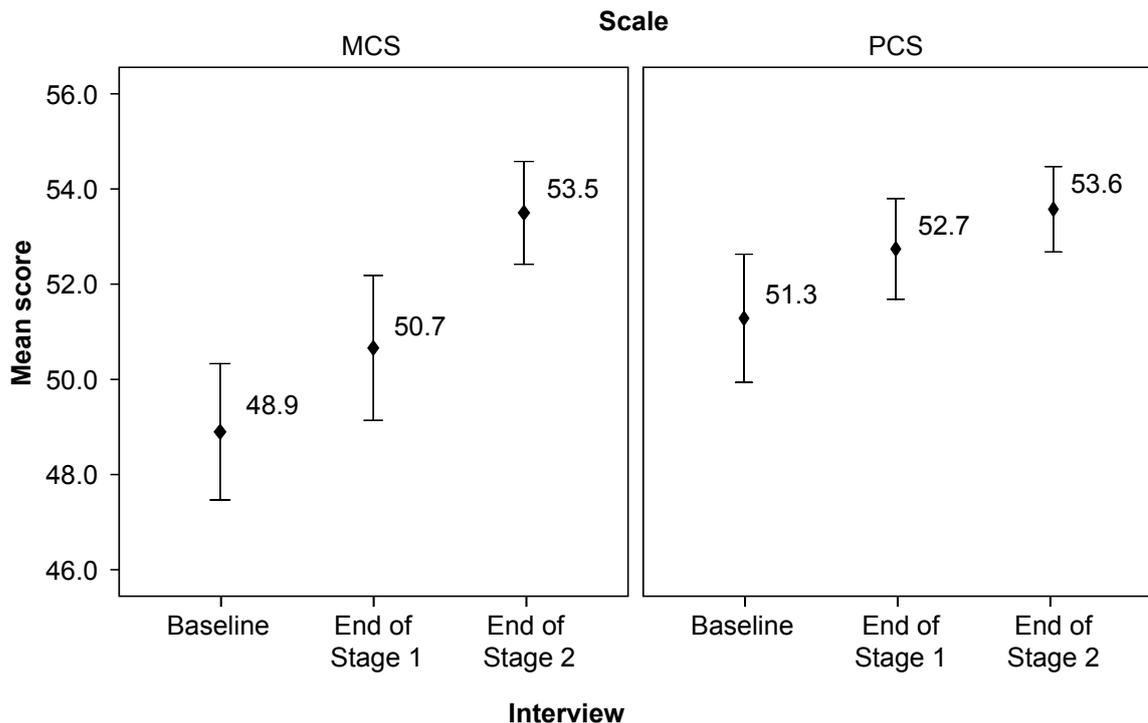


Figure 4 shows the mean SF-12 mental and physical health component summary scores (MCS and PCS) for the 38 participants who completed Stage 2 and responded to the SF-12. The mean baseline mental health score for this group was 48.9, the mean Stage 1 score was 50.7 and the mean Stage 2 score was 53.5. This upward linear trend was statistically significant ( $F(1,37) = 9.96, p = 0.003$ ). Pair-wise comparisons revealed that there was a significant increase in the average mental health scores between baseline and the end of Stage 2 (mean increase in MCS score was 4.6, 95% confidence interval around the mean difference ranged from 1.6 to 7.6) but no difference across any of the other comparisons.

The mean baseline physical health score for this group was 51.3, the mean Stage 1 score was 52.7 and the mean Stage 2 score was 53.6. This upward linear trend was statistically significant ( $F(1,37) = 4.15, p = .049$ ). Pair-wise comparisons revealed that there was a significant increase in the average physical health scores between baseline and the end of Stage 2 (mean increase in PCS score was 2.3, 95% confidence interval around the mean difference ranged from 0.0 to 4.6) but no difference across any of the other comparisons.

**Figure 4. Mean and standard errors for SF-12 mental and physical health component summary scores by interview stage, for those who completed Stage 2 and responded to the SF-12 (N = 38)**

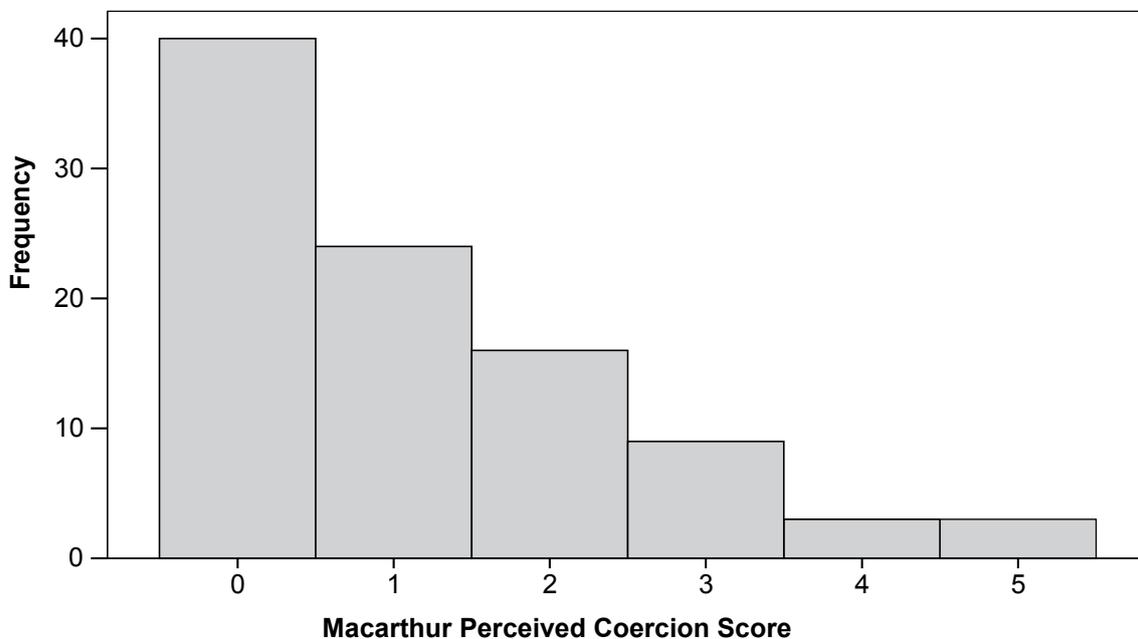


### 3.3 PERCEIVED COERCION, AFFECTIVE REACTIONS, TREATMENT READINESS AND THERAPEUTIC ALLIANCE

#### PERCEIVED COERCION

Low scores on the Macarthur Perceived Coercion Scale (MPCS) indicate low perceived coercion. The MPCS was only administered at baseline as no changes in this type of perceived coercion were expected across time. Hoge et al. (1997) suggested that participants with MPCS scores greater than two have a high level of perceived coercion and participants scoring two or less generally perceive admission as voluntary. Figure 5 shows the distribution of MPCS scores. The mean MPCS score was 1.15 (95% confidence interval 0.88 to 1.42, minimum = 0, maximum = 5). The vast majority of participants (84.2%) had MPCS scores of two or less, therefore were considered to have perceived admission to the CDTP as voluntary.

**Figure 5. Histogram of Macarthur Perceived Coercion Scale, for those who participated in the baseline interview (N = 95)**



The first item from the Program Interest Questionnaire asked participants whether their attendance on the program was “a requirement or condition of their current status”. This is another measure of the level of perceived coercion. Of the 74 participants who had an end of Stage 1 interview, there was no difference in the proportion of participants who perceived that their attendance at the centre was voluntary at the baseline interview (54.1%) compared to the end of Stage 1 interview (55.4%; test of difference between proportions found  $p = .869$ ). However, within participants there was a change in the perception of their attendance at the centre as voluntary, 25 per cent of participants who had perceived that their attendance was voluntary at baseline no longer felt this way by the end of Stage 1 and 32.4 per cent of participants who had perceived that their attendance was not voluntary at baseline felt it was voluntary by the end of Stage 1 (Chi-square test  $p < .001$ ). Of the 38 participants who had an end of Stage 2 interview and responded to the item, the proportion that perceived that the program was voluntary appeared to increase as they progressed through the program (34.2% at baseline, 39.5% at the end of Stage 1 and 50% at the end of Stage 2), however this was not statistically significant (test of difference between proportions at baseline and end of Stage 1, baseline and end of Stage 2, and end of Stage 1 and end of Stage 2 all had  $p > .15$ ).

## CHANGES IN AFFECTIVE REACTIONS

High scores on the affective reactions to hospitalisation scale (ARHS) indicate more negative reactions to participating in the program. Table 5 shows participants' mean scores and the percentage of participants with scores of one or more on the ARHS scale.

**Table 5. Affective reactions to hospitalisation by stage completed and interview**

	Baseline interview only N = 95		Completed Stage 1 N = 74		Completed Stage 2 N = 39	
	Mean	Per cent with scores of one or more	Mean	Per cent with scores of one or more	Mean	Per cent with scores of one or more
Sentenced	1.43	40.0	1.57	44.6	1.51	43.6
Baseline	0.54	20.0	0.61	21.6	0.46	15.4
End of Stage 1			0.78	23.0	0.33	12.8
End of Stage 2					0.69	25.6

For the 95 participants who had a baseline interview, there was a statistically significant decrease in negative affective reactions to participating in the program between sentencing (according to retrospective responses at the baseline interview on how they felt at the time of the sentencing) and the baseline interview (Friedman's non-parametric test of differences in scores over time,  $p < .001$ ). Forty per cent of participants scored one or more on the ARHS based on how they felt at sentencing, whereas, only 20 per cent scored one or more on the ARHS based on how they felt at baseline.

For the 74 participants who completed Stage 1, there was a statistically significant decrease in negative affective reactions to participating in the program between sentencing and the baseline interview (Friedman's  $p < .001$ ) and between sentencing and the end of Stage 1 interview (Friedman's  $p = .004$ ). However, for those who completed Stage 1, there was no change in affective reactions to participating in the program between the baseline and end of Stage 1 interviews (Friedman's  $p = .532$ ).

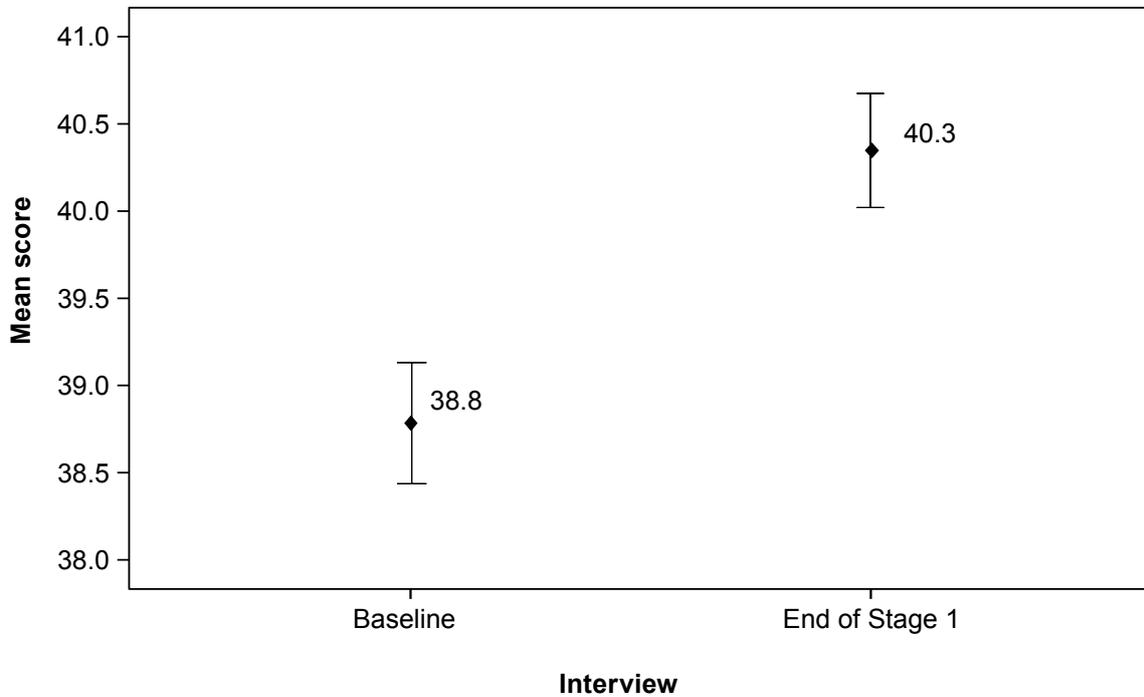
For the 39 participants who completed Stage 2, there was a statistically significant decrease in negative affective reactions to participating in the program between sentencing and the baseline interview (Friedman's  $p = .005$ ) and between sentencing and the end of Stage 1 interview (Friedman's  $p = .007$ ). For those who completed Stage 2, there was no change in affective reactions to participating in the program between sentencing and the end of Stage 2 interview (Friedman's  $p = .180$ ). There was also no change in negative reactions to participating in the program between baseline and the end of Stage 1 interview (Friedman's  $p = .739$ ), between baseline and the end of Stage 2 interview (Friedman's  $p = .083$ ), or between the end of Stage 1 and end of Stage 2 interview (Friedman's  $p = .096$ ).

The analyses indicated that there was a significant difference in affective reactions only between sentencing and the baseline interview, and between sentencing and the end of Stage 1. However, affective reactions to participating in the program at the time of sentencing were obtained by asking participants at their baseline interview to retrospectively recall how they felt at the time of the sentencing. Hence, the difference between affective reactions to participating in the program at sentencing and at baseline or the end of Stage 1 could merely be due to recall bias and should be interpreted with caution.

## TREATMENT READINESS

Figure 6 shows the mean scores on the Serin Treatment Readiness Scale at the baseline and the end of Stage 1 interviews for the 74 participants who completed Stage 1. Higher scores on the Serin Treatment Readiness Scale reflect a higher level of treatment readiness.<sup>16</sup> For the 74 participants who had an end of Stage 1 interview, a paired *t*-test was conducted to compare scores on treatment readiness at baseline and at the end of Stage 1. Treatment readiness was significantly higher at the end of Stage 1 than at baseline ( $t(73) = 2.9, p = .004$ ; mean increase in readiness was 1.1, 95% confidence interval around the mean difference ranged from 0.4 to 1.8).

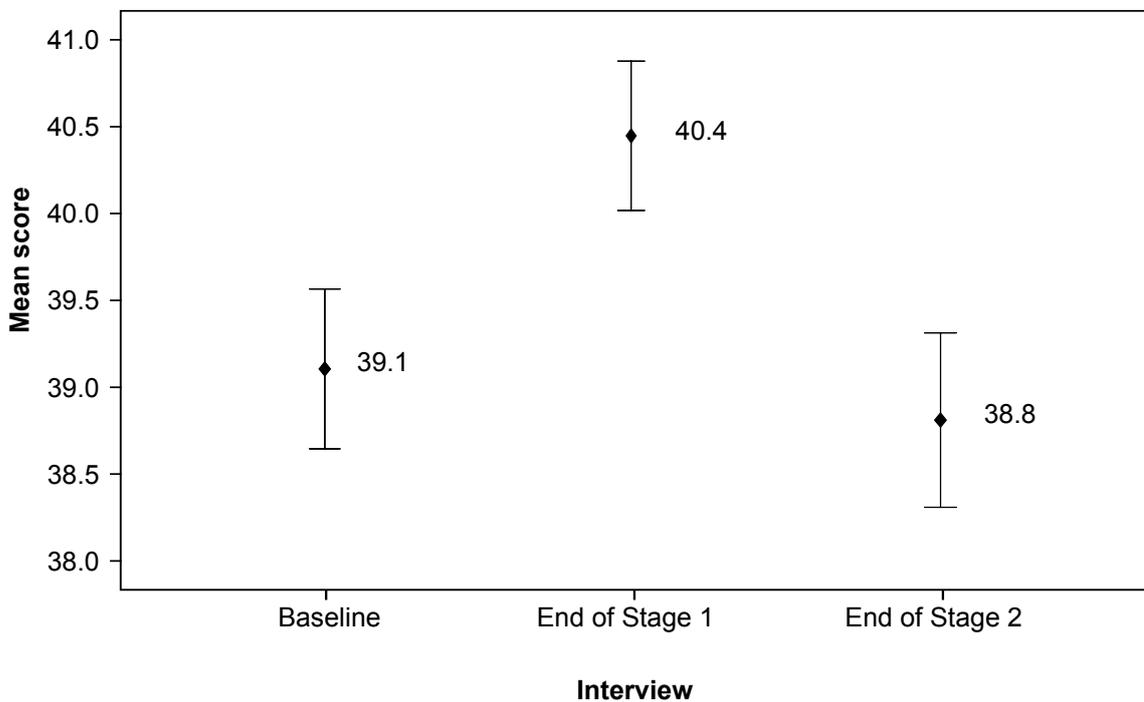
**Figure 6. Mean and standard error for Serin Treatment Readiness scores by interview stage, for those who completed Stage 1 (N = 74)**



<sup>16</sup> The Serin Treatment Readiness Scale used in this study was a 9-item questionnaire adapted from the 11-item Serin Treatment Readiness Scale (Serin & Kennedy, 1997). As such, it was not possible to use cut-off scores that had been established using the 11-item scale or to compare our data with 11-item scores in the literature.

A one-way repeated measures ANOVA was conducted to compare scores on the Serin Treatment Readiness Scale at baseline and at the end of Stages 1 and 2. A significant quadratic trend in the change in treatment readiness over time was found ( $F(1,37) = 16.10, p < .001$ ). Pair-wise comparisons revealed that treatment readiness significantly increased from the baseline to the end of Stage 1 interview ( $t(37) = 2.88, p = .007$ ; mean increase in readiness was 1.4, 95% confidence interval around the mean difference ranged from 0.4 to 2.3). Treatment readiness significantly decreased from the end of Stage 1 to the end of Stage 2 ( $t(37) = 3.11, p = .004$ ; mean decrease in readiness was 1.5, 95% confidence interval around the mean difference ranged from 0.5 to 2.5). Treatment readiness was similar at baseline and at the end of Stage 2 ( $t(37) = 0.21, p = .837$ ). Therefore, as Figure 7 shows, for this subgroup of participants, treatment readiness appears to peak at the end of Stage 1. One reason for this might be that Stage 2 involves increased contact with the outside world, and a corresponding increase in challenges. Motivation and treatment readiness is prone to fluctuation, does not always progress in a linear manner, and can be particularly influenced by environmental factors (Prochaska & DiClemente, 1986). The change in participants' treatment readiness may simply reflect their response to a new and more difficult phase of the program, as opposed to a disengagement from the program.

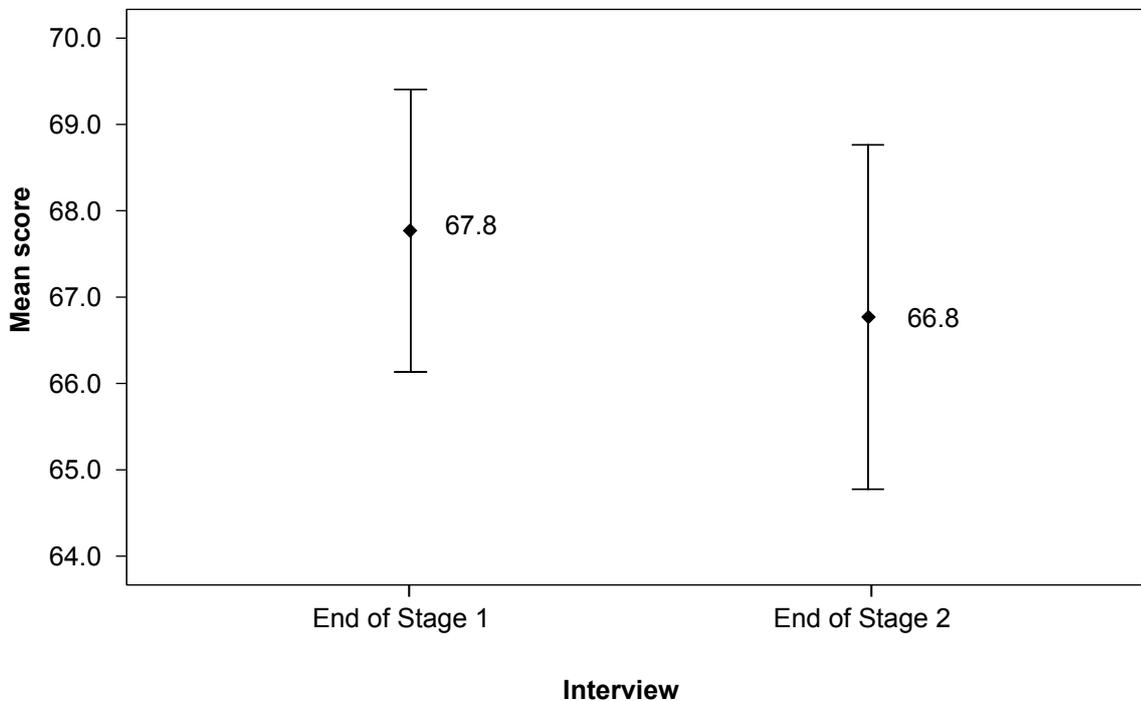
**Figure 7. Mean and standard error for Serin Treatment Readiness scores by interview stage, for those who completed Stage 2 (N = 39)**



## THERAPEUTIC ALLIANCE

As mentioned earlier, no therapeutic alliance measures were collected at baseline because participants had not had the opportunity to build a relationship with the therapist at that time. A paired *t*-test was conducted to compare total scores on the Working Alliance Inventory (WAI) at the end of Stage 1 and Stage 2 for the 39 participants who had an end of Stage 2 interview. As shown in Figure 8, there was no significant change in therapeutic alliance between Stages 1 and 2 ( $t(38) = 0.55, p = .587$ ). The total WAI scores were also broken down into the summary scores: Goals, Tasks and Bonds. Again, no significant changes in summary scores were observed across the two different time points.

**Figure 8. Mean and standard error for Working Alliance Inventory scores by interview stage, for those who completed Stage 1 (N = 38)**

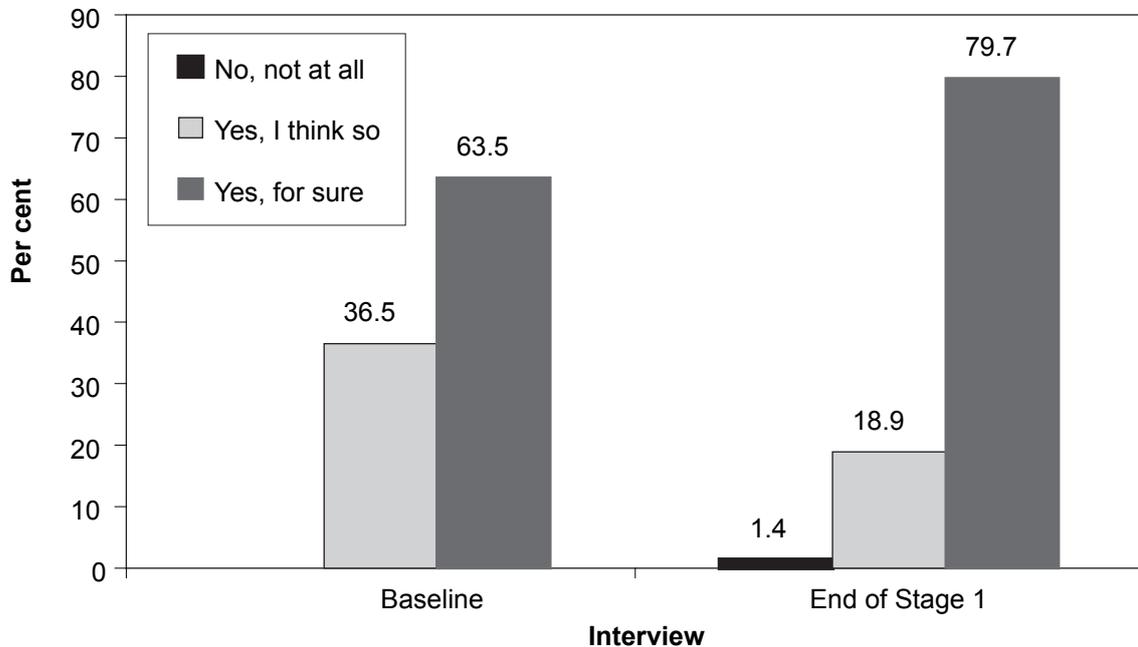


## 3.4 PROGRAM PERCEPTIONS

### PROGRAM INTEREST QUESTIONNAIRE (PIQ)

At each interview, participants were asked whether they thought the program would be of help to them. Figure 9 shows that, for the 74 participants who had an end of Stage 1 interview, the proportion of participants who responded 'yes, for sure' they think that the program will be of help to them increased from baseline to the end of Stage 1 (test of difference between proportions found  $p = .029$ ). However, for those who completed Stage 2 (N = 39), the apparent increase in the proportion of participants who responded 'yes, for sure' they think that the program will be of help, from baseline (66.7%) to the end of Stage 2 (82.1%), just failed to reach statistical significance ( $p = 0.065$ ).

**Figure 9. Differences in responses to the question "From what you know of this program, do you think it will be of help to you?" from baseline to the end of Stage 1, for those who completed Stage 1 (N = 74)**

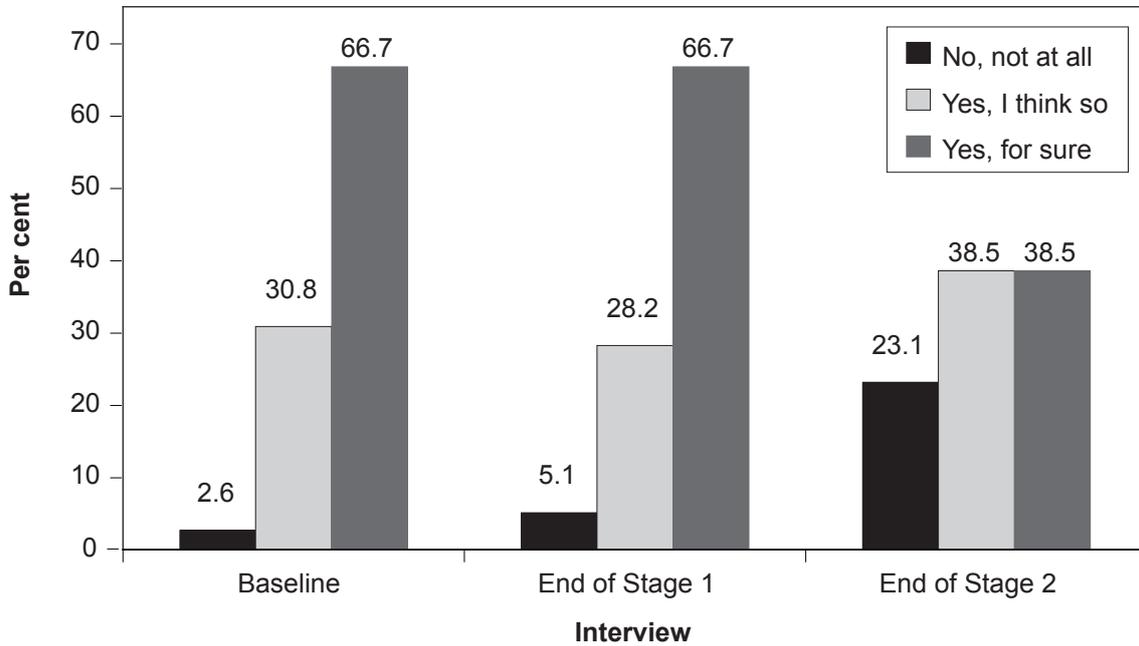


Participants were asked whether they felt they needed help to keep from going back to using drugs. Of the 74 participants who had an end of Stage 1 interview, there was no difference in the proportion of participants who responded 'yes, for sure' they needed help to keep from relapsing to drug use from baseline (59.5%) to the end of Stage 1 (50.0%; test of difference between proportions found  $p = .248$ ). As shown in Figure 10, for the 39 participants who had an end of Stage 2 interview, the proportion who responded 'yes, for sure' they needed help to keep from relapsing to drug use decreased from the end of Stage 1 (66.7%) to the end of Stage 2 (38.5%;  $p = .013$ ). There was no difference in the proportion who responded 'yes, for sure' they needed help to keep from relapsing to drug use from baseline to the end of Stage 1 ( $p > .99$ ), for those who completed Stage 2.

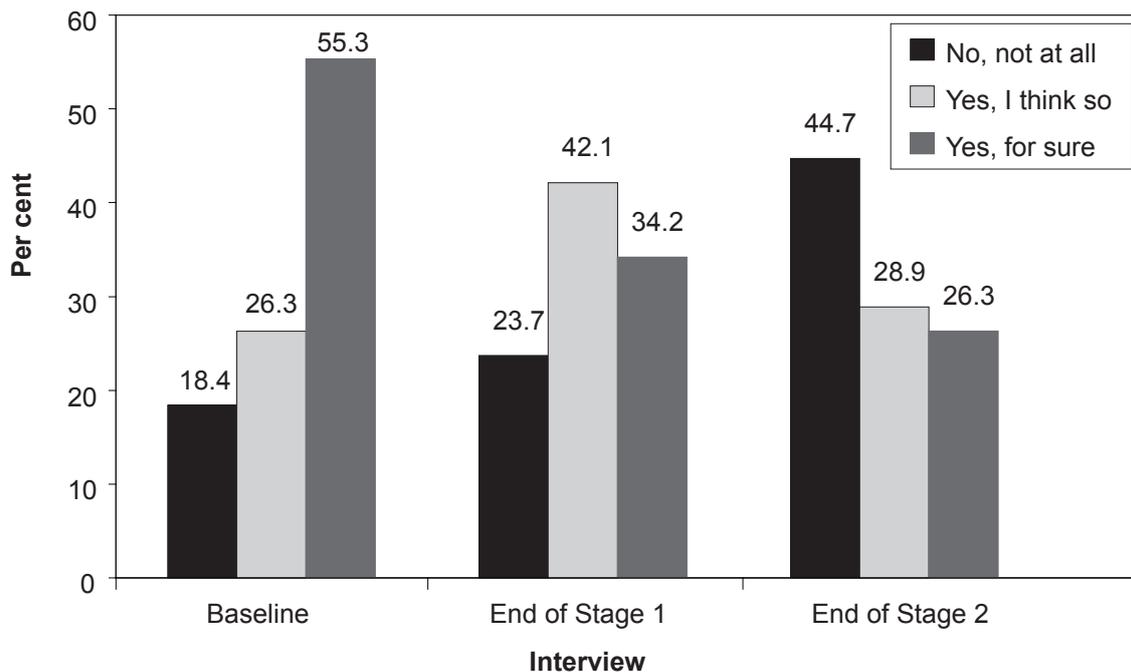
Participants were asked whether they believed that they needed help to prevent them from taking part in further criminal acts or behaviour. Of the 74 participants who had an end of Stage 1 interview, there was a decrease in the proportion of participants who responded 'yes, for sure' they needed help to prevent them from taking part in further criminal acts or behaviour from baseline (44.6%) to the end of Stage 1 (31.1%); however, this did not quite reach statistical significance (test of difference between proportions found  $p = .090$ ). As shown in Figure 11, for the 38 participants who had an end of Stage 2 interview and had completed data for this item, the proportion who responded 'yes, for sure' they needed help to keep from taking part in further criminal acts or behaviour decreased from baseline (55.3%) to the end of Stage 2 (26.3%;  $p = .010$ ). There was no difference in the proportion who responded 'yes, for sure' they needed help to keep from taking part in further criminal acts or behaviour from the end of Stage 1 (34.2%) to the end of Stage 2 (26.3%,  $p = .454$ ).

Participants were asked how they felt about attending the CDTP. This question was asked at each interview with the exception of the end of Stage 3 interview. At each interview, the proportion of participants who responded 'yes, for sure' they wanted to attend the program was greater than 90 per cent.

**Figure 10. Differences in responses to the question "Do you feel you need help to keep from going back to using drugs?" from baseline to the end of Stage 2, for those who completed Stage 2 (N = 38)**



**Figure 11. Differences in responses to the question "Do you think you need help to keep you from taking part in further criminal acts or behaviour?" from baseline to the end of Stage 2, for those who completed Stage 2 (N = 38)**



## SATISFACTION WITH ASPECTS OF THE PROGRAM AND PERCEIVED COPING SKILLS

Across the three stages in the program, participants were asked to rate how much they agreed or disagreed with a number of statements regarding aspects of the CDTP. There were five anchor points on the scale of agreement ranging from strongly disagree to strongly agree. However during analysis percentages of those who agreed and strongly agreed were combined.

As Table 6 shows:

- **Understanding program requirements:** At the beginning of Stage 1, the vast majority (95.8%) of participants agreed that they understood what was required of them on the CDTP.
- **Stage 1 Visits:** At the end of Stage 1, 64.8 per cent of participants agreed that box visits (i.e. visits where the offender and visitor cannot make contact with one another) upset them. 'Box' visits ensure that meetings between participants and visitors are non-contact and are employed to minimise the amount of drugs leaking into the centre. Further, 31.5 per cent of participants agreed that it upset them to have only one visiting time per week.
- **Being drug-free:** Across stages, participants unanimously agreed that being drug-free was an important aspect of the program.
- **Ease of CDTP stages:** from baseline to the end of Stage 2, the minority of participants agreed (baseline: 14.8%, end of Stage 1: 33.8%, end of Stage 2: 38.5%) with the statement that the stage they had just completed was easy.
- **Personal Plans:** at the end of Stages 1 and 2, 77.0 per cent and 53.9 per cent of participants, respectively, agreed that the Personal Plans were helpful.
- **Satisfaction:** at the end of Stages 1 and 2, 83.8 per cent and 79.5 per cent of participants, respectively, agreed that they were satisfied with the stage they had just completed.

**Table 6. Percentage of participants who 'agreed or strongly agreed' with statements about their satisfaction with aspects of the CDTP and their coping skills**

	Baseline (N = 95)	End of Stage 1 (N = 74)	End of Stage 2 (N = 39)
I understand what is required of me on this program	95.8		
Having only box visits in Stage 1 upset me		64.8	
Only having one visiting time per week in Stage 1 upset me		31.5	
Being drug-free is an important part of this program	100.0	100.0	100.0
This program will be easy/that stage was easy	14.8	33.8	38.5
My Stage 1,2 personal plan helped me a lot		77.0	53.9
I am satisfied with Stage 1,2 of this program		83.8	79.5
I will cope well with life in the community after finishing Stage 2 of this program		77.0	84.6
I would rather be in a mainstream gaol	2.1	4.1	0.0

- **Coping in the community:** At least three-quarters of the participants agreed they would cope well with life in the community after finishing Stage 2.
- **Preference of gaol:** Across all interviews, very few participants agreed that they would prefer mainstream gaol to the CDTP (2.1% at Baseline, 4.1% at the end of Stage 1 and 0.0% at the end of Stage 2).

At the end of Stage 2 participants were asked how confident they were about being able to stay drug-free in the community. The majority of participants were 'confident' (58.3%) or 'very confident' (36.1%) of being able to stay drug-free in the community at the end of Stage 2.

At the beginning of the program, 42 per cent of participants were on methadone and at the end of Stage 1 almost 85 per cent of these participants reported they were 'very happy' to be taken off methadone, while 3.1 per cent were 'happy', another 3.1 per cent were 'unhappy' and 9.4 per cent were 'unsure'.<sup>17</sup>

Table 7 shows the proportion of participants who indicated that they liked various aspects of the CDTP. As Table 7 illustrates, aside from the number of drug tests, the majority of participants reported that they liked various aspects of the abstinence-based nature of the CDTP (i.e. getting help for their drug problem, being drug-free, being in a drug-free gaol and being taken off drugs). About half of the participants liked the number of drug tests over the program. The majority of participants also reported that they liked the opportunities offered at each stage, such as work release, support finding a job, living in the community, training and education and support from staff. Another program aspect that most participants reported that they liked was not being in a mainstream gaol.

**Table 7. Proportion of participants reporting 'yes' they like this aspect of the program in each interview**

	Baseline (N = 95)	End of Stage 1 (N = 74)	End of Stage 2 (N = 39)
<b>Abstinence based nature of the program</b>			
Getting help for your drug problem	100.0	97.3	100.0
Being drug-free	96.8	98.6	100.0
Being in a drug-free gaol	95.8	97.3	97.4
Being taken off drugs	89.5	94.6	94.7 <sup>a</sup>
Number of drug tests	54.7	56.8	46.2
<b>Opportunities at each stage</b>			
Work release in Stage 2	100.0	98.6	89.7
Getting support finding a job			79.5
Living in the community in Stage 3	98.9	97.3	92.3
Getting training and education	98.9	98.6	100.0
Support from staff	90.5	94.6	82.1
<b>Other program aspects</b>			
Not being in a mainstream gaol	87.4	87.8	94.9
Non-contact box visits	16.8	9.7	5.1
Number of visiting times per week in Stage 1	48.4	37.1	28.2
Possibility of being regressed	29.5	25.7	15.4

<sup>a</sup> One participant did not respond to this item so N = 38.

<sup>17</sup> This may, in part, reflect the fact that referred persons who were unwilling to abstain from methadone would not have met the CDTP suitability criteria.

The programmatic aspects that the majority of participants did not like were non-contact box visits, the number of visiting times per week in Stage 1 and the possibility of being regressed. More than 70 per cent of participants disliked non-contact box visits at each interview. The proportion of participants liking the number of visiting times per week in Stage 1 seemed to decline over the program. More than 65 per cent of participants disliked the possibility of being regressed at each interview.

### 3.5 CHARACTERISTICS OF THE END OF STAGE 3 SAMPLE

Participants who reached the end of Stage 3 (N = 13) were asked about a range of factors that might act as either risk or protective factors for relapse:

- **Education:** Ninety-two per cent (n = 12) of those who had an end of Stage 3 interview reported that they were not studying at the time of the interview. Furthermore, just over half (53.8%; n = 7) reported that they did not spend any time in Stage 3 studying and 61.5 per cent (n = 8) of participants stated they were satisfied with how much time they spent studying in Stage 3.
- **Employment:** 61.5 per cent (n = 8) of participants were unemployed at the time of their end of Stage 3 interviews. The remainder were employed and worked full-time. Over a third (38.5%, n = 5) of participants were unemployed either all of the time or most of the time during Stage 3. Three-quarters (n = 10) of participants were either satisfied or very satisfied with the amount of time they had been employed while on the program.
- **Relationship conflict:** When asked how often participants had conflict with their relatives, most participants (n = 9) reported that they either never had conflict or that they only sometimes had conflict with their relatives. Furthermore, three of the eight participants who had partners reported that they never had conflict with their partner (2 rarely, 2 often and 1 sometimes had conflict with their partners). More than three-quarters (76.9%, n = 10) of participants reported that they never had conflict with friends or acquaintances. Indeed, almost half (46.2%, n = 6) of the participants reported that they spent none of the time being dissatisfied with their personal relationships during Stage 3, and 30.8 per cent (n = 4) said they were dissatisfied only 'a little' of the time.
- **Accommodation:** Over three-quarters (76.9%, n = 10) of participants stated that they had lived in one place during Stage 3. No participants lived in more than two places. While nearly two-thirds (61.5%, n = 8) of participants were 'very satisfied' or 'satisfied' with their housing arrangements during Stage 3, 38.5 per cent (n = 5) reported that they were 'very dissatisfied' with their housing arrangements.
- **Peer associations:** 77 per cent (n = 10) of participants stated that they had three or more close friends (i.e. people they felt they could rely on). Ninety-two per cent (n = 12) of participants stated that they were either 'satisfied' or 'very satisfied' that they could get support from friends if they were having problems. In terms of drugs and crime, 77 per cent (n = 10) of participants reported that either less than half (38.5%, n = 5) or none (38.5%, n = 5) of the people they had been in contact with used drugs. Sixty-two per cent (n = 8) of participants reported that the people they had been in contact with were not involved in crime, while 15.4 per cent (n = 2) said less than half were involved in crime.
- **Alcohol:** Just over 60 per cent (n = 8) of participants consumed alcohol during Stage 3 and the remainder indicated that they were abstinent.

### 3.6 TARGETED OPEN-ENDED QUESTIONS

At various interviews across the program, participants were asked open-ended questions about specific aspects of the program. As stated previously, the sample size for the baseline interviews was 95, end of Stage 1 interviews was 74, end of Stage 2 interviews was 39 and end of Stage 3 interviews was 13. Their responses to these questions are presented in this section.

#### RESIDENTIAL REHABILITATION

At the end of Stage 2, participants were asked “now that you have participated in this residential rehabilitation program: what are your views of residential rehabilitation programs?” The majority of participants were positive about rehabilitation programs in general and stated that the CDTP was particularly helpful for those who wanted to change. A few participants commented that the CDTP as a residential rehabilitation program in a correctional centre was helpful and contrasted this experience to community-based residential rehabilitation programs where they felt their needs were not addressed. In addition, two participants suggested that residential rehabilitation programs focussed too much on negative behaviour and that positive behaviour was not sufficiently rewarded. When asked: “would you participate in a community-based residential rehabilitation program, if necessary?” almost half (45.7%) of participants responded that they would not, whereas almost a third (31.4%) said that they would. The remainder were unsure.

#### PHARMACOTHERAPY

At the end of Stage 2, participants were asked: “do you think this program would be better if you had access to methadone or buprenorphine?” The vast majority (97.1%) said the program would not have been better with this access. Reasons for this revolved around the positive effects of abstaining and being drug-free (e.g. being mentally and physically stronger, having improved sleep patterns and having improved job prospects). Participants also believed that being on methadone or buprenorphine would just be reliance on another drug and likened this to being “handcuffed” to another drug. On a related note, two participants emphasised that living drug-free made them realise there is a way to live life that does not involve drugs and that this, in turn, builds confidence in maintaining that lifestyle. Finally, three participants suggested that their own cravings could increase if other participants had access to drug substitutes. When asked whether they would consider treatment using methadone or buprenorphine in the future, 85.7 per cent of participants said they would not consider it.

#### HEALTH AS A PRIORITY

At the end of Stages 2 and 3, participants were asked: “do you consider your health more of a priority now, than you did before you started this program?” and 97.2 per cent (n = 72) and 92.3 per cent (n = 12) of participants at the end of Stage 2 and 3 respectively, considered their health more of a priority than compared to when they first started the program. When asked to explain why it was more of a priority now, 24 participants and 5 participants at the end of Stage 2 and Stage 3 respectively, explained the change was a consequence of being drug-free, whereas when they were on drugs they did not care about their health, they only cared about their next “hit.” To a lesser degree, participants mentioned getting older, wanting to have a good life and family responsibilities as reasons they cared more about their health now than prior to program commencement. These reasons were consistent across Stage 2 and 3 interviews.

#### SUPERVISION

At the end of Stage 3, participants were asked: “do you think that the level of supervision you experienced throughout the program, was reasonable and fair?” Eighty-five per cent (n=11) of participants agreed that

supervision was reasonable and fair. Of those who responded 'yes' to this question, most indicated that supervision maintained a focus on behaviour change (e.g. one person reported that "it stops you from playing up") and that supervision gives extra support.

## **IMPACT OF THE PROGRAM**

When asked at the end of Stage 3: "do you feel that this treatment program has changed you and/or had an impact on your life (i.e. do you think differently about yourself and/or your life)?" participants unanimously agreed that it had (n=13). Participants were asked an open-ended question to explain the reasons for their answer. Participants made positive comments about being drug-free and made specific referrals to the benefits of developing problem-solving skills, self-awareness, decision-making skills and sorting out finances, accommodation and support mechanisms.

### **3.7 GENERAL OPEN-ENDED QUESTIONS**

Participants were also asked for their comments and suggestions regarding the CDTP in general at each of the interviews. The following issues were raised as participants progressed through the program.

#### **BOX VISITS**

Both at the baseline and end of Stage 1 interviews, participants made comments regarding non-contact box visits. Participants expressed their dislike of these visits, with several adding that non-contact meant a lack of support from family and friends, at a time when it is most needed. Some participants suggested adding contact visits in Stage 1 as a reward for positive behaviour, or adding contact visits after a certain amount of time spent in Stage 1 had elapsed or allowing contact visits under stringent supervision.

#### **SANCTIONS**

Comments regarding sanctions occurred at most interview stages. These comments included the inconsistency with which people were given sanctions stating that the rules and punishments kept changing over time, the unfairness of collective punishment and the severity of sanctions for returned very dilute drug tests and non-admitted drug use. The perceived lack of reward for positive behaviour was also mentioned and participants expressed their frustration and feelings of being let down because they expected something in return for doing 'the right thing'. Additionally, one participant questioned the value of regression, suggesting that problems be dealt with in whatever stage they are in.

#### **STAFF**

Participants mentioned issues to do with staff at the baseline and end of Stage 1 and 2 interviews. Opposing views were held regarding the staff at the CDTP. Some participants reported positive feedback in terms of the staff in general and of program staff and officers more specifically. For example, participants often stated that the staff were genuinely helpful and appeared "not to be there just for their pay cheque" and that they actually cared. On the other hand, there were mixed views about the custodial staff. A number of participants reflected positively *and* negatively on the officers. In negative comments, officers were chiefly criticised in terms of their "attitude" and treatment of participants. Specifically, officers were accused of playing "power games" like penalising participants for petty mistakes and treating participants as they are treated in mainstream gaols instigating an atmosphere of prisoners versus officers. Several participants suggested officers wear plain clothes at the Centre. While there were minimal negative comments about counsellors and program staff, some participants commented that some of the counsellors and program staff "viewed you as a number" through the program and that others "gave up on you if you stuffed up."

## EMPLOYMENT

At the end of Stage 1 and 2 interviews, several comments were made regarding the employment agency utilised by participants. Several participants expressed a need for increased access to employment, claiming that the employment agency had limited resources and suggested that they contact potential employers themselves or alternatively ask the education officer to do so. Another suggestion was to prepare participants in Stage 1 for job searching one or two months before commencing Stage 2. Participants said that work was important for their gradual re-integration into the community, for a 'kick-start' after their release to parole and for developing skills. However, frustration was expressed about having to wait a long time to get a job, with some participants reporting that they waited for months without gaining employment and that only a small number of participants in the CDTP were actually hired. One participant mentioned that some of the employed participants had their jobs set up from previous employment prior to incarceration, independent of the employment agency.

## OTHER COMMENTS

The vast majority of other comments consisted of positive responses regarding the program, with many saying the program should have been implemented years ago, that there should be more programs like it and that more people should have the chance to participate. Furthermore participants spoke positively of the insight they gained, the support they received and the atmosphere and lifestyle at the CDTCC. For instance, one participant explained, "it's a friendly environment and makes you concentrate more on parts where you go wrong and helps you see where you relapse. It makes you wiser. I'm lucky to be here to have this chance to change. I'm blessed for being here. Everything's all good." Several participants also spoke positively of the opportunities they were given by the program, with many reporting that the program is a life-changing opportunity for those who want to change (e.g. "It will change your life if you take the chance").

## 3.8 DRUG USE

Drug test data were analysed at both the unique test and at the unique person level.

### UNIQUE TESTS

Of 109 baseline drug tests, that is, before participants enter the program proper, 21.1 per cent (n = 23) were positive for non-prescribed drugs, 3.7 per cent (n = 4) were dilute, 3.7 per cent (n = 4) were inconclusive and 71.6 per cent (n = 78) were non-prescribed drug free.

A total of 14,529 non-baseline unique drug tests were conducted between 1st September 2006 and 30th September 2009. Table 8 shows the results of these drug tests by program treatment stage. Overall, the vast majority (95.7%) of the drug tests conducted during this study period were classified as 'non-prescribed drug free'. Small proportions were classified as 'positive' (257 tests, 1.8%), 'dilute' (160 tests, 1.1%) and 'inconclusive' (209 tests, 1.4%).

Of the 257 'positive' tests, 212 (82.5%) were due to the detection of non-prescribed drugs, 37 (14.4%) were due to 'very dilute' samples, and for the remaining 8 (3.1%) tests the participant failed or refused to supply a sample. Of the 887 tests conducted in Stage 3, 4.5 per cent returned a 'positive' result. In contrast, a smaller proportion of tests conducted in Stage 1 (1.3% of the 6820 Stage 1 tests) and Stage 2 (1.8% of the of the 6822 Stage 2 tests) were 'positive' (tests of difference in proportions both had  $p < .001$ ).

**Table 8. Urinalysis results by program stage on the test demand date**

Test Outcome	Stage 1		Stage 2		Stage 3		All tests	
	n	%	n	%	n	%	n	%
Positive	91	1.3	126	1.8	40	4.5	257	1.8
Dilute	65	1.0	88	1.3	7	0.8	160	1.1
Inconclusive	96	1.4	85	1.2	28	3.2	209	1.4
Non-prescribed drug free	6568	96.3	6523	95.6	812	91.5	13903	95.7
<b>Total n</b>	<b>6820</b>	<b>100.0</b>	<b>6822</b>	<b>100.0</b>	<b>887</b>	<b>100.0</b>	<b>14529</b>	<b>100.0</b>

Only one type of drug was detected for the majority (80.2%) of the samples where non-prescribed drugs were detected. Two types of drugs were detected in 11.7 per cent of the 'positive' samples and three or more drugs were detected in 8.1 per cent of the 'positive' samples. Table 9 shows the types of drugs detected across the three program stages.

**Table 9. Type of non-prescribed drug detected, by program stage and the proportion of positive test results where each drug was detected**

Type of drug detected <sup>a</sup>	Stage 1 (N = 91)		Stage 2 (N = 126)		Stage 3 (N = 40)		All tests (N = 257)	
	n	%	n	%	n	%	n	%
<b>Illicit</b>								
Cannabis	33	36.3	17	13.5	8	20.0	58	22.6
Amphetamine	2	2.2	8	6.3	4	10.0	14	5.4
Heroin	0	0.0	6	4.8	3	7.5	9	3.5
Other illicit <sup>b</sup>	0	0.0	6	4.8	5	12.5	11	4.3
<b>Licit</b>								
Buprenorphine	15	16.5	26	20.6	12	30.0	53	20.6
Morphine	2	2.2	35	27.8	14	35.0	51	19.8
Benzodiazepine	3	3.3	5	4.0	8	20.0	16	6.2
Antidepressant	7	7.7	5	4.0	0	0.0	12	4.7
Antipsychotic	10	11.0	2	1.6	0	0.0	12	4.7
Methadone	4	4.4	2	1.6	2	5.0	8	3.1
Other licit <sup>c</sup>	5	5.5	6	4.8	2	5.0	13	5.1
<b>No drug type</b>								
Unidentified	8	8.8	2	1.6	0	0.0	10	3.9
Missing <sup>d</sup>	14	15.4	29	23.0	2	5.0	45	17.5

<sup>a</sup> There are more drugs identified than the number of positive tests, as multiple drugs could be detected per positive test

<sup>b</sup> Includes cocaine, methylenedioxy methylamphetamine (MDMA), methylenedioxy ethylamphetamine (MDE)

<sup>c</sup> Includes carbamazepine, promethazine, phentermine, quinine, ibuprofen, metoclopramide, paracetamol, dextromethorphan and codeine

<sup>d</sup> Drug type was missing, as these are the 'very dilute' and 'fail/refuse to supply' test outcomes

For the 'positive' urine samples in Stage 1, cannabis was the drug most commonly detected (36.3 per cent of the 'positive' samples); this was followed by non-prescribed buprenorphine (16.5%). In Stage 2, the drug most commonly detected in positive samples was morphine<sup>18</sup> (27.8%); this was followed by failure or refusal to supply a sample or returning a very dilute sample (23.0% of positive tests results were type of drug detected was 'missing'). Buprenorphine (20.6%) was the third most commonly detected drug for positive urine tests in Stage 2. Morphine (35.0% of the positive tests in Stage 3) and buprenorphine (30.0%) were the drugs most commonly detected in Stage 3 of the program.

Given the closed nature of detention and the strict non-contact visits enforced during Stage 1 of the program, the number of positive tests returned during this stage was unexpectedly high (n = 91). This might suggest that drugs were, on occasion, filtering into the CDTCC. However, it is also possible that these positive tests reflect residual trace metabolites associated with substance use prior to entering the program. Alternatively, they could reflect residual trace metabolites associated with substance use during a later stage of treatment for those who had been regressed into Stage 1.

To investigate the first of these possibilities, that positive tests reflect residual trace metabolites associated with substance use prior to entering the program, the proportion of positive tests returned within a short time of program entry was calculated.<sup>19</sup> Of the 91 positive tests detected in Stage 1 the large majority (92.3%, n = 84) were for tests conducted more than one week after the participants' entry into the program. This data shows that the bulk of the positive tests in Stage 1 do not reflect residual trace metabolites associated with substance use prior to entering the program.

To investigate whether the detection of drugs could be explained by residual trace metabolites associated with substance use during a later stage of treatment for those who had been regressed into Stage 1, the proportion of positive tests returned from new program entrants rather than from those who had been regressed from a later treatment stage to Stage 1 was calculated. A large majority of the 91 positive test results (80.2%, n = 73) for participants in Stage 1 occurred when participants were in Stage 1 for the first time. Data does not reflect residual trace metabolites associated with substance use in a later stage of the program when allowed contact with the community. It appears the drugs were filtering into the CDTCC despite the closed nature of detention and the strict non-contact visits enforced during Stage 1 of the program.

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<sup>18</sup> Tests results showing up morphine may reflect the use of heroin because heroin use can show up as morphine after 6 to 12 hours.

<sup>19</sup> The date of program entry was defined as the date on which a participant's CDTO was made. The test demand date was taken from the Corrective Services NSW urinalysis dataset.

## UNIQUE PERSONS

By the 31st July 2009 (end of recruitment into the study), 108 offenders who had entered the CDTCC had non-baseline drug test data.<sup>20</sup> As Table 10 shows, of these 108 CDTCC participants, 66 (61.1%) participants returned at least one positive test result.

**Table 10. Participants' urinalysis results by exit type**

	Total (N = 108)		Test results			
			Any positive (n = 66; 61.1%)		No positives (n = 42; 38.9%)	
	n	%	n	% of positives	n	% of no positives
Died	2	1.9	2	3.0	0	0.0
Paroled	26	24.1	22	33.3	4	9.5
Revoked	25	23.1	20	30.3	5	11.9
Remain on program	55	50.9	22	33.3	33	78.6

As Table 10 shows, of the 66 participants who returned at least one positive test result, 2 (3.0%) died, 22 (33.3%) have been released to parole, 20 (30.3%) were revoked from the program and 22 (33.3%) remain on the program. Of the 42 participants who have never returned a positive test result, 4 (9.5%) have been released to parole, 5 (11.9%) were revoked from the program and 33 (78.6%) remain on the program.

Of the 26 participants who were paroled, 22 (84.6%) had returned at least one positive test result. Similarly, of the 25 participants who were revoked from the program, 20 (80.0%) had returned at least one positive test result. Both of the participants who died had returned at least one positive test result.<sup>21</sup>

Table 11 shows the types of drugs detected across participants. Cannabis was detected in at least one of the test samples from 22 participants, which represents 33 per cent of those who returned a positive sample. Non-prescribed morphine was detected in at least one of the test samples for 23 (34.9%) participants who returned a positive sample.<sup>22</sup> There were 26 (39.4%) participants who were missing drug type because they returned at least one test sample that was very dilute or refused/failed to supply at least one test sample.

<sup>20</sup> One participant was revoked before taking any drug tests other than their baseline drug test.

<sup>21</sup> Reminder: a positive test result can be from the detection of non-prescribed drugs, a very dilute sample or failing/refusing to supply a sample when requested.

<sup>22</sup> Tests results showing up morphine may reflect the use of heroin because heroin use can show up as morphine after 6 to 12 hours.

**Table 11. Percentage of participants with at least one positive test by type of non-prescribed drug detected (N = 66)**

Type of drug detected <sup>a</sup>	n	% of participants with a positive test (N = 66)
<b>Illicit</b>		
Cannabis	22	33.3
Amphetamine	7	10.6
Heroin	8	12.1
Other illicit <sup>b</sup>	6	9.1
<b>Licit</b>		
Morphine	23	34.9
Buprenorphine	19	28.8
Antidepressant	9	13.6
Antipsychotic	6	9.1
Methadone	6	9.1
Benzodiazepine	5	7.6
Other licit <sup>c</sup>	12	18.2
<b>No drug type</b>		
Unidentified	4	6.1
Missing <sup>d</sup>	26	39.4

<sup>a</sup> There are more drugs identified than the number of positive tests, as multiple drugs could be detected per positive test

<sup>b</sup> Includes cocaine, methylenedioxy methylamphetamine (MDMA), methylenedioxy ethylamphetamine (MDE)

<sup>c</sup> Includes carbamazepine, promethazine, phentermine, quinine, ibuprofen, metoclopramide, paracetamol, dextromethorphan and codeine

<sup>d</sup> Drug type was missing, as these are the 'very dilute' and 'fail/refuse to supply' test outcomes

## 4 DISCUSSION

The CDTP had four program objectives:

1. to provide a comprehensive program of compulsory treatment and rehabilitation under judicial supervision for drug dependent persons who repeatedly resort to criminal activity to support their dependency;
2. to effectively treat those persons for drug dependency, eliminating their illicit drug use while in the program and reducing the likelihood of relapse on release;
3. to promote the re-integration of those persons in the community; and
4. to prevent and reduce crime by reducing those persons' need to resort to criminal activity in support of their drug dependency

*(Crimes (Administration and Sentencing) Act 1999, Section 106B).*

For reasons already explained, it was impossible to evaluate the effectiveness of the program in relation to the fourth objective. The first objective to provide a program of compulsory treatment and rehabilitation for drug dependent persons was largely met once the CDTP became operational. In discussing the findings, then, we focus our attention on the second and third objectives.

Prima facie, the aim of effectively treating drug dependency appears to have been successful. The majority of unique drug tests conducted during the study period were classified as non-prescribed drug free (95.7%). Only a small proportion was classified as positive (1.8%, n = 257). It is likely, moreover, that a proportion of the positive tests were due to one incident of drug use showing up in two or more consecutive test results. The proportion of positive tests, therefore, may overstate the frequency of drug use. The aim of completely eliminating drug use while on the program, however, has clearly not been met. The majority (61.1%) of participants returned at least one positive test result (excluding their baseline drug test before participants started the program proper). It is true that cannabis, morphine and buprenorphine (rather than heroin) were the most commonly detected non-prescribed drugs. The detection of morphine, however, may signal heroin use because heroin can show up in drug tests as morphine after 6 to 12 hours.

Viewed from a research (rather than legislative policy) perspective, the high proportion of participants who tested positive at least once to non-prescribed drugs is less alarming than it might appear. The elimination of illegal drug use among chronic drug users is a very ambitious objective except in conditions where it is impossible to obtain illegal drugs (see below). Heroin addiction has often been characterized as a chronic relapsing condition, and for many addicts, it is a persistent, long-term affliction (Hser, Hoffman, Grella, & Anglin, 2001; Termorshuizen, Krol, Prins, & van Ameijden, 2005; Vaillant, 1973). Kellogg (2003) asserts that there is a high rate of relapse among alcohol and drug-dependent patients, while Owen and Marlatt (2001) maintain that only half of the patients in alcohol treatment will be likely to achieve sobriety. Prochaska and DiClemente (1986) have argued that the experience of relapse into drug use is an integral part of the process of giving up drug use. In hindsight, it might have been more realistic to set a reduction in drug use as the goal of the program rather than its elimination. Had it been possible to evaluate the CDTP against this criterion, the CDTP might have turned out (like the NSW Drug Court) to be significantly better than the available alternatives.

If elimination of drug use among *all* participants in the CDTP was an overly ambitious policy objective, the elimination of drug use among participants in Stage 1 of the program might nonetheless have reasonably been expected. After all, during Stage 1, participants are in the CDTCC (i.e. they are in detention) and visitors are prevented from making any physical contact with them. A significant number of participants in Stage 1, however, did test positive for use of illegal drugs. The positive tests could in theory have resulted from drug use prior to entry on the program but most of the tests that turned out positive for drug use were conducted more than a week after program entry. As some participants were returned to Stage 1 from Stage 2 or 3, the positive tests in Stage 1 could have resulted from drug use in Stage 2 or 3. However the bulk of the positive tests for Stage 1 involved participants who had not yet progressed to Stage 2. It is hard to avoid the conclusion that illegal drugs were filtering into the CDTCC despite the precautions taken to prevent this occurring. If the program is to continue, this is a problem that clearly needs to be addressed.

In addition to eliminating drug use among participants, the program also sought to reduce the likelihood of relapse. To properly determine whether it achieved this objective, it would have been necessary to compare participants in the CDTP with a (control) group matched on relevant particulars that did not enter the CDTP. For a number of reasons (including lack of access to information about the drug use history of offenders in the general inmate population and the small number of participants in the CDTP) it proved impossible to construct a suitable comparison group. It is therefore impossible to say whether the program reduced the likelihood of relapse into drug use. The best that can be said is that the majority of participants wanted to be on the program, thought it would be helpful and made positive comments regarding the program. Despite its coercive nature, the vast majority (84.2%) of participants appeared to consider that attending the program was voluntary. These findings suggest that participants in the program at the very least wanted to reduce their drug use. The relatively high revocation rate highlights the difficulty faced by offenders in achieving this goal.

We turn, then, to the question of offender re-integration. Although the enabling legislation does not stipulate any criteria for successful re-integration, our approach was to examine improvements in health and wellbeing. The results on measures of health and wellbeing were fairly positive. Participants who were interviewed within one month of entering the CDTP reported significantly lower physical wellbeing scores than participants interviewed more than one month after entering the CDTP. The results from the SF-12 also indicate improvements in physical and mental health from the baseline interview to the end of Stage 2. Negative affective reactions to the program declined from sentencing to baseline. Treatment readiness improved (albeit only between baseline and the end of Stage 1) and the proportion of participants who were 'sure' they needed help to prevent further involvement in crime declined from baseline to the end of Stage 2. The vast majority of respondents at the end of Stage 2 reported being confident or very confident of being able to stay drug free in the community. Just how indicative these results are of substantial and durable behavioural change is impossible to say. More importantly, the lack of a control group makes it impossible to determine whether these favourable outcomes would have occurred even without the CDTP.

Employment is an important aspect of effective social functioning. Eight of the 13 participants who reached the end of Stage 3 and were approaching their parole date reported that they were unemployed. Participants in both Stages 1 and 2 expressed frustration with the employment agency ('WISE' Employment) linked to the CDTP. 'WISE Employment' is a community service organisation that assists disadvantaged members of the community through employment and support services. Participants' comments on the agency included: "WISE has limited resources so there are not enough opportunities for work"; "there is not much support for job hunting"; "getting work is impossible, only four people got jobs through WISE in two years"; "WISE are useless"; "more needs to be done to help us get work during Stage 2"; "Work's good when we can get it. We're connected to one agency and they can only do so much"; "No one got a job through WISE since I was here".

Although this evidence raises doubts about the effectiveness of the program in finding employment for participants, the comments of participants on the issue of employment have to be placed in context. The small sample size at the end of Stage 3 makes it difficult to be sure the experiences of those interviewed are representative of participants in general. Because the study lacked a comparison group, it is impossible to say whether CDTP participants were any worse off (in terms of employment) than offenders leaving mainstream gaols. Finally, ex-offenders in general face significant barriers to gaining employment. Having a criminal record, lack of recent job experience and skill atrophy all represent substantial barriers to legal employment (Visher, Winterfield, & Coggeshall, 2005). Furthermore, international meta-analyses show that interventions to combat these barriers, in both custodial and non-custodial settings, have only had limited success (Wilson, Gallagher, Coggeshall, & MacKenzie, 1999; Wilson, Gallagher, & MacKenzie, 2000; Visher et al., 2005).

The question naturally arises as to whether, in light of the current results, the CDTP ought to be continued, abandoned or expanded. The evaluation, unfortunately, does not provide the kind of information needed to give a definitive answer to this question. In its current form the CDTP is too small to permit a rigorous assessment of its effectiveness in reducing re-offending or long-term drug use. The lack of a comparison group, moreover, makes it impossible to determine with any degree of certainty whether the positive outcomes observed in connection with the program would have occurred in its absence.

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## APPENDIX – INTERVIEW SCHEDULES

### DEMOGRAPHIC QUESTIONS (administered at baseline only)

Q1. What is your date of birth? ...../...../.....

Q2. What is your cultural background?

- <sub>1</sub> European/Caucasian
- <sub>2</sub> Asian
- <sub>3</sub> Middle Eastern
- <sub>4</sub> Aboriginal or Torres Strait Islander
- <sub>5</sub> Other (please specify) .....

Q3. What is your current relationship status?

- <sub>1</sub> Married/defacto
- <sub>2</sub> Single

Q4. What was your illicit drug (or drugs) of choice?

*(Choose multiple responses, if necessary)*

- <sub>1</sub> Heroin
- <sub>2</sub> Cocaine
- <sub>3</sub> Amphetamine
- <sub>4</sub> Benzodiazepine
- <sub>5</sub> Cannabis
- <sub>6</sub> Other opiates
- <sub>7</sub> Other drug (please specify) .....

Q5. How many times have you started each of the following treatments?

- Inpatient detoxification \_\_\_\_\_
- Outpatient detoxification \_\_\_\_\_
- Inpatient or residential rehabilitation (other than detoxification) \_\_\_\_\_
- Outpatient counselling \_\_\_\_\_
- Self-help groups such as NA \_\_\_\_\_
- Prescribed methadone \_\_\_\_\_
- Naltrexone \_\_\_\_\_
- Total N \_\_\_\_\_

Q6. How old were you when you received your first criminal conviction?

## SF-12 HEALTH SURVEY (administered at each interview)

This part of the questionnaire asks for your views about your health. Listen to each question carefully and choose the option that best describes your answer.

Q1. In general, would you say your health is .....

- <sub>1</sub> Excellent      <sub>2</sub> Very Good      <sub>3</sub> Good      <sub>4</sub> Fair      <sub>5</sub> Poor

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

Q2. Moderate activities such as moving a table, pushing a vacuum cleaner or washing clothes.

- <sub>1</sub> Limited a lot      <sub>2</sub> Limited a little      <sub>3</sub> Not limited at all

Q3. Climbing stairs, mowing lawns, playing sport or going to the gym?

- <sub>1</sub> Limited a lot      <sub>2</sub> Limited a little      <sub>3</sub> Not limited at all

Q4. During the past four weeks, have you accomplished less than you would like as a result of your physical health?

- <sub>1</sub> No      <sub>2</sub> Yes

Q5. During the past four weeks, were you limited in the kind of regular activities you do as a result of your physical health?

- <sub>1</sub> No      <sub>2</sub> Yes

Q6. During the past four weeks, have you accomplished less than you would like to as a result of any emotional problems, such as feeling depressed or anxious?

- <sub>1</sub> No      <sub>2</sub> Yes

Q7. During the past four weeks, did you not do regular activities as carefully as usual as a result of any emotional problems such as feeling depressed or anxious?

- <sub>1</sub> No      <sub>2</sub> Yes

Q8. During the past four weeks, how much did pain interfere with your regular activities, including cleaning, doing your washing and other daily chores?

- <sub>1</sub> Not at all      <sub>2</sub> Slightly      <sub>3</sub> Moderately      <sub>4</sub> Quite a bit      <sub>5</sub> Extremely

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

- <sub>1</sub> All of the time      <sub>2</sub> Most of the time      <sub>3</sub> A good bit of the time  
<sub>4</sub> Some of the time      <sub>5</sub> A little of the time      <sub>6</sub> None of the time

Q9. How much time during the past four weeks have you felt calm and peaceful?

- Q10. How much of the time during the past four weeks did you have a lot of energy?
- Q11. How much time during the past four weeks have you felt down?
- Q12. During the past four weeks, how much of the time has your physical health or emotional problems interfered with your social activities like contact with your family or getting along with other participants in the program?

### **SERIN TREATMENT READINESS SCALE (administered at each interview)**

The following questions are designed to identify how you personally feel about your drug-taking behaviour. Please listen to each question carefully and then decide whether you agree or disagree with each statement.

<sub>1</sub> Strongly disagree    <sub>2</sub> Disagree    <sub>3</sub> Unsure    <sub>4</sub> Agree    <sub>5</sub> Strongly agree

- Q1. My drug use has contributed to my current situation.
- Q2. I have at least one short-term goal and one long-term goal which I hope to achieve by completing this treatment program.
- Q3. I know that by participating in this treatment program I will be able to deal with others and future situations better.
- Q4. When I have to attend a program or meeting, I always show up and do what is required.
- Q5. Drug treatment programs can't help me.
- Q6. I believe it is possible to change my drug use behaviour.
- Q7. I feel distressed and dissatisfied with my present situation and because of this I want to succeed in this drug treatment program.
- Q8. There are important people in my life who support me when I participate in programs such as this drug treatment program.
- Q9. I am comfortable in talking about my feelings in a group situation.

### **MACARTHUR PERCEIVED COERCION SCALE (administered at baseline only)**

The following statements are about your participation in the treatment program. Please answer either yes or no to each question.

<sub>1</sub> No    <sub>2</sub> Yes    <sub>3</sub> I don't know

- Q1. I felt free to do what I wanted about participating in this treatment program.
- Q2. I chose to participate in this treatment program.
- Q3. It was my idea to participate in this treatment program.

Q4. I had a lot of control over whether I participated in this program.

Q5. I had more influence than anyone else on whether I participated in this program.

**AFFECTIVE REACTIONS TO HOPITALISATION SCALE AT SENTENCING  
(administered at baseline only)**

Q1. How did being sentenced to this treatment program make you feel?  
Did it make you feel:

	No	Yes	Don't know
Angry	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Sad	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Pleased	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Relieved	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Confused	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Frightened	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>

**AFFECTIVE REACTIONS TO HOPITALISATION SCALE AT THE TIME OF  
INTERVIEW (administered at each interview)**

Q1. Now, how do you feel about participating in this program?  
Do you feel:

	No	Yes	Don't know
Angry	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Sad	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Pleased	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Relieved	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Confused	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Frightened	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>

**PROGRAM INTEREST QUESTIONS (administered at each interview; questions 1  
and 5 excluded from end of Stage 3 interview)**

The following section includes questions about whether you would like to be involved in the program.  
Please listen to the questions and select the option that best describes your answer.

Q1. From your understanding, is attending this program a requirement or a condition of your current status?

<sub>1</sub> No                      <sub>2</sub> Yes

Q2. From what you know of this program, do you think it will be of help to you?

<sub>1</sub> No, not at all              <sub>2</sub> Yes, I think so              <sub>3</sub> Yes, for sure

Q3. Do you feel you need help to keep you from going back to using drugs?

- <sub>1</sub> No, not at all      <sub>2</sub> Yes, I think so      <sub>3</sub> Yes, for sure

Q4. Do you think you need help to keep you from taking part in further criminal acts or behaviour?

- <sub>1</sub> No, not at all      <sub>2</sub> Yes, I think so      <sub>3</sub> Yes, for sure

Q5. Now, how do you feel about attending this program?

- <sub>1</sub> I do not want to attend this program  
<sub>2</sub> I am not sure if I want to attend this program  
<sub>3</sub> For sure, I want to attend this program

**PROGRAM PERCEPTION QUESTIONS (administered at each interview; question 6 excluded from baseline and end of Stage 1 interview)**

	Strongly disagree	Disagree	Unsure	Agree	Strongly agree
Q1. This program will be easy/Stage 1,2, 3 was easy	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Q2. I am satisfied with Stage 1/2/3 of this program	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Q3. My stage 1/2/3 personal plan helped me a lot	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Q4. Being drug-free is an important part of this program	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Q5. I would rather be in a mainstream gaol	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Q6. I will cope well with life in the community after finishing Stage 2/3 of this program	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

Q7. Do you **like** the following aspects of this program?

	No	Yes	Don't know
Support from staff	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Work release in Stage 2	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Living in the community in Stage 3	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Getting help for my drug problem	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Getting training and education	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Don't have to be in mainstream gaol	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Non-contact box visits in Stage 1	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Number of visiting times per week in Stage 1	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Being taken off drugs	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Being drug-free	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Possibility of moving back to previous stage	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
The number of drug tests	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Being in a drug-free gaol	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>

Q8. Do you have any comments that you would like to make about this program? (Open-ended)

**PROGRAM PERCEPTION QUESTIONS (administered at baseline only)**

The next questions are about your perceptions of the treatment program. Listen to each one carefully and then decide whether you agree or disagree with each statement.

Q1. I understand what is required of me on this program.

- <sub>1</sub> Strongly disagree    <sub>2</sub> Disagree    <sub>3</sub> Unsure    <sub>4</sub> Agree    <sub>5</sub> Strongly agree

**PROGRAM PERCEPTION QUESTIONS (administered at end of Stage 1 interview only)**

Q1. Were you on methadone when you started this program?

- <sub>1</sub> No    <sub>2</sub> Yes

Q2. If you were on methadone, how did you feel about being taken off methadone?

- <sub>1</sub> Very unhappy    <sub>2</sub> Unhappy    <sub>3</sub> Unsure    <sub>4</sub> Happy    <sub>5</sub> Very happy

Q3. Only having one visiting time per week in Stage 1 upset me.

Strongly disagree    Disagree    Unsure    Agree    Strongly agree

<sub>1</sub>    <sub>2</sub>    <sub>3</sub>    <sub>4</sub>    <sub>5</sub>

Q4. Having only box visits in Stage 1 upset me.

<sub>1</sub>    <sub>2</sub>    <sub>3</sub>    <sub>4</sub>    <sub>5</sub>

**PROGRAM PERCEPTION QUESTIONS (administered at the end of Stage 2 only)**

- Q1. Now that you have participated in this residential rehabilitation program:
- a. What are your views of residential rehabilitation programs? (open ended)
  - b. Would you participate in a community-based residential rehabilitation program, if necessary?
    - <sub>1</sub> No
    - <sub>2</sub> Yes
    - <sub>3</sub> Don't know
- Q2. Would you consider treatment using methadone or buprenorphine in the future?
- <sub>1</sub> No
  - <sub>2</sub> Yes
  - <sub>3</sub> Don't know
- Q3. a. Do you think this program would be better if you had access to methadone or buprenorphine?
- <sub>1</sub> No
  - <sub>2</sub> Yes
- b. Why? (open ended)

**PROGRAM PERCEPTION QUESTIONS (administered at the end of Stage 2 and 3 interviews only; questions 3 and 4 only asked at the end of Stage 3 interview)**

- Q1. Now that you have participated, how confident are you that you will be able to stay drug-free in the community?
- <sub>1</sub> Not at all confident
  - <sub>2</sub> Not confident
  - <sub>3</sub> Unsure
  - <sub>4</sub> Confident
  - <sub>5</sub> Very confident
- Q2. a. Do you consider your health more of a priority now, than you did before you started this program?
- <sub>1</sub> No
  - <sub>2</sub> Yes
- b. Please explain (open ended)
- Q3. a. Do you think that the level of supervision you experienced throughout the program was reasonable and fair?
- <sub>1</sub> No
  - <sub>2</sub> Yes
- b. Please explain (open ended)

Q4. a. Do you feel that this treatment program has changed you and/or had an impact on your life (i.e. do you think differently about yourself and/or your life)?

<sub>1</sub> No

<sub>2</sub> Yes

b. Please explain (*open ended*)

### **CRIMINOGENIC MEASURES (administered at the end of Stage 3 only)**

#### **Education**

Q1. Are you currently studying?

<sub>1</sub> No

<sub>2</sub> Yes

Q2. How much of the time during Stage 3 did you spend studying?

<sub>1</sub> All of the time

<sub>2</sub> Most of the time

<sub>3</sub> A good bit of the time

<sub>4</sub> Some of the time

<sub>5</sub> A little of the time

<sub>6</sub> None of the time

Q3. How satisfied are you with the amount of study you undertook while on the program?

<sub>1</sub> N/A

<sub>2</sub> Very satisfied

<sub>3</sub> Satisfied

<sub>4</sub> Unsure

<sub>5</sub> Dissatisfied

<sub>6</sub> Very dissatisfied

#### **Employment**

Q4. Are you currently employed?

<sub>1</sub> No

<sub>2</sub> Yes

Q5. If you are currently employed, what type of employment is this?

<sub>1</sub> Full-time

<sub>2</sub> Part-time

<sub>3</sub> Casual

Q6. How much time during Stage 3 were you unemployed?

- <sub>1</sub> All of the time
- <sub>2</sub> Most of the time
- <sub>3</sub> A good bit of the time
- <sub>4</sub> Some of the time
- <sub>5</sub> A little of the time
- <sub>6</sub> None of the time

Q7. How satisfied are you with the amount of employment you had during the program?

- <sub>1</sub> N/A
- <sub>2</sub> Very satisfied
- <sub>3</sub> Satisfied
- <sub>4</sub> Unsure
- <sub>5</sub> Dissatisfied
- <sub>6</sub> Very dissatisfied

**Relationship conflict**

Q8. How often during Stage 3 did you have conflict with your relatives, including any relatives that you don't live with?

- <sub>1</sub> N/A
- <sub>2</sub> Never
- <sub>3</sub> Rarely
- <sub>4</sub> Sometimes
- <sub>5</sub> Often
- <sub>6</sub> Very often

Q9. How often during Stage 3 did you have conflict with your partner(s)?

- <sub>1</sub> N/A
- <sub>2</sub> Never
- <sub>3</sub> Rarely
- <sub>4</sub> Sometimes
- <sub>5</sub> Often
- <sub>6</sub> Very often

Q10. How often during Stage 3 did you have conflict with your acquaintances or friends?

- <sub>1</sub> N/A
- <sub>2</sub> Never
- <sub>3</sub> Rarely
- <sub>4</sub> Sometimes
- <sub>5</sub> Often
- <sub>6</sub> Very often

Q11. How much of the time during Stage 3 did you feel dissatisfied with your personal relationships? (i.e. family and/or your partner).

- <sub>1</sub> All of the time
- <sub>2</sub> Most of the time
- <sub>3</sub> A good bit of the time
- <sub>4</sub> Some of the time
- <sub>5</sub> A little of the time
- <sub>6</sub> None of the time

### **Accommodation**

Q12. How many different places did you live in during Stage 3?

- <sub>1</sub> One
- <sub>2</sub> Two
- <sub>3</sub> Three
- <sub>4</sub> Four or more

Q13. How satisfied were you with your housing arrangements during Stage 3?

- <sub>1</sub> N/A
- <sub>2</sub> Very satisfied
- <sub>3</sub> Satisfied
- <sub>4</sub> Unsure
- <sub>5</sub> Dissatisfied
- <sub>6</sub> Very dissatisfied

**Peer associations/Social functioning**

Q14. About how many close friends would you say that you have – that is, people you feel you can rely on – including your partner, if you have one?

- <sub>1</sub> Four or more
- <sub>2</sub> Three
- <sub>3</sub> Two
- <sub>4</sub> One
- <sub>5</sub> No close friends

Q15. When you are having problems, are you satisfied with the support that you get from your friends?

- <sub>1</sub> N/A
- <sub>2</sub> Very satisfied
- <sub>3</sub> Satisfied
- <sub>4</sub> Unsure
- <sub>5</sub> Dissatisfied
- <sub>6</sub> Very dissatisfied

Q16. How many of the people that you have been hanging around with use drugs? (Include partners, friends, and acquaintances that have used drugs).

- <sub>1</sub> N/A
- <sub>2</sub> All of them
- <sub>3</sub> More than half
- <sub>4</sub> About half
- <sub>5</sub> Less than half
- <sub>6</sub> None

Q17. How many of the people that you have been hanging around are involved in crime? (Include partners, friends, and acquaintances that have been engaged in crime).

- <sub>1</sub> N/A
- <sub>2</sub> All of them
- <sub>3</sub> More than half
- <sub>4</sub> About half
- <sub>5</sub> Less than half
- <sub>6</sub> None

**Alcohol**

Q18. Did you consume alcohol during Stage 3?

<sub>1</sub> No

<sub>2</sub> Yes

**WORKING ALLIANCE INVENTORY – CLIENT FORM (administered at the end of Stage 1, 2 and 3 interviews)**

Below is a list of statements about your relationship with your therapist. Consider each item carefully and indicate your level of agreement for each of the following items.

Does not  
correspond at all

<sub>1</sub>

<sub>2</sub>

<sub>3</sub>

Corresponds  
moderately

<sub>4</sub>

<sub>5</sub>

<sub>6</sub>

Corresponds  
exactly

<sub>7</sub>

Q1. My therapist and I agree about the things I will need to do in therapy to help improve my situation.

Q2. What I am doing in therapy gives me new ways of looking at my problem.

Q3. I believe my therapist likes me.

Q4. My therapist does not understand what I am trying to accomplish in therapy.

Q5. I am confident in my therapist's ability to help me.

Q6. My therapist and I are working towards mutually agreed upon goals.

Q7. I feel that my therapist appreciates me.

Q8. We agree on what is important for me to work on.

Q9. My therapist and I trust one another.

Q10. My therapist and I have different ideas on what my problems are.

Q11. We have established a good understanding of the kind of changes that would be good for me.

Q12. I believe the way we are working with my problem is correct.