

DRUG POLICY MODELLING PROGRAM
MONOGRAPH 25

**EVALUATION OF AUSTRALIAN CAPITAL
TERRITORY DRUG DIVERSION
PROGRAMS**

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THE DRUG MODELLING POLICY PROGRAM

This monograph forms part of the Drug Policy Modelling Program (DPMP) Monograph Series.

Drugs are a major social problem and are inextricably linked to the major socio-economic issues of our time. Our current drug policies are inadequate and governments are not getting the best returns on their investment. There are a number of reasons why: there is a lack of evidence upon which to base policies; the evidence that does exist is not necessarily analysed and used in policy decision-making; we do not have adequate approaches or models to help policy-makers make good decisions about dealing with drug problems; and drug policy is a highly complicated and politicised arena.

The aim of the Drug Policy Modelling Program (DPMP) is to create valuable new drug policy insights, ideas and interventions that will allow Australia to respond with alacrity and success to illicit drug use. DPMP addresses drug policy using a comprehensive approach that includes consideration of law enforcement, prevention, treatment and harm reduction. The dynamic interaction between policy options is an essential component in understanding best investment in drug policy.

DPMP conducts rigorous research that provides independent, balanced, non-partisan policy analysis. The areas of work include: developing the evidence-base for policy; developing, implementing and evaluating dynamic policy-relevant models of drug issues; and studying policy-making processes in Australia.

Monographs in the series are:

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19. Media reporting on illicit drugs in Australia: Trends and impacts on youth attitudes to illicit drug use
20. Cannabis use disorder treatment and associated health care costs in New South Wales, 2007
21. An assessment of illicit drug policy in Australia (1985 to 2010): Themes and trends
22. Legal thresholds for serious drug offences: Expert advice to the ACT on determining amounts for trafficable, commercial and large commercial drug offences
23. Prevalence of and interventions for mental health and alcohol and other drug problems amongst the gay, lesbian, bisexual and transgender community: A review of the literature
24. Government drug policy expenditure in Australia – 2009/10
25. Evaluation of Australian Capital Territory Drug Diversion Programs

DPMP strives to generate new policies, new ways of making policy and new policy activity and evaluation. Ultimately our program of work aims to generate effective new illicit drug policy in Australia. I hope this Monograph contributes to Australian drug policy and that you find it informative and useful.



Alison Ritter

Director, DPMP

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TABLE OF CONTENTS

Executive Summary	1
Introduction	10
Drug and alcohol use in the ACT.....	12
Criminal justice responses in the ACT.....	15
Legislative and policy context in the ACT	15
Legislation.....	15
ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014.....	16
Emerging policy directions: Diversion and early intervention for young people	17
Attorney General’s review of drug trafficking thresholds.....	20
Reforms to infringement schemes and other criminal justice arenas	20
Methods	22
Component 1: Conceptual map of current system	22
Component 2: Resources - costing the resource implications of the ACT drug diversion system.....	22
Component 3: Evaluation Roadmap.....	23
Component 4: Future system: opportunities for system improvement.....	23
Results	24
Conceptualising the ACT AOD diversion system	24
AOD diversion goals	24
The ACT AOD diversion programs: history, objectives, eligibility criteria and governing directives	25
Conceptual maps of the ACT drug diversion system	33
Data on program referrals and throughput in 2010/11	36
Program referrals.....	36
Throughput of diverted offenders.....	41
CADAS knowns and unknowns	45
Trends from 2001/02 to 2010/11	46
Program reach.....	48
Impact on diverted clients.....	51
Resource flows.....	52
General sources of funding.....	54
Resource costs by program.....	54
Summary of resource flows.....	60
An Evaluation Roadmap.....	62
Purpose	62
Evaluability assessment.....	62
Outline of the Evaluation Roadmap at the system level	63

Strengths and challenges with the ACT drug diversion system	77
Strengths.....	77
Challenges.....	79
Ways forward and recommendations.....	89
System level recommendations	89
Program level recommendations	91
References	96
Appendix A: Roundtable participants	102
Appendix B: Timeline of key diversion related events in the ACT	104
Appendix C: Procedures for ACT AOD Diversion Programs	106
Appendix D: Outline of a proposed evaluation of the Youth Drug and Alcohol Court	113
Appendix E: Some key monitoring and evaluation indicators for SCON, PED, EIPP and CADAS	119
Appendix F: Evidence on school drug education.....	123
Appendix G: Comparison of SCON scheme with other cannabis expiation schemes	126
Appendix H: Lessons from other court diversion programs	128

LIST OF FIGURES

Figure 1: Trends in daily drinking status in the ACT and Australia amongst people aged 14 years and over, 2001-2010	12
Figure 2: Trends in recent use of any illicit substance in ACT and Australia amongst people aged 14 and over, 1998 – 2010.....	13
Figure 3: Conceptual map of ACT AOD police diversion.....	34
Figure 4: Conceptual map of ACT AOD court diversion.....	35
Figure 5: EIPP referrals by month, Jan-Dec 2011	37
Figure 6: Quantity of cannabis seized on offenders diverted to PED and SCON for cannabis possession in 2010/11, by program.....	38
Figure 7: Age of PED and CADAS referrals, 2010/11	40
Figure 8: Response of AOD offenders issued with SCONs in 2010/11, by mode.....	42
Figure 9: Percentage referrals/assessments/treatment completions for AOD offenders referred through EIPP, PED and CADAS, 2010/11.....	42
Figure 10: Distribution of treatment provision* for PED and CADAS, 2010/11	44
Figure 11: Trends in the total number of referrals to the ACT drug diversion system, 2001/02 to 2010/11	46
Figure 12: Trends in the number of referrals to the ACT drug diversion system, by program, 2001/02-2010/11.....	47
Figure 13: Potential reach of court drug diversion to eligible AOD-related offenders, comparing reach of the ACT CADAS in 2008/09, 2009/10 and 2010/11, and the NSW MERIT program in 2009.....	51
Figure 14: Major events to which EIPP diversion officers have attended versus number of young people referred from the event during 2011 and 2012.....	81
Figure 15: Number of referrals to CADAS, compared to changes in Magistrates (2001/02 to 2011/12).....	87

LIST OF TABLES

Table 1: Recent use of an illicit substance in the ACT and Australia amongst people aged 14 and over, 2010, by drug	14
Table 2: Recent use of an illicit substance in the ACT and Australia amongst people aged 14 and over, 2010, by sex.....	14
Table 3: Recent use of an illicit substance in the ACT and Australia amongst people aged 14 and over, 2010, by age.....	14
Table 4: Number of arrests (consumer, provider), in the ACT, 2009/10, by drug	15
Table 5: Current ACT legal thresholds as per Criminal Code Regulation 2005 for trafficable, commercial and large commercial quantities, by drug type and threshold category (pure drug).16	
Table 6: Some of the actions and lead agencies for the ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014.....	17
Table 7: Summary of key stakeholders in the ACT AOD diversion system and their roles	32

Table 8: AOD and AOD-related offenders referred to ACT police and court diversion programs in 2010/11, by program	36
Table 9: EIPP offence at point of referral – Dec 2010-Dec 2011.....	37
Table 10: PED offence at point of referral – 2010/11, by drug type	38
Table 11: CADAS offence at point of referral in 2010/11.....	39
Table 12: Gender of referrals, EIPP, PED and CADAS, 2010/11	39
Table 13: Aboriginal and Torres Strait Islander (ATSI) status of referrals, EIPP, PED and CADAS, 2010/11	40
Table 14: Primary drug of concern, EIPP, PED and CADAS, 2010/11	41
Table 15: Throughput of AOD offenders issued with SCONS, 2010/11	41
Table 16: No. referrals/assessments/treatment engagements/treatment completions for AOD offenders referred through PED and CADAS, by youth and adults, 2010/11	43
Table 17: EIPP, PED & CADAS treatment utilisation in 2010/11, by treatment type and age.....	44
Table 18: Referral routes for CADAS in 2010/11, by age, number and percentage.....	45
Table 19: Trends in treatment completion for PED and CADAS, 2007/08 to 2010/11.....	48
Table 20: Charges for juvenile alcohol offences – purchase, possession or consumption of liquor – by clearance mode, Dec 2010-Dec 2011	48
Table 21: Number of consumer arrests versus number of diversions by drug type.....	49
Table 22: Number of offences committed by CADAS clients, number of offences in the ACT courts in 2010/11 and estimated number of offences that were attributed to AOD use.....	50
Table 23: Incidence of any recorded subsequent offending for diverted clients, by program.....	52
Table 24: SCONS compliance and subsequent responses	55
Table 25: SCON resource flows, 2010/11 AUD	56
Table 26: Costs related to PED, 2010/11 AUD	57
Table 27: EIPP resource flows, 2010/11 AUD	59
Table 28: Court Alcohol and Drug Assessment Service resource flows, 2010/11 AUD	60
Table 29: Total program cost and cost per completed referral in 2010/11 (SCON, PED and EIPP)	60
Table 30: A generic rubric for converting descriptive data into absolute determinations of merit	75
Table 31: Hypothetical costs of increasing use of non-therapeutic police diversion in the ACT.....	83
Table 32: Summary of ACT diversion program reach, by target AOD population	85
Table 33: Threshold quantities, penalties and payment options under all Australian cannabis infringement notice schemes.....	126

EXECUTIVE SUMMARY

Diversion refers to a variety of programs which divert alcohol and other drug (AOD) users into education and treatment responses or away from criminal justice system responses. Diversion has become one of the most used policy interventions in Australia (Hughes and Ritter 2008; Ritter et al. 2011). Once seen as controversial (Hughes 2009), it is now deemed an increasingly pragmatic response: increasing the capacity to reduce subsequent offending, reduce drug use and/or harmful use and decrease criminal justice costs.

Relative to other states and territories, the Australian Capital Territory (ACT) has been a leader in drug diversion provision; the first jurisdiction to introduce a court drug diversion program (1989) and the second to introduce civil penalties for cannabis possession (1992). This report outlines an evaluation of the ACT AOD diversion programs commissioned by the ACT Health Directorate. It was conducted by the Drug Policy Modelling Program, National Drug and Alcohol Research Centre and the ACT based consultancy Social Evaluation and Research in 2012. It used a systems approach, built on dialogue methods and incorporated collection of resources data and the development of a robust evaluation plan. The evaluation focussed on how the system of five programs operates together, rather than merely the inputs and outcomes of individual programs. This is a different approach to traditional methods of evaluation, and is based on the recognition that the outcomes from programs are often more affected by the intersections of programs, than any one individual program.

Our work entailed the following components and associated questions:

1. Conceptual map of current system: What is the current map of the ACT drug diversion system in its entirety taking into account its contexts and the full range of programs? How are the programs delineated? How do clients move around the system? What outputs are being attained?
2. Resources: What resources are being allocated and what are the costs of service provision?
3. Evaluation roadmap: What indicators and evaluation designs can be established so as to assess implementation, outputs and outcomes (positive and negative, intended and unintended) from the ACT drug diversion system?
4. Future system: Where can improvements be made, including but not limited to program access, program barriers to be overcome, referral systems, program components and so on?

Key findings

The ACT AOD diversion system has changed significantly since the first AOD diversion program was introduced. The two most noted changes include the adoption of two new programs in 2010 and 2011. This means that as of 2012 there are five diversion programs in operation: these cross police, health and courts and target alcohol, illicit drugs and AOD-related offenders. The 5 programs are:

- Simple Cannabis Offence Notice (SCON) Scheme
 - Established in 1989
 - \$100 fine issued by police, payable within 60 days for cannabis possession or cultivation
 - Threshold amount: 25 grams cannabis or 2 non-hydroponic plants

- Police Early Intervention and Diversion (PED)
 - Introduced December 2001 through the Illicit Drug Diversion Initiative
 - Police referral to assessment and education or treatment for possession of cannabis, other illicit drugs or illicit possession of a licit drug (not alcohol)
 - Threshold amount: cannabis = 25 grams or 2 non-hydroponic plants; other illicit drugs = 2 ‘ecstasy’ pills or 0.5 pure grams of heroin, amphetamine or cocaine (25% of the trafficable amount as per the Criminal Code Regulation 2005 (ACT))
- Early Intervention Pilot Program (EIPP)
 - Introduced July 2010 as part of the National Binge Drinking Strategy
 - Police referral for education and support of young people aged under 18 years who are found to be intoxicated or in possession of or consuming alcohol
- Court Alcohol and Drug Assessment Scheme (CADAS)
 - Introduced October 2000 as a pilot program by the Alcohol and Drug Service and Chief Magistrate Cahil
 - A pre-sentencing and sentencing assessment/treatment option to engage clients charged with AOD-related offences
- Youth Drug and Alcohol Court (YDAC)
 - Introduced September 2011 by the Chief and Children’s Court Magistrates
 - A pre-sentencing program of the Children’s Court that utilises judicial and therapeutic interventions to address AOD and other needs of children and young people who may otherwise be imprisoned

How do the programs work together?

The ACT stakeholders involved in our evaluation concurred that the ACT drug diversion system has two primary objectives:

1. To divert drug offenders away from the criminal justice system
2. To divert drug and drug-related offenders into:
 - a) Contact with the ACT AOD treatment system
 - b) Education
 - c) Assessment and treatment

The SCON program is closest to the first objective, while the others work towards both objectives.

The system involves a wide array of stakeholders. At its most simple, the key stakeholders are sworn police and unsworn police diversion officers (for the SCON diversion program). For the EIPP and PED programs, the stakeholders include the above plus treatment assessors and providers. At its most diverse, the system involves Judges and Magistrates, Youth Justice, Director of Public Prosecutions (DPP), legal representatives (particularly LegalAid ACT), Alcohol and Drug Services (ADS) assessors and treatment providers, and representatives from associated health services such as mental health, housing, employment and so on. The different objectives and stakeholders add to the complexity of this system, hence a key question is to what extent and how do the programs and key stakeholders intersect and/or work together (and what are the avenues where they conflict)?

For the police diversion programs:

- Referral routes are relatively streamlined with one route into and out of programs. The main exception is for cannabis offenders, who have two routes for diversion: through SCON or PED, and can even be sent from one program to another if they are non-compliant. That said, police directives from June 2010 prioritise PED over SCON.
- For PED and EIPP, connections between police and health are fostered by an online referral system, SupportLink. This notifies diversion assessors in the Alcohol and Drug Services (ADS) of new referrals, often within hours of collecting an offender, and enables appointments to be swiftly established.

For the court diversion programs:

- Referral routes are more diverse particularly for CADAS, with offenders able to be referred by the Magistrates Court, Supreme Court, Children's Court, Youth Justice, or from a pre-sentence CADAS option to a sentence CADAS option. For example, 82.7% of young people referred to CADAS in 2010/11 were referred by youth justice (with the remainder through the Children's and Supreme Court). For adults, 62.1% of adults were referred by Magistrates Court and 37.9% through the Supreme Court.
- Relative to the police diversion programs, getting into CADAS and YDAC programs requires many more steps, and contact with different stakeholders. While this increases the potential that offenders will be referred but not engage with AOD treatment, strong collaborative working relationships and close follow up mean that the vast majority of referred offenders in the ACT end up in AOD treatment. Unlike the police programs, there are different models afforded to diverted clients – both in program length (e.g. a one off CADAS assessment or a 12 month period of CADAS assisted treatment and case management) and/or the nature of the program plan (e.g. whether it is AOD treatment specific, or also addresses other offender needs).
- Relative to the police system, time between referrals and assessment/ treatment may be more delayed. Moreover, our court key informants suggested the potential for delays has increased since June 2010 when due to the absence of a court facility that could meet OHS requirements CADAS assessors relocated offices outside the court complex. While historically the CADAS defendant could see the magistrate/judge, attend a CADAS assessment, return back to the magistrate/judge and be released on condition of CADAS-assisted treatment all on the same day, with the relocation of CADAS offices there is increased potential for a delay in these steps: particularly in the time taken to get back to see the magistrate/judge.

Referrals and throughput in 2010/11

In 2010/11 there were a total of 555 referrals into the ACT drug diversion system (across the programs of SCON, PED, EIPP and CADAS – YDAC was not operational at that time). The two largest sources of referral were the EIPP program (28%) and CADAS program (32%). However, 68.1% of all referrals were from the police programs.

Patterns of referrals, completion and treatment varied across the programs, particularly the SCON program compared with the programs that divert offenders for AOD assessment and treatment (PED, EIPP and CADAS).

- For SCON program – 59.6% of the minor cannabis offenders issued with a SCON paid within 60 days. This meant 40.4% required at least some form of follow up, including 14.9% who were forwarded to court.
- For the PED, EIPP and CADAS programs there were very high rates of assessment of referred offenders (91.0-92.5%).
- Overall rates of treatment completion were substantially lower for those referred to CADAS (44.1% compared to 91.0-92.5% for PED and EIPP). This appears to reflect, in part, a rise in CADAS being used for assessments only, as CADAS offenders who were engaged in treatment had a very high likelihood of treatment completion (83.9%).
- In accordance with the diversion program requirements, the nature of that treatment differed: 100% EIPP clients received assessment and education, 100% PED clients received assessment and education or assessment and counselling; and CADAS clients received in the main a combination of assessment, counselling, residential rehabilitation and/or pharmacotherapy.

Comparing referrals between 2001/02 and 2010/11 a number of findings were clear:

- The total number of referrals into the ACT drug diversion system has remained fairly stable (500-600 per year).
- The pattern of referrals by programs has changed significantly. Most notably, from 2002/03 to 2010/11 CADAS referrals have decreased by 50% and PED referrals have increased by 188%. CADAS referrals moreover have dropped particularly significantly in the last 24 months: from 263 in 2008/09 to 177 in 2010/11. The decline in CADAS referrals appears attributable to multiple factors, including a loss of champions for CADAS in the courts (a by-product of staff turnover) and a lack of suitable court facilities to house CADAS assessors (see pages 88-90 for details).
- The overall rate of referral and treatment for PED has remained high: this is a notable achievement given the 188% increase in referrals.
- The percentage completing CADAS treatment increased in 2010/11, reversing the earlier downward trend. This suggests that while referrals to CADAS have declined, more intensive work is being done with the people who are engaged in treatment.

Program reach for 2010/11

To what extent are the programs being fully utilised? One way of assessing this is to examine the size of the potential eligible population, and compare that with the actual referral numbers into the programs ('program reach'). There are caveats with this approach (see pages 50 to 53 for details). Due to the overlap in client pools of PED and the SCON scheme we consider the program reach of these together.

- Simple Cannabis Offence Notice (SCON) Scheme and Police Early Intervention and Diversion (PED)
 - For cannabis, 70.9% of eligible offenders are dealt with through PED or SCON.
 - For heroin, methamphetamine, ecstasy and cocaine, 0-7.9% of eligible offenders receive PED.
- Early Intervention Pilot Program (EIPP)
 - For young, alcohol infringers, 82.9% of eligible offenders received EIPP.

- Court Alcohol and Drug Assessment Scheme (CADAS)
 - 16.2% of eligible offenders in court receive CADAS. This is double the equivalent population diverted through the NSW court drug diversion scheme – MERIT (8.3%), but has declined since 2008/09 (24%).

Resource flows

Assessments of resources included police time, diversion staff (police and health), treatment costs where relevant, and any additional court or correctional involvement (see pages 54 to 63 for full details). Complexities in CADAS meant this was not able to be fully costed at this time. The average cost per referral and per completed referral ¹ is outlined below. SCON is the cheapest of the police diversion programs, and EIPP the most expensive. Costs by comparison for a criminal justice response are \$1,640-1,900 – greater than the cost of a SCON referral, but less than a PED or EIPP referral.

Average costs per referral and completed referral in 2010/11 (AUD)

Program	Average cost per referral	Average cost per completed referral
SCON	\$1067	\$1337
PED	\$2011	\$2173
EIPP	\$2215	\$2415

Summary: Referrals, reach and cost in 2010/11

Program	No. referrals	Reach	Cost per completed referral
SCON	114	70.9% cannabis	\$1337
PED	107	<7.9% for other illicit drugs	\$2173
EIPP	157	82.9%	\$2415
CADAS	177	16.2%	n.a.
YDAC	n.a.	n.a.	n.a.

Summary: Throughput in 2010/11

Diversion away from the CJS	% paid	% sent to court
SCON	59.6%	14.9%
Diversion into education/treatment	% assessed	% complete
PED	92.5%	92.5%
EIPP	91.0%	91.0%
CADAS	91.0%	44.1%
YDAC	n.a.	n.a.

Impacts per referral

While there is good knowledge on current referrals and throughputs, and the cost per referral have been calculated for this evaluation, the ACT has scant data on the outcomes of the system, individual programs, or client groups within programs. The best available data is on subsequent offending, albeit even this does not take into account pre-existing levels of offending. A key unknown thus remains whether the additional expense of a diversion into education/treatment is translating into impacts on future drug use and/or offending, and to what extent the impacts differ across the programs. It is for this reason that developing an Evaluation Roadmap was a core component of this project.

¹ That is the average costs of the program to achieve a completion; averaged over those who complete the program and/or are known to have been dealt with through other means. This takes into account the costs that may accrue for following up non-completers, including non-paying SCON offenders who are sent to court.

Evaluation roadmap

An evaluability assessment has been undertaken, concluding that the ACT has the capacity to build a sustainable evaluation system for its diversion program and to implement this into the future. The roadmap outlines key steps towards improving system and program capacity to assess impacts now and into the future. Adopting the roadmap will necessitate a number of decisions be made, including deciding who are the most relevant stakeholders who should be involved and the questions that the ACT want to be able to answer.

Strengths and challenges:

There are a lot of strengths about the ACT AOD diversion system, including:

- the breadth of diversionary options;
- high rates of referrals for most programs;
- the adaptability of the system/system players to perceived gaps/needs, including the recent adoption of EIPP and YDAC as strategies to target young AOD offenders;
- the good will/enthusiasm of key stakeholders, which increases capacity to deal with complex clients and system challenges;
- the streamlined referral process between police and health;
- the use of a centralised assessment and treatment agency, through which all health referrals are processed;
- the high rates of treatment assessment and completion.

Yet like all systems there are also challenges, at both the system level and program level. Some appear exacerbated by changes outside of the ACT AOD diversion system (for example changes within the youth justice system). Notable challenges at the system level include:

- Lack of adequate goals and direction for the ACT drug diversion system, including emphasis upon increasing referrals, without specification of to what extent referrals ought translate to benefits for clients or the system, or system needs for attaining these objectives;
- Increasing use of programs (and scarce program resources) for activities that do not fit the primary goals of the ACT AOD diversion system, including school drug education, community education and youth justice protocols leading to CADAS assessments for young offenders regardless of whether they are being diverted or not;
- Gaps in system knowledge and siloed knowledge, for example clients in police programs for which no known criminal justice outcomes were available (e.g. whether they were subsequently charged or not); Potentially resolvable frustrations about program operations;
- Lack of adequate data collection and skills in analysis, particularly about program impacts. One example of missing data was outcome measures (such as drug use and criminal behaviour in the 3, 6 and 12 months following each of the diversion program interventions);
- Evidence of a potential disconnect between drug diversion and broader system changes in the ACT, for example in ongoing discussions about the youth justice system in the ACT there was a lack of recognition of the role of drug diversion for many young offenders.

Challenges at the program level included:

- Low police support for SCON and low compliance with the SCON scheme;
- Low referrals through PED for possession of drugs other than cannabis;
- The high expense of the EIPP program, with it being the most resource intensive of the police diversion programs, least emphasis upon utilizing sworn police officers' time to undertake the referral process and greatest emphasis upon using the program for community education and school drug education;
- Lack of awareness of CADAS in the courts, DPP and Legal AID ACT, geographical barriers to accessing CADAS assessors in the courts and confusion over what is and is not CADAS.

Recommendations

In considering all of the data collected over the course of the evaluation, stakeholder input, program costs, strengths and barriers, the following recommendations have emerged. The set of recommendations is designed to increase the capacity of the ACT AOD diversion system to build upon its strengths, and minimise the most noted system barriers. Adopting these will cement the ACT at the forefront of Australian and potentially international drug diversion system design.

System level

1. Document a comprehensive ACT AOD diversion strategy

Eleven years post the COAG-ACT IDDI agreement the ACT needs an AOD diversion strategy to provide vision and direction. This will remind stakeholders why AOD diversion is important, the key players, how it operates and both system level and individual level targets to maximise goal attainment.

2. Establish a facilitator position for the whole ACT AOD diversion system

While there is an existing ADS Diversion Manager who works well across 4 of 5 programs, there are an increasing number of protocols, procedures and program changes that warrant a facilitator position. The facilitator position would be responsible for system improvements, information exchange, facilitating review of trends in referral patterns, establishing forums of discussion to highlight program successes, coordinating a workforce development strategy, and ensuring diversion has the high profile and recognition within the ACT that it deserves.

3. Refocus all programs on drug diversion

The rise in 'program creep' across many different parts of the system e.g. programs being utilised for community education and school drug education puts additional strain on the system and dilutes resources. All programs must be refocused onto drug diversion, so as to ensure that 'diversion' resources are used for the central and agreed objectives of the system.

4. Establish an improved capacity for data management and evaluation of the AOD diversion system in the ACT

Gaps in outcome data prevent many key questions from being answered. The evaluation roadmap has been established to overcome this. Implementing this is critical so that current and future questions can be answered.

Program level

5. Reform the Simple Cannabis Offence Notice (SCON) payment system to bring it in line with other infringement schemes in the ACT

The SCON system has ongoing problems with non-payment. Changes are warranted to the payment system. Specifically we recommend that the payment system be dealt with as per other ACT infringement notices, particularly Criminal Infringement Notices with online payment options.

6. Increase Police Early Diversion (PED) thresholds for maximum quantity of heroin, methamphetamine, ecstasy and cocaine that can be possessed

While there were 107 offenders diverted through PED in 2010/11, only 11 were diverted for possession of drugs other than cannabis. Indeed, of all types of drug and drug-related offenders in the ACT system, individuals found in possession of ecstasy, cocaine, methamphetamine and heroin are the least likely to be diverted. The low thresholds for these drugs and conservative application of thresholds by ACT Policing creates a need to either increase the maximum quantity that can be possessed or remove reference to thresholds entirely.

7. Build a less resource intensive and more sustainable Early Intervention Pilot Program (EIPP)

While a youth oriented alcohol diversion program is an important addition for the ACT, the high cost of the program and Commonwealth funding constraints means that a less resource intensive and more sustainable EIPP is required. One area for cost improvement is police processing of EIPP offenders. Sworn officers should be instructed to process EIPP offenders themselves, rather than relying on EIPP diversion officers to do the referrals for them. Moreover, EIPP diversion officer involvement in school-based information sessions should be dropped or funded from other sources.

8. Re-define and re-launch the Court Alcohol and Drug Assessment Scheme (CADAS)

The declining referrals to CADAS, confusion amongst key stakeholders and large numbers of changes in recent years demands efforts to rebuild legitimacy of the CADAS program. Key tasks include deciding whether (as per our advice) all current CADAS models are to be retained, and if so, clarifying goals and processes for each and re-promoting the new CADAS options amongst all affected stakeholders.

9. Adopt short and long term solutions to get Court Alcohol and Drug Assessment Scheme (CADAS) assessors into the ACT courts

The absence of CADAS assessors from the courts due to lack of suitable accommodation has reduced awareness of the program and the number of referrals. Getting CADAS assessors back into the ACT Courts is thus a top priority. The ideal, but long term solution is for dedicated space in the new ACT Supreme Court. Plans are in the final stages, hence if desired this must be actioned swiftly. The short term solution is for CADAS to team up with ACT Mental Health Court Assessment and Liaison Service to conduct daily assessments in court cells. This short-term solution will not cater for every eventuality, for example offenders not in cells, which reinforces why the long-term solution warrants prioritisation.

10. Establish by the end of 2012 performance indicators and data systems for the Youth Drug and Alcohol Court (YDAC), and initiate work on developing an evaluation strategy for implementation in the second half of 2013

YDAC while new and small is likely to be the most resource intensive per referral of any of the ACT drug diversion program. Individual services have started to collect data on the program, but an evaluation framework and comprehensive set of performance indicators has yet to be developed for YDAC. To enable informed judgements about the program value, performance indicators and data systems need to be established by the end of 2012.

INTRODUCTION

Drug diversion is one of the most utilised policy interventions in responding to drug and drug-related offenders in Australia (Hughes and Ritter 2008; Ritter et al. 2011). Once seen as controversial (Hughes 2009), it is now deemed an increasingly pragmatic response at both a national and international level. Indeed, at the 2012 Commission on Narcotic Drugs a draft resolution on diversion was moved by Mexico and the United States of America to consider: 'alternatives to imprisonment as effective demand reduction strategies that promote public health and public safety' (Commission on Narcotic Drugs 2012). The irony is that, in spite of the years of provision, increasing popularity and multiple evaluations, many of the most basic questions have yet to be resolved: What ought 'best practice' diversion involve? And how can governments maximise desired outputs from their scarce resources?

Diversion has multiple meanings. As noted by Cohen (1979) and Cressey and McDermott (1973) traditional or "true" diversion involves diversion out of the system, with no further treatment, conditions or follow up. In contrast, the "new" diversion involves diversion into a program, including but not limited to education and treatment programs. These approaches reflect the very different rationales for diversion: to either minimise the harmful effects of formal criminal justice interventions or to provide opportunities to address drug use/offending. The first reflects deconstructing rationales (see for example Polk 1987) whereas the latter reflects therapeutic rationales (see for example McMahon and Wexler 2002).

The multiple meanings lend themselves towards different program goals. Evaluations have shown that multiple positive outcomes are possible from drug diversion:

- Reduced utilisation of criminal justice system resources (Baker and Goh 2004);
- Reduced incidence of reoffending (Lulham 2009; Bright and Matire 2012; Mitchell et al. 2012);
- Increased time to re-offending and decreased likelihood of imprisonment (Payne et al. 2008);
- Reduced drug use and/or harmful use (Crime Research Centre 2007; Bright and Matire 2012);
- Improved physical health, mental health and relationships (Northern Rivers University Department of Rural Health 2003);
- Improved cost-effectiveness (Shanahan et al. 2004).

However, counter-productive consequences from drug diversion programs can also ensue:

- Net-widening: increasing the likelihood of formal criminal justice intervention (and CJS resource use, etc.) (Roberts and Indermaur 2006);
- Increased inappropriate referrals (Crime Research Centre 2007).

The tension remains in that not all desirable outcomes are equally likely from all programs and elicited outputs/outcomes vary considerably from program to program (see for example Bright and Matire 2012).

Relative to other states and territories the Australian Capital Territory (ACT) has been a leader in drug diversion provision. The ACT was the first jurisdiction to introduce dedicated diversion in courts for drug related offenders, namely through the Treatment Referral Program which was adopted in 1989. Then in 1992 the ACT became the second jurisdiction in Australia (after South

Australia) to adopt a cannabis expiation notice scheme (Hughes and Ritter 2008). Today five different programs operate, crossing police and courts and targeting alcohol, illicit drugs and AOD-related offenders.

Yet, like most jurisdictions, the ACT has also had a history of diversionary evaluations, which have shown consistent problems: poor data collection, misconceptions about programs, and concern about the number of referrals. For example, in 2003 the first evaluation of the CADAS program identified a number of problems in data collection, which led them to conclude that while the available data “suggested” a degree of success in linking clients to treatment (Morgan Disney 2003:42-44), impacts on reoffending were unclear. In 2009 the Health Outcome International evaluators came to an even more damning conclusion that across all five diversion programs:

The current information systems employed across the various diversion programs in the ACT do not cater for client outcomes measurement beyond their compliance in attending treatment services. Consequently, it is not feasible in this evaluation to provide a direct assessment of the effectiveness of the ACT Diversion Programs based on data specific to these programs (Hales and Scorsonelli 2009).

This fostered a number of common recommendations, including improved data collection, to increase program access and increase training and encouragement to utilise drug diversion programs.

Work by Hughes and Ritter (2008) has contended that the lack of progress is attributable to the continued focus on individual drug diversion programs in isolation (and the implicit or explicit assumption that measured effects are or can be attributable solely/primarily to the program). Such an approach is problematic—as drug diversion, like many complex systems, operates as a “complex adaptive system” where program effects and policy interventions will not necessarily be intuitive (Checkland 1981). What is done (or not done) in one program/agency impacts on other programs/agencies. The benefits to one may increase the costs on another, and similarly delay by one program or one agency may have an exponential effect across the system. Sometimes these impacts can be predicted and other times they cannot. The consequence is that program outputs can be heavily affected by a host of other factors, including the rate of police detection, the prevalence and patterns of drug use, and by the general operation of the health and criminal justice systems. Equally importantly, program effectiveness is shaped by a jurisdiction’s entire system of drug diversion: the number of programs, their delineation and the extent to which they work synergistically or antagonistically (Hughes and Ritter 2008).

The inability to foresee all consequences demands a new way of addressing the issue: one that at the most basic level requires a thorough understanding of the operation of all diversionary programs, their inter-connectedness and key factors that affect their operation, such as resourcing. It also requires a deep understanding of the ‘active ingredients’ that convert the programs’ inputs and activities into outputs and outcomes. The current evaluation therefore adopts a systems approach to examining the ACT diversion system in 2012.

Our work entails the following components and associated questions:

1. Conceptual map of current system: What is the current map of the ACT drug diversion system in its entirety, taking into account its contexts and the full range of programs? How are the programs delineated? How do clients move around the system? What outputs are being attained?

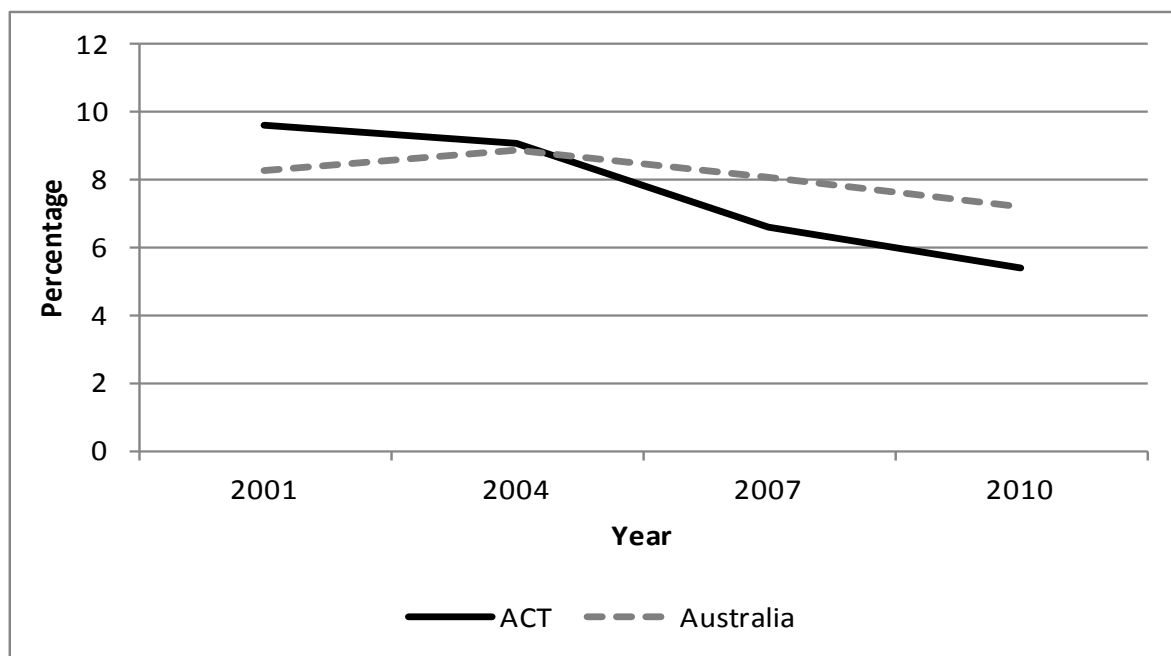
2. Resources: What resources are being allocated and what are the costs of service provision?
3. Evaluation Roadmap: What indicators and evaluation designs can be established so as to assess implementation, outputs and outcomes (positive and negative, intended and unintended) from the ACT drug diversion system?
4. Future system: Where can improvements be made to the ACT drug diversion system, including but not limited to program access, program barriers to be overcome, referral systems, program components and so on?

The timing is particularly ripe as not only is the ACT drug diversion system changing but the system around it is changing (see pages 15 to 21). All such factors increase the need and opportunities to identify and leverage opportunities to better position and improve the ACT drug diversion system.

Drug and alcohol use in the ACT

The 2010 National Drug Strategy Household Survey (NDSHS) indicates that the majority of ACT residents aged 14 and over report having used alcohol in the last months (86.5%) (AIHW 2011). But reported prevalence of daily use is small: 5.4%. Moreover, between 2001 and 2010 the reported prevalence of daily drinking has declined in the ACT, from 9.6% to 5.4%. Indeed, the ACT is the only Australian state/territory to have exhibited a consistent decline over this period (see for example trends in the ACT versus the national level in Figure 1). Consequently, in 2010 the ACT has the smallest proportion of daily drinkers in Australia (AIHW 2011).

Figure 1: Trends in daily drinking status in the ACT and Australia amongst people aged 14 years and over, 2001-2010



Source: National Drug Strategy Household Survey, 2010, (AIHW 2011).

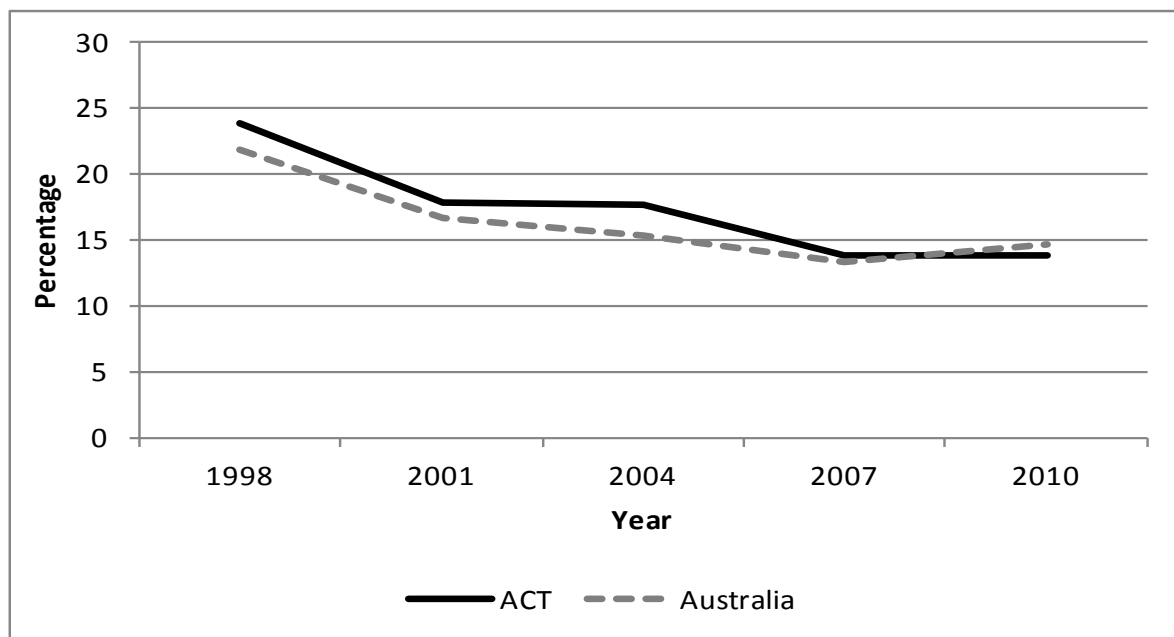
In 2010 19.5% of the ACT population aged 14 years and over placed themselves at lifetime risks of alcohol related harm, as measured using the 2009 National Health and Medical Research Council guidelines. This was almost identical to the national prevalence – 20.1% (AIHW 2011). As with the rest of Australia, the incidence of lifetime harm was higher amongst males (29.9%),

compared to females (9.4%). Prevalence across different age groups within the ACT or other states and territories was not publicly reported.

Examining specifically the school population, in 2008, 85.9% of students surveyed reported that they had consumed at least a few sips of alcohol in their lifetime. This proportion equates to an estimated 22,678 ACT secondary students between 12 to 17 years of age had ever consumed alcohol (males: 11,584; females: 11,094). Just under a quarter (24.2%, or an estimated 5,488 secondary students) reported consuming alcohol on at least one day in the last seven days (current drinkers), and 7.1% reported harmful drinking (Epidemiology Branch ACT Health 2010). There was no significant increase in harmful drinking from the 2005 survey results. Finally, turning to patterns of binge drinking, in 2008, 8.7% and 5.6% reported to have consumed 5 drinks or more and 7 drinks or more respectively in one session (Epidemiology Branch ACT Health 2010). This was unchanged over the last 12 years.

Approximately 13.9% of ACT residents aged 14 and over have reported recent use of an illicit substance including pharmaceuticals (or 11.4% excluding pharmaceuticals). As with daily drinking, the reported prevalence of illicit drug use in the ACT has been declining. Indeed, as shown in Figure 2 the prevalence of recent drug use, including illicit use of pharmaceuticals, fell from 23.9% in 1998 to 13.9% in 2010 (AIHW 2011). This mirrors the trend seen in other parts of Australia.

Figure 2: Trends in recent use of any illicit substance in ACT and Australia amongst people aged 14 and over, 1998 – 2010



Source: National Drug Strategy Household Survey, 2010, (AIHW 2011).

As shown in Table 1, the most commonly reported illicit drugs in the ACT were cannabis and ecstasy (AIHW 2011). For all substances excluding heroin the prevalence of recent use is lower in the ACT than the rest of Australia.

Table 1: Recent use of an illicit substance in the ACT and Australia amongst people aged 14 and over, 2010, by drug

Drug	ACT	Australia
Cannabis	9.5	10.3
Ecstasy	2.3	3.0
Meth/amphetamine	1.2	2.1
Cocaine	1.8	2.1
Heroin	0.3	0.2
Any illicit except pharmaceuticals	11.4	12.0
Any illicit including pharmaceuticals	13.9	14.7

Source: National Drug Strategy Household Survey, 2010, (AIHW 2011).

The recent prevalence of illicit drug use in the ACT was higher amongst males than females. For example, males were almost twice as likely to report recent use of cannabis (12.6% compared to 6.6% for females). Compared to the national picture, ACT females were less likely to report use of different substances (see Table 2).

Table 2: Recent use of an illicit substance in the ACT and Australia amongst people aged 14 and over, 2010, by sex

Drug	ACT		Australia	
	Male	Female	Male	Female
Cannabis	12.6	6.6	12.9	7.7
Ecstasy	2.9	1.7	3.6	2.3
Meth/amphetamine	1.4	0.9	2.5	1.7
Any illicit including pharmaceuticals	17.9	10.0	17.0	12.3

Source: National Drug Strategy Household Survey, 2010, (AIHW 2011).

*Data was not-available for cocaine and heroin. Data is not age standardised.

Recent use of an illicit substance in the ACT was concentrated amongst those aged 18-19 years and 20-29 years. Yet, compared to the national picture, there were lower levels of reported recent drug use by those aged 19 and under, which suggests a slightly older cohort in the ACT (see Table 3). The ACT school survey found 14.8% of students in 2008 reported having used at least one illicit substance in their lifetime (an estimated 3,907 ACT secondary students) and 3.7% reported having used an illicit substance at least once in the last seven days (Epidemiology Branch ACT Health 2010). This demonstrates that both the overall levels of problematic drinking and recent use of illicit drugs have declined in the ACT, but that risk remains elevated amongst males, and for illicit drugs specifically, males aged 18 and over.

Table 3: Recent use of an illicit substance in the ACT and Australia amongst people aged 14 and over, 2010, by age

Age	ACT	Australia
12-17	6.4	10.4
18-19	20.4	25.1
20-29	25.7	27.5
30-39	14.8	18.8
40-49	13.5	12.8
50-59	7.3	8.8
60+	5.5	5.2

Source: National Drug Strategy Household Survey, 2010, (AIHW 2011).

Criminal justice responses in the ACT

The licit nature of alcohol means police predominantly respond to alcohol in the context of other offences such as drink driving. Nevertheless, police can take individuals into protective custody without arrest, if they are intoxicated, disorderly or likely to cause injury. In 2011 there were 1,093 instances recorded, incorporating 1,047 adults and 46 juveniles (McDonald 2012). During 2009-10 there were a total of 459 recorded illicit drug offences in the ACT, including 386 arrests and 73 SCONS issued. As shown in Table 4 the majority of legal actions were targeted at illicit drug consumers: 86% excluding SCONS and 88% including SCONS (Australian Crime Commission 2011). This is higher than the national average (80.6%).

Table 4: Number of arrests (consumer, provider), in the ACT, 2009/10, by drug

	Consumer	Provider	Total
Cannabis arrests	223	21	244
Cannabis SCONS	73	-	73
ATS arrests	76	24	100
Cocaine arrests	8	0	8
Heroin arrests	21	9	30
Any illicit (including SCONS)	405	52	459

Source: Australian Crime Commission (Australian Crime Commission 2011).

At 30 September 2011 there were 171 inmates in the Alexander Maconochie Centre (AMC) (ACT Government Justice and Community Safety Directorate 2011). Only three (1.75%) had a drug offence as their most serious offence leading to custody. This is lower than the national rate. For example, 11.3% of all Australian prisoners imprisoned on 30 June 2011 were imprisoned with a drug offence as their most serious offence (n=29,106 prisoners, 3,296 with a most serious offence of a drug offence) (Australian Bureau of Statistics 2011). That said, most of the inmates within the AMC reported that their offending was related to alcohol, drugs or a combination. An Inmate Health Survey of AMC prisoners found 74% of inmates reported that they were imprisoned for a drug-related crime and 79% said their offence was committed under the influence (Stoové and Kirwan 2011). Drug-related, rather than drug, offending is thus the key challenge within the ACT prison system.

Legislative and policy context in the ACT

Legislation

With the exception of the Simple Cannabis Offence Notice (SCON) scheme, drug diversion programs in the ACT are not legislated (instead, dealt with by way of practice directives, Memoranda of Understandings etc.). These are outlined on pages 25 to 31. Nevertheless, pertinent legislation for understanding the current and potential drug diversion practices in the ACT include the Drugs of Dependence Act 1989, Criminal Code 2002 and Criminal Code Regulation 2005, the Human Rights Act 2004 and the Children and Young People Act 2008.

The Drugs of Dependence Act 1989 prohibits and outlines the applicable penalty ranges for minor drug offences including the possession of drugs of dependence and cultivation of 1-2 cannabis plants. Possession of a drug of dependence or a prohibited substance attracts a penalty of 2 years imprisonment, 50 penalty units or both (Drugs of Dependence Act 1989, ACT). An exception to this is if the person is in possession of up to 25g of cannabis, in which case they may be eligible for an offence notice or receive 1 penalty unit. All serious drug offences including trafficking, manufacturing and cultivation are prohibited through the Criminal Code 2002.

Whether an offence is deemed possession for personal use or for the purposes of trafficking is further distinguished by reference to the Criminal Code Regulations 2005, which outlines the quantity of drugs at which it will be presumed that a defendant has the intention or belief to traffick (or minor, mid or high end trafficking). The threshold quantities for the five most commonly used illicit drugs are listed in Table 5 (Criminal Code Regulations 2005, ACT). This is listed in terms of pure drug – i.e. active principle, albeit purity is not in practice taken into consideration with regards to cannabis (Hughes and Ritter in press).

Table 5: Current ACT legal thresholds as per Criminal Code Regulation 2005 for trafficable, commercial and large commercial quantities, by drug type and threshold category (pure drug)

Drug	Trafficable quantity (g)	Commercial quantity (g)	Large commercial quantity (g)
Heroin	2	800	1,500
Meth/amphetamine	2	1,000	2,000
Cocaine	2	1,000	2,000
MDMA	0.5	250	500
Cannabis	300*	25,000*	125,000*

*Purity not taken into consideration.

Each quantity threshold triggers the applicable penalty ranges that can be applied to drug offenders within the ACT. For example, in the ACT possession of a trafficable quantity e.g. 2 g pure heroin, is sanctionable with <10 years imprisonment, possession of a commercial quantity e.g. 800 g pure heroin with <25 years imprisonment and a large commercial quantity e.g. 1.5 kg pure heroin with a maximum of life imprisonment (Criminal Code 2002, ACT).

In 2004, the ACT became the first jurisdiction in Australia to adopt human rights legislation (Human Rights Act 2004, ACT). The Human Rights Act 2004 outlines the civil and political rights of all individuals in the ACT, including the rights for equality before the law and protection from torture and cruel, inhumane or degrading treatment. Of relevance for criminal proceedings, it outlines the right to be presumed innocent until proven guilty in a court of law (HRA, section 22.1), the rights for accused children to be segregated from accused adults (HRA, section 20.1) and for anyone deprived of liberty to be treated with humanity and with respect for the inherent dignity of the human person (HRA, section 19.1). A further implication of adopting the Human Rights Act is a requirement that all Territory statutes and statutory instruments are interpreted in a way that is compatible with human rights (HRA, section 30). An ACT Human Rights Commission was established to promote and protect rights through in particular audits and reviews of legislation.

The Children and Young People Act 2008 is the key ACT legislation outlining standards of care and protection to be provided to young people by responsible adults, services or organisations. In particular, the legislation details the necessity for young offenders to receive support and opportunities for rehabilitation and reintegration into the community (Children and Young People Act 2008, ACT). As such, the availability of programs that divert children and young people with AOD issues away from the criminal justice system and into the health system provides such support.

ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014

The ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014 is the fourth iteration of the ACT drug strategy. Like its precursors it seeks to minimise the harm from alcohol, tobacco and other drugs and to develop evidence-informed policies and initiatives (Alcohol and Other Drug Policy Unit 2010). Core principles for attaining this include harm minimisation, enhancing health

promotion, early intervention and resilience building, and strengthening partnerships and collaboration.

The strategy outlines a number of priority populations. For alcohol-related interventions this includes young and Aboriginal and Torres Strait Islander people. The former were a noted priority in spite of declining prevalence of high frequency use in recognition of the danger for this population. For illicit drugs, the key target groups were Aboriginal and Torres Strait Islander people, people in detention and people with mental illness.

The ACT drug strategy includes a mixture of supply reduction, demand reduction and harm reduction activities, including targeting drug traffickers, reducing youth exposure to alcohol advertising, marketing campaigns and improved treatment access (see Table 6). Complementing these is the need to review and expand drug diversion: or more specifically to:

- Increase the uptake of diversion programs.
- Increase the effectiveness of diversion programs.
- Develop partnerships and strategies to promote the uptake of evidence-based diversionary initiatives.

Table 6: Some of the actions and lead agencies for the ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014

Action	Lead agency
Target manufacturers and distributors of illicit drugs to reduce and disrupt illicit drug supply	ACT Policing
Reduce young people's exposure to alcohol advertising	DJACS
Expand and improve the quality of drug related community education campaigns and programs offered to target groups	ACT Health
Provide better access to drug counselling, withdrawal, rehabilitation and relapse prevention services	ACT Health
Review and expand the investment and effectiveness of diversion programs	ACT Health DJACS DHCS

Emerging policy directions: Diversion and early intervention for young people

There has been increased concern about the high rate of young people in the ACT who are placed on remand, under community supervision, and in detention. For example, in 2007-2008 the ACT had the second highest rate per 1,000 young people aged 10-17 under community supervision in Australia (data on NSW was unavailable) (ACT Government Department of Disability Housing and Community Services 2011). This has given rise to three separate government reviews (see Appendix B for a timeline of key policy events in the ACT within and outside the AOD diversion system), all of which have touched on issues pertaining to the diversion of youth:

- Diversions Framework Consultation – by the ACT Government Department of Disability Housing and Community Services.
- ACT Human Rights Commission audit of conditions at Bimberi Youth Justice Centre
- Commissioner for Children and Young People – inquiry into youth justice system including the effectiveness of diversionary strategies.

Diversiory Framework Consultation

The Diversiory Framework Consultation ‘Towards a diversionary framework for the ACT’ acknowledged the need for a much more whole of government approach to diversion (ACT Government Department of Disability Housing and Community Services 2011). It also acknowledged the data limitations on diversionary activity in the ACT. For example, there is no publicly available data that distinguished diversionary responses for youth versus adults.

Responses to the consultation paper were summarised by Noetic Solutions (2011). There was a resounding sense that data on diversionary activity was poor, and specifically that it was not sufficiently available due to insufficient information sharing; of poor quality and poorly used; and too focused on participation and not outcomes. A direct consequence was conflict amongst stakeholders on whether the diversionary system was properly resourced. Some said they could not tell, others that it was under-resourced, others still that it was adequately resourced but poorly focused. Other problems identified included uneven knowledge of services across ACT Government agencies and the service agencies themselves, inappropriate funding models (including short funding periods), the under-utilisation of evidence and previous learning, the limited availability of services, and inadequate coordination and strategic planning.

Many respondents agreed there was a need for more strategic direction in the ACT responses, but others said there were too many strategies already and a lack of attention to how this new strategy might meet up or integrate with these. Of critical relevance to this was the submission by the Alcohol Tobacco and Other Drug Association ACT (ATODA) that there was a lack of recognition in discussion of youth diversionary responses of existing diversionary responses provided to AOD offenders and/or perceptive on optimal approaches for reducing offending:

A full policy context should be reflected in the Framework. The discussion paper did not refer to the range of other key policies that relate specifically to young people and diversion, such as the ACT Alcohol, Tobacco and Other Drug Strategy 2010 – 2011 and the Illicit Drug Diversion Initiative through the Council of Australian Governments (COAG)..... It is important that the Diversiory Framework reflect this aspect of diversion (Alcohol Tobacco & Other Drug Association ACT (ATODA) 2011:1).

Other stakeholders expressed concerns about where and how the consultation on youth diversion fit with the other ACT reviews of the criminal justice system being undertaken, including the audit of the Bimberi Youth Justice Centre and review of the youth justice system by the Human Rights and Children and Young People’s Commissioner. The concern was thus raised that the ACT Government was undertaking a fragmented or piecemeal approach to the development of the Diversiory Framework, which was not only leading to consultation fatigue, but also in danger of continuing a disjointed approach.

ACT Human Rights Commission Report

The ACT Youth Justice System 2011: A Report to the ACT Legislative Assembly by the ACT Human Rights Commission (Roy and Watchirs 2011). This noted that “mental health issues (including alcohol and other drug issues) are some of the most pressing and influential for young people in Australia, particularly those in the youth justice system” (Roy and Watchirs 2011:12), but noted key gaps in AOD responses to youth at the Bimberi Youth Justice Centre. For example, in their survey of young people, they found only 20% of those who identified having alcohol and other drug issues reported that support for this was offered. They attributed this in part to a culture within the Bimberi Youth Justice Centre of abstinence, rather than harm

minimisation. As the Commission noted, the tension between the two is always evident, but appears exacerbated within the youth justice system.

The report also noted the inherent links between the court diversionary practices, and numbers within the Bimberi Youth Justice Centre, and in that regard drew attention to the decline in CADAS referrals for youth through the Children's Court (from 40 referrals per year to 1). "The Commission is anxious that young people with identified alcohol and other drug issues are diverted out of the criminal justice system and into treatment" (Roy and Watchirs 2011:301).

The report notes: "a quality youth justice system is embedded in a human service system that seeks to prevent young people's criminal behaviour and divert young people from unnecessary engagement" (Roy and Watchirs 2011:172). This emphasises both the need to prevent crime in the first place, then divert those that do have contact with the criminal justice system away. It acknowledges the legal precedence for diversions, including Article 40(3) of the United Nations Convention on the Rights of the Child (CROC) which requires signatories to, whenever appropriate and desirable; promote measures for dealing with children without resort to judicial proceedings. Yet, it noted the considerable challenges in assessing the extent to which the ACT was diverting young people, due to both poor data collection and restricted access to guidelines on policing procedures (Roy and Watchirs 2011:182). Nevertheless, based on the full extent of the available evidence it concluded that the diversionary strategies in the ACT were effective but under-utilised:

Based on the material reviewed, the Commission finds that diversion strategies are effective for young people, in that completion rates are high, and research suggests diversion reduces re-contact with the criminal justice system. However, the Commission further finds that the legislated opportunities for diversion of young people are not being fully realised due to the low referral rates by both the police and Courts. It is the Commission's view that current diversionary strategies in the ACT are not fully effective. In its submission to the Review, the ACT Government acknowledged that the current system 'is not sufficiently providing effective diversion for those young people who are at the periphery in terms of their risk taking behaviours' (Roy and Watchirs 2011:184).

Further issues raised include that the rate of diversion was much less for Aboriginal and Torres Strait Islander young people, than other young people, that the rate of breaching youth on bail was far higher in the ACT than other jurisdictions, and a perception that ACT Policing and members of the ACT Courts such as Judges, Magistrates, Director of Public Prosecutions (DPP), Legal Aid ACT were not as informed about prevention and diversion options as they ought be. As the review noted "the effectiveness of the ACT's diversionary strategy is almost fully dependant on the actions of individuals and agencies outside the control of CSD (Community Services Directorate)" (Roy and Watchirs 2011:194). The final report contained 224 recommendations, including that the government develop an integrated ACT diversion plan outlining:

- A vision for diversion in the ACT;
- A set of objectives drawn from an evidenced-based theory of change;
- The outcomes measures and performance indicators Government agencies and community providers will pursue in order to contribute to the objectives;
- A commitment to continuous improvement through evaluation, action learning and innovation (Roy and Watchirs 2011:195).

The ACT Human Rights Commission also recommended that the Community Services Directorate consider training days for the ACT judiciary, specifically to:

- a) Work with The National Judicial College to develop and implement an annual training program for Judges and Magistrates on issues relevant to youth justice; and
- b) Develop and implement an annual education program for ACT Policing, Director of Public Prosecution, Legal Aid, Aboriginal Legal Services and the private legal profession on a range of issues relevant to youth justice.²

ACT Government response to the HCR report

The ACT Government response to the HCR report noted the need for considerable change within the Bimberi Youth Justice Centre, but also across the whole youth justice system. They noted in particular the need for a stronger focus on diverting young people from the youth justice system, for a protocol to be established on alcohol and other drug interventions in the Bimberi Youth Justice Centre and for better reintegration of young people exiting into the community (Youth Justice Implementation Taskforce 2011). The Government noted the considerable resource implications of much of the report, but the intent to address many through a 5-10 year Blueprint for Youth Justice in the ACT (Youth Justice Implementation Taskforce 2011). The call for an ACT diversionary framework, had been heeded, with it being made a key action area in the new Blueprint, noting in particular that “overall expenditure in the youth justice system is reduced when there is investment in evidence based early intervention, prevention and diversion programs.”

Attorney General's review of drug trafficking thresholds

The Drug Policy Modelling Program at the University of New South Wales was engaged as a consultant to provide expert advice to the ACT Justice and Community Safety Directorate on determining amounts for trafficable, commercial and large commercial drug offences for five main classes of illicit drugs: heroin, methamphetamine, cocaine, MDMA (ecstasy) and cannabis. The report and recommendations have been completed, and have recommended reform to the current threshold quantities. These are currently under consideration by the Justice and Community Safety Directorate (Hughes and Ritter in press).

Reforms to infringement schemes and other criminal justice arenas

Following the release of a Street Law Report – “The Downward Spiral: How a fine can cause homelessness in the ACT” – there have been a number of proposals and reforms to the infringement schemes in the ACT. The report identified that the ACT infringement system was having a disproportionately negative impact on vulnerable populations, including those with serious AOD issues.

In February 2012 the ACT Greens issued a bill for reform of the infringement system relating to road traffic offences: Road Transport (General) (Infringement Notices) Amendment Bill 2012 (2012). The bill, which proposed to enable payment of a road traffic infringement notice penalty by instalments or discharge of the infringement notice penalty by attending an approved community work or social development program, was passed on 9 May 2012: the Road Transport (General) (Infringement Notices) Amendment Act 2012. The ACT Government also issued, in March, their own bill for reform of the infringement system: The Road Transport (General) Amendment Bill 2012. This bill proposed that a person may make a late application

² The ACT Human Rights Commission report notes that this possibility is being followed up with Magistrate Fryar.

for additional time to take action in response to receiving an infringement notice, allowing more of an opportunity to dispute the notice in court if necessary. This has not been passed.

While these reforms pertain specifically to road traffic offences they have generated broader discussions about all infringement schemes in the ACT, and the extent to which they ought to be reformed to reduce negative impacts on vulnerable populations. Most notably the Alcohol Tobacco and Other Drugs Association ACT (2012) argued that reform of infringement systems in the ACT be extended to cover all infringements and fines, including infringements for smoking, drinking alcohol, or possession of illicit drugs through schemes such as the Simple Cannabis Offence Notice (SCON) Scheme and public order offences related to alcohol. The ATODA report argued that avenues be made available for offenders to make payments for their fines in instalments; that options for community service, education or treatment as substitutes for financial payment be also considered (Alcohol Tobacco and Other Drug Association (ATODA) 2012). Discussions in this arena are ongoing.

Finally, there are continued initiatives to improve/overhaul ACT responses to reoffending in the ACT. Key strategies include breaking the cycle of offending through early intervention and diversion programs and justice re-investment to address the causes rather than the effects of crime (Justice and Community Safety 2012). Both strategies are central to the ACT Property Crime Reduction Strategy 2012 – 2015, adopted May 2012. Yet there are additional whole-of-government initiatives on through-care (Social Policy and Implementation Branch 2011). Led by Chief Minister and Cabinet these have arisen out of the need to ensure appropriate support for offenders leaving the Alexander Maconochie Centre so as to reduce the risk of recidivism and promote the reintegration of offenders into the community.

In summary, in mid-2012 the context is one where alcohol and drug use has in the main been stable or declining in the ACT and where drug diversion constitutes a core platform of the ACT alcohol and other drug strategy. There are a host of changes pertaining to young people, youth justice and criminal justice more specifically characterised by: an increasingly strong focus on diversion, early intervention and prevention responses for youth and on maintaining and extending reforms across the criminal justice system to improve system responses, whether it be by reducing laws that have proven deleterious consequences, or better utilisation of resources to promote reintegration and address the causes of offending.

METHODS

The methods in this evaluation have four components and each is described in some detail below.

Component 1: Conceptual map of current system

To commence understanding the ACT drug diversion system a thorough conceptual map was generated of the ‘current system’, as it operates on the ground (as well as in policy), the contexts in which it operates (as described earlier) and the potential barriers that affect system operation. This was generated through holding two roundtables and reviewing the literature and documentation. Roundtable 1 involved stakeholders directly involved in the AOD diversion programs e.g. police and drug diversion assessors as well as treatment providers. Roundtable 2 involved stakeholders with a more peripheral involvement in drug diversion e.g. from legal aid, corrections, drug user groups and the peak drug and alcohol body. See Appendix A for a detailed list.

At the roundtables the ACT stakeholders were requested to identify system flows into, through and out of the alcohol and drug diversion programs:

- Simple Cannabis Offence Notice (SCON) Scheme
- Police Early Diversion (PED)
- Early Intervention Pilot Program (EIPP)
- Court Alcohol and Drug Assessment Service (CADAS)
- Youth Drug and Alcohol Court (YDAC)

All routes by which users/offenders may enter the system were identified, along with what options are available to police, magistrates, assessors and service providers, what actions are taken, what guides the decision making process of stakeholders and what guides the decision making process of users/offenders, particularly whether they accept a diversion opportunity.

This process was useful in developing the system map, identifying where additional clarifications were necessary, identifying barriers and strengths in the system.

Component 2: Resources - costing the resource implications of the ACT drug diversion system

We compiled, subject to data availability, program throughputs and resource implications of operating the mapped ACT drug diversion system (Component 1). This commenced by documenting the client groups and throughput, covering the following aspects of drug diversion processes and outcomes:

- Participant throughput/referral;
- The services that diverted offenders receive: types of interventions e.g. assessment only, assessment plus education, assessment plus counselling;
- Levels of compliance.

The resource implications of operating the ACT drug diversion system with the current throughput were then documented. We costed each intervention taking into account core program elements. For example:

- Policing time and cost for charging a person (e.g. 1.5 hours for the arrest, returning to police station, paper work, etc., and preparation and court time for those offences which proceed to court)
- Treatment costs, cost per session * typical number of sessions.

As much as possible, given available data, this included both the fixed costs (administration and overheads) and those costs which may vary with changes in throughput (police time, courts, treatment costs, assessment and education).

Previous work conducted by researchers on this team in estimating the costs of policing cannabis offenses (Shanahan 2011) and the costs of cannabis treatment in NSW (Ngu and Shanahan 2010) provided additional inputs to this analysis.

Component 3: Evaluation Roadmap

A desk exercise was implemented, taking into account the information elicited in the other parts of this evaluation, to develop an Evaluation Roadmap. Its purpose is to guide future ACT work in developing indicators and evaluation designs that can be used to assess the diversion program's implementation, outputs and outcomes (positive and negative, intended and unintended) from the ACT drug diversion system. It included developing lists of potential performance indicators for the diversion system overall and, separately, for each of the five component programs. A separate exercise was to prepare an initial evaluation protocol for YDAC.

Component 4: Future system: opportunities for system improvement

The research team used the generated system map (Component 1) and data on resources and throughputs (Component 2) to develop suggestions as to optimal system operation. The research team then conducted a third roundtable (Roundtable 3) for stakeholders, during which throughput, resource flows, barriers and strengths were presented and discussed with participants, with the goal of:

- Identifying errors or omissions in the research team's assessments or interpretation.
- Generating new insights on the elicited findings about the current ACT drug diversion system.
- Discussion about what works and what doesn't and intended and unintended consequences from the current system.
- Identify the most important blocks and enablers in the current system; the extent to which each can be influenced/controlled by the actions of the ACT; and the policy levers that can and ought (and ought not) be used to improve system functioning (whether that be in regards to increasing throughput or other identified problems).

This was then used to generate recommendations for improvement.

RESULTS

Conceptualising the ACT AOD diversion system

This section includes: a summary of the goals of the ACT diversion system; an overview of each program (history, objectives, governing directives, key stakeholders, etc.); and a conceptual map of how the programs connect, intersect and/or potentially compete.

AOD diversion goals

Roundtables 1 and 2 were utilised to canvass the goals of the ACT drug diversion system and programs. The overall or primary objectives of the ACT drug diversion system can be summarised as twofold:

1. To divert drug offenders away from the criminal justice system
2. To divert drug offenders into:
 - a) Contact with the ACT AOD treatment system
 - b) Education
 - c) Assessment and treatment

These two objectives broadly fit the objectives outlined earlier (see 1.0). It is clear that programs utilise these to different extents: for example the SCON scheme is clearly focused on diversion of drug offenders away from the criminal justice system. The other programs all work towards both the first and second objectives. That said, they clearly favour different versions of the second objective: diversion of drug offenders into education and/or treatment, whether to make people aware of the array of services offered in the ACT, to educate about the harms from drug use or to treat AOD problems.

A wide and diverse range of secondary objectives also exist. These include:

1. To minimise harms associated with unnecessary involvement in the criminal justice system (CJS)
2. To strength partnerships (between law enforcement, courts, health and other stakeholders)
3. To educate police and courts regarding what are the appropriate responses to AOD issues
4. To fulfil the community expectation of community protection and the punishment of offenders
5. To educate young people and families
6. To deter encounters with the CJS
7. To reduce AOD use
8. To reduce cost to the CJS and reduce social cost of AOD
9. To reduce AOD-related crime

This list indicates that whilst there are two main objectives of the ACT AOD diversion system, not all stakeholders hold the same views on the secondary objectives. For example, some stakeholders argued that ACT AOD diversion is not only about diverting away from the CJS or into education/treatment. Instead, it is also about broader community benefits, including educating families. Yet, most had a much narrower lens. Some stakeholders placed a strong emphasis upon diversionary opportunities translating into impacts for clients and/or the criminal justice system: reducing drug use, reducing AOD-related crime and reducing the cost of

responding. From this perspective diverting away from the CJS and diverting into education/treatment was only useful if the intervention works. Still others argued diverting away from the CJS or into education/treatment is not necessarily about long term behavioural change, but about reducing the harms from unnecessary involvement in the criminal justice system, born by the prohibition of illicit drug use. As one stakeholder remarked it helps “to make the best of what we have got”. From this perspective, impacts e.g. increased knowledge, attitudinal changes are bonuses, but the key is to ensure that those referred are not worse off. As noted in later sections the presence of different perspectives means that there will not necessarily be consensus amongst ACT stakeholders about the priorities or where (or how) resources should be directed.

The ACT AOD diversion programs: history, objectives, eligibility criteria and governing directives

As of 2012 there are five programs operating in the ACT:

- Simple Cannabis Offence Notice (SCON) Scheme - \$100 fine issued by police for cannabis possession or cultivation, payable within 60 days;
- Police Early Intervention and Diversion (PED) - police referral for possession of cannabis, other illicit drugs or illicit possession of a licit drug (not alcohol) to AOD assessment, education and/or counselling;
- Early Intervention Pilot Program (EIPP) – police referral for youth aged under 18 years who are found in possession, consuming or intoxicated from alcohol to AOD assessment, education and support;
- Court Alcohol and Drug Assessment Scheme (CADAS) – a pre-sentencing and sentencing assessment/treatment option to engage clients charged with AOD-related offences in AOD services;
- Youth Drug and Alcohol Court (YDAC) – a pre-sentencing program of the Children’s Court that utilises judicial and therapeutic interventions to address alcohol and other drug (AOD) and other needs of children and young people who may otherwise be imprisoned.

Throughout their existence most of the programs have been subject to program changes: some minor, some major. In this section we draw upon practice directives, roundtables and stakeholder interviews to outline for each program the history, goals, eligibility criteria and governing directives. We then conclude with a summary of the key stakeholders and roles for each program. Detailed procedures for each program as per the governing directives and lessons from the evaluation are contained in Appendix C.

Simple Cannabis Offence Notice (SCON)

History

The SCON scheme was introduced in 1992 following a recommendation by a Select Committee of the ACT Legislative Assembly that minor cannabis offences would be better dealt with through non-criminal means. Changes of note to the program include reductions to the eligibility criteria and ongoing concerns over non-payment of civil penalties which has reduced police emphasis upon its utilisation. In the early stages, an offender was eligible for a SCON if they were in possession of not more than 25 grams of cannabis or for cultivation of not more than 5 cannabis plants. In 2005 the Drugs of Dependence Act was amended to reduce eligibility to cultivation of not more than 2 plants excluding all artificially (hydroponically grown) cultivated. Second, in 2010 new directives were issued (outlined below) that the scheme was to be used as a

second-option to the PED program: “before a SCON may be issued, the case officer must first determine if the offender qualifies for the Drug Diversion Program. If the Drug Diversion Program can be utilised it will take preference over the issue of a SCON” (Australian Federal Police 2010). This followed ongoing concerns over non-payment of civil penalties which has reduced police emphasis upon its utilisation.

Objective

The SCON Scheme provides minor cannabis offenders with the option to avoid a criminal conviction by paying a penalty notice of \$100.

Eligibility criteria

Target: Youth and adults

Offence: Possession of up to 25 grams of cannabis and cultivation of not more than 2 non-hydroponic cannabis plants. The practice directives clarify that a SCON may only be issued “if the cannabis is believed to be for personal use.”

Policy directives

- Drugs of Dependence ACT 1989 (ACT)
- AFP Practical Guide on Simple Cannabis Offence Notices (Australian Federal Police 2010)

Police Early Intervention and Diversion (PED)

History

The PED was introduced in December 2001 following the Council of Australian Government Illicit Drug Diversion Initiative agreement to expand drug diversionary options for minor drug offenders. Confusingly it was (and continues to be) referred to as PED, PEID, Drug Diversion Program or ACT Policing and Early Intervention Diversion Program.

The PED program struggled with low referral numbers, which has been attributed to two key reasons: police resistance as it was seen as a ‘soft option’ and a low awareness of the scheme. For example in 2009 Health Outcomes International attributed PED’S low referrals to poor knowledge by police at the point of arrest of the availability of the scheme, for example if the Illicit Drug Diversion Officer (IDDO) was on leave referrals reduced (Hales and Scorsonelli 2009).

In 2010 two key changes occurred in PED:

First, in January 2010, SupportLink was adopted to facilitate PED referrals. SupportLink was a pre-existing e-based scheme used by ACT Policing to increase knowledge of and referrals to support services e.g. for welfare, etc. The first commercial agreement to use SupportLink in the ACT was signed between the AFP and SupportLink in 2003. By 2010/11, 6,004 referrals were made by ACT Policing through SupportLink (ACT Policing 2010).

Second, police training and marketing about PED also expanded. Specifically, PED training ceased to be only directed at recruits, and to also include operational members. The nature and

content of training also shifted to indicate that, with the introduction of SupportLink, the PED process was not only effective, but also fast and easy. For example the training material emphasises that “the program has proved to be very successful with reported 2 year period reduction in re-offending rates of more than 90%” (ACT Policing 2010) and that all you need to do is “jump on SupportLink”.

Objectives

Under the MOU between AFP (ACT Policing) and ACT Health (now the Health Directorate) the goals are to provide opportunities for individuals to access assessment, with a view to treatment, rather than progress through the criminal justice system, often before incurring a criminal record (Australian Federal Police and ACT Health 2010).

Eligibility

The target group are youths or adults at the early stages of their drug use, who have had little or no contact with the criminal justice system. The practice directive - AFP Practical Guide on drug diversions – was introduced in July 2010 and is due for review in July 2012 (Australian Federal Police 2010). This notes that eligible offenders must have been apprehended for a minor possession offence, defined as no more than 25 grams of cannabis or 2 plants (both not hydroponic), no more than 2 amphetamine-type stimulant tablets e.g. ‘ecstasy’ or ‘MDMA’, or for all other drugs, no more than 25% of the trafficable amount as per the Criminal Code Regulations 2005 (ACT). This equates to 0.5 pure grams of heroin, meth/amphetamine or cocaine, or 0.125 pure grams of MDMA

Other eligibility criteria include that the offender must be willing to admit to the offence, consent to the diversion (and to attend one assessment and one treatment session), not have previously participated in the drug diversion program on more than two occasions, not have committed their offence in circumstances involving violence, and the apprehending officer must be satisfied that the drugs were for personal use.

Policy directives

- MOU between AFP (ACT Policing) and ACT Health (Australian Federal Police and ACT Health 2010).
- AFP Practical Guide on Drug Diversions (Australian Federal Police 2010).

Early Intervention Pilot Program (EIPP)

History

The Early Intervention Pilot Program (EIPP) is a federal government initiative under the National Binge Drinking Strategy, which included social marketing campaigns, community level interventions and police diversion. The national framework was endorsed by the Ministerial Council on Drug Strategy in April 2009, the ACT EIPP Agreement in December 2009, and the MOU between the AFP and ACT Health in June 2010 (see timeline in Appendix B). The national framework for EIPP put forward two different options for jurisdictions to consider:

- Option 1: An informal caution and information card

- Option 2: A police diversion and requirement for a formal assessment and information session (Department of Health and Ageing 2009).

It is clear that the ACT has adopted the second option.

Both the Health Directorate and ACT Policing report that the EIPP program was modelled on PED. Yet some changes have been introduced to streamline processes and increase ACT Policing support for the program. One noted example is the EIPP diversion officers, rather than the arresting officer, undertake the more time consuming components of the referral (such as contacting and sitting down with parents and doing the paperwork). Other activities are also undertaken, most notably targeting major events at which youth are likely to be engaged in binge drinking (see Appendix C).

While the ACT EIPP was launched on 1 July 2010, EIPP diversion officers were not employed until November and December 2010. Hence activities such as training police and youth referrals did not really commence until 2011 (Australian Federal Police 2010; Australian Federal Police 2010; Australian Federal Police 2011). Other changes that have been introduced are the ACT clinicians being allowed to contact young people to arrange an assessment as soon as practicable, rather than waiting four days for documentation to be sent through to parents; and the Alcohol and Drug Services (ADS) introducing consistent forms/paperwork for EIPP referrals and development of resources..

Objectives

The goal of the National Binge Drinking Strategy, including EIPP, were to reduce levels of alcohol intoxication by young people, foster acceptable standards of alcohol use, and to provide police and health with options to address risky drinking of young people (Department of Health and Ageing 2009). The goal of the EIPP specifically was to provide youth with early incentives to address their alcohol use, before incurring a criminal record.

Eligibility

The target group are young people (under 18 years) in the early stages of their alcohol use, who have little or no contact with the criminal justice system. According to the police protocol - AFP Practical Guide on Alcohol Diversions – which was introduced in September 2010 (Australian Federal Police 2010) the key eligibility criteria are:

- a child/young person is identified as being ‘intoxicated’ in a public place; or
- purchasing, possessing or consuming liquor in a public place.

An offender is eligible for a maximum of two diversions through EIPP.

Policy directives

- MOU between AFP (ACT Policing) and ACT Health (Australian Federal Police and ACT Health 2010).
- AFP Practical Guide on Alcohol Diversions 2010 (Australian Federal Police 2010).

Court Alcohol and Drug Assessment Scheme (CADAS)

History

The Court Alcohol and Drug Assessment Scheme (CADAS) was introduced in October 2000 as a result of the Chief Magistrate requesting the Alcohol & Drug Program to develop a Court based program, whereby offenders could be assessed in relation to their alcohol and other drug use at the time they appeared before the Court. While it began in the ACT Magistrates Court it expanded to the ACT Children's Court in 2001 after attaining COAG-IDDII funds. It then further expanded into the Supreme Court, informally from 2005, and formally from 2010.

The CADAS scheme has gone through a large number of changes over time, in terms of the objectives and the target populations and location of operation. All have importance for understanding the current program. Originally CADAS was introduced as an immediate, short-term intervention, when a client first appeared before the Court (pre-plea).

The program was designed to provide a maximum duration of 8 weeks CADAS facilitated treatment from the time of first referral (ACT Magistrates Court 2000). Over time it has also become a post-sentencing option, with CADAS facilitated treatment lasting 6 to 12 months. There is a perception that this has occurred after the closure of the post-sentencing scheme, the Treatment Referral Program (TRP), in August 2010. However, the HOI evaluators noticed that CADAS was starting to be provided as a post-sentencing scheme prior to TRP ceasing (Hales and Scorsonelli 2009). Nevertheless, new directives outlining use as a pre-sentence and sentencing option have only been adopted in 2010 (for the Supreme Court specifically) (Supreme Court of the Australian Capital Territory 2010).

Accordingly, the role of CADAS has become much broader, providing both pre-plea and sentencing assistance, assessments of AOD needs and suitability/readiness for treatment, and supervision and monitoring of court-mandated treatment clients.

For example, the combination of CADAS skill and the lack of another service means that CADAS is also increasingly requested to assess youth clients of Youth Justice who are not eligible for diversion but who have identified drug or alcohol problems (Community Youth Justice et al. 2012). All of this means that the boundaries around the nature of CADAS have expanded.

The process of obtaining CADAS assessments has also changed. Originally the courts utilised court-based CADAS clinicians who, by being located at the Court, could provide an immediate assessment, and recommend an appropriate treatment plan, even if brief, and identify if there was treatment availability within the current sitting of the court. This meant a Magistrate could order a CADAS assessment, and direct the defendant immediately to see the CADAS clinician in Court cells (if in custody) or in Court office (if in community). The defendant would then be bailed or directed to return to Court on the same day for determination of CADAS eligibility/support by the court (ACT Magistrates Court 2000). In June 2010 CADAS assessors relocated offices outside the court complex due to OHS requirements, namely the lack of a suitable space which contained two doors and a duress alarm. Since that time CADAS assessors have been off site at the Alcohol and Drug Services (ADS) premises.

Our court key informants suggest that while historically the CADAS defendant could see the magistrate/judge, attend a CADAS assessment, return back to the magistrate/judge and be released on condition of CADAS-assisted treatment all on the same day, with the relocation of

CADAS offices there is increased potential for a delay in these steps: particularly in the time taken to get back to see the magistrate/judge. Indeed, some court key informants suggest it may now take up to 3-6 weeks for a matter to be re-docketed and for the magistrate/judge to be able to see the defendant again. Defendants who are in custody and cannot get bail appear at greatest risk of such delays.³

Objectives

In the original conceptualisation CADAS (as an immediate, short-term intervention, when a client first appeared before the Court) the goals were:

- To provide drug treatment for offenders, by making assessment and appropriate treatment available immediately upon appearing in Court;
- To develop a commitment to treatment by the drug dependent offender;
- To divert drug using offenders from further involvement in the criminal justice system through drug treatment programs;
- To reduce the risk of further offending to support their drug use; and,
- To broaden the court's sentencing options (ACT Magistrates Court 2000:1).

While these goals still hold, goals under current model also include:

- To provide young offenders identified as needing the support of an alcohol and other drug service by Community Youth Justice with assessments and recommendations on treatment need/options. This includes youth on bail, deferred sentencing orders, youth on remand and youth within Bimberi Justice Centre potentially being released into the community (Community Youth Justice et al. 2012).
- To assist the court in consideration of bail applications and sentencing by providing assessments and recommendations on whether there is a need for AOD treatment, and if desired a means to facilitate access to AOD treatment services, monitoring and supervision (Supreme Court of the Australian Capital Territory 2010; ACT Health and ACT Corrective Services 2011).

Eligibility criteria

The eligibility criteria differ, depending upon the different CADAS referral options, target groups and CADAS models. For pre-plea the principal eligibility criteria are that alcohol and/or drug use must be a contributing factor, and that the defendant must agree to undertake treatment and comply with the conditions.

For youth justice the MOU states:

- Young people can be referred to CADAS by an ACT Court (Children's Court or Supreme Court) or Youth Justice Services (YJS).
- YJS can refer a YJS client (pre- or post-sentence) when it believes the client would benefit from an AOD assessment and possible referral to AOD agencies.

³ Feedback on the draft report suggested the 'delay for defendants in the community' may not be any greater since the relocation of CADAS offices. The difference may reflect in part the defendant pools to whom you are referring: those who are versus those who are not eligible for bail. There was no data to assess this in practice.

Policy directives

- Magistrate Court Practice Direction No. [] of 2000 Court Alcohol and Drug Assessment Service (CADAS) (sic).
- Practice Direction No. 1 of 2010: Using CADAS in the Supreme Court.
- Memorandum of Understanding between ACT Health and ACT Corrective Services 2010 to 2013 in relation the Court Alcohol and Drug Assessments for the Supreme Court of the Australian Capital Territory (2011).
- Memorandum of Understanding Between Community Youth Justice Services (“YJS”) and Court Alcohol Drug Assessment Service (“CADAS”) Act Community Health Alcohol & Drug Program” N.B. This was never formally adopted, in spite of four years of efforts to get this adopted (2003-2007).
- Protocol for community youth justice, Bimberi and alcohol and other drug services working with young people (2012).

Youth Drug and Alcohol Court (YDAC)

History

YDAC is a pre-sentencing program of the Children’s Court that was introduced in September 2011 by the Chief and Childrens Court Magistrates (Children’s Court of the Australian Capital Territory 2011). There were no specific resources attached. A large number of stakeholders have been involved in establishing the YDAC model and agreed protocols/templates, including Magistrates, DPP, Legal Aid ACT, Youth Justice the Health Directorate diversion team and other non-government stakeholders.

Objective

- Aims to divert young offenders (who are otherwise likely to be imprisoned) from custody by addressing the issues related to drug and alcohol offending in a holistic way, utilising therapeutic jurisprudence principles.

Eligibility

- The child or young people must have pleaded guilty to or admitted the offence(s), or the court can exercise discretion to refer and accept a child or young people who has plead not guilty to some offence(s) but guilty to the majority of matters.

Policy directives

- Practice Direction No. 1 of 2011: Youth Drug and Alcohol Court Program (Children’s Court of the Australian Capital Territory 2011).

Key stakeholders within each program

Table 7 provides a summary of the key stakeholders operating in each AOD diversion program and their roles. It is important to note this is a simplification and that not all roles are included e.g. ongoing data entry and reporting. Nevertheless, this indicates that the number and nature of stakeholders varies across the programs: from principally police focused for SCON, to a large network for YDAC, involving the court, Youth Justice, treatment agencies, DPP and potentially

mental health and housing support etc. Moreover, even amongst the three police diversion programs, the roles of the sworn police versus the diversion officers can be variable.

Table 7: Summary of key stakeholders in the ACT AOD diversion system and their roles

Program	Key stakeholders and their roles
SCON	<p>Police – sworn officers: detect offender, determine eligibility, issue SCON, secure drug for subsequent destruction</p> <p>Police – Illicit Drug Diversion Officer (IDDO): Identify unpaid SCONs and issues reminder notice – and for completed SCONs authorise destruction of drug, refer unpaid SCONs back to arresting officer</p> <p>Court/PED: Manage unpaid SCONs, not elsewhere dealt with</p>
PED	<p>Police – sworn officers: detect offender, transfer to police station, determine eligibility (including weighing drug), secure drug for subsequent destruction, enter referral onto SupportLink</p> <p>Police – IDDO: monitor compliance, train police, provide school drug diversion education</p> <p>ADS – diversion officers: Assess clients, education and counselling, follow up non-attendance, report on compliance/non-compliance, referrals to other agencies as necessary</p> <p>Other treatment agencies: Provide education and counselling as per referrals</p>
EIPP	<p>Police – sworn officers: detect offender, transfer to police station (or take alternate action if too inebriated), and when EIPP officers are not available contact parents, explain options and enter EIPP referral into SupportLink</p> <p>Police – EIPP diversion officers: Contact parents, explain options, enter EIPP referral into SupportLink, monitor compliance, train police, attend major youth events and assist sworn officers, provide school drug education</p> <p>ADS – diversion officers: assess clients, education and counselling, follow up non-attendance, report on compliance/non-compliance, referrals to other agencies as necessary</p> <p>Other treatment agencies: Provide education and counselling as per referrals</p>
CADAS	<p>Magistrates and Judges: refer defendants at bail or sentencing hearing to CADAS, at subsequent hearing decide on whether to order ongoing treatment – that fits or does not fit CADAS recommendation and is with or without CADAS supervision</p> <p>Youth Justice (YJ): refer potential defendants for assessment, monitor compliance, breach non-compliant juveniles</p> <p>DPP: decide on whether to request a referral or support a CADAS recommendation</p> <p>Legal representatives: decide on whether to request a referral or support a CADAS recommendation</p> <p>CADAS assessors: assess clients, write CADAS assessment report for court, make treatment recommendations, monitor progress/compliance with treatment – report non-compliance to Magistrates/Corrections/Youth Justice, prepares additional assessment report as requested</p> <p>Treatment providers – ADS, NGOs including interstate: provide ongoing treatment, provide reports to CADAS where applicable</p> <p>ACT Corrections: monitor defendants, receive reports of non-compliance from CADAS, breach non-compliant adults</p>
YDAC	<p>Children’s Court: refer defendants to CADAS, make final determination of YDAC suitability</p> <p>CADAS: Conduct initial assessment of client suitability and reports to Children’s Court and YDAC court team. If accepted onto YDAC, CADAS provides a weekly update on compliance</p> <p>DPP: determine whether to support YDAC option, respond to major breaches</p> <p>Legal representatives: determine whether to support YDAC option</p> <p>Joint Assessment and Review Team (JART): prior to acceptance on YDAC undertake comprehensive assessment of client needs, including employment, family relationships and recommends program plan, review/revise program plan as necessary</p> <p>YDAC court team (YDAC Magistrate, prosecutor, legal rep and person from JART): provide intensive monitoring of compliance and progress with program plan</p> <p>YJ: the lead agency within JART and represents JART on the YDAC court team. In addition to above, respond to reports of non-compliance</p> <p>Treatment providers – ADS, NGOs including interstate: provide ongoing treatment, provide reports to CADAS where applicable</p>

Conceptual maps of the ACT drug diversion system

Figures 3 and 4 outline conceptual maps of the ACT drug diversion system. Figure 3 outlines police diversion (SCON, PED and EIPP). Figure 4 outlines court diversion (CADAS and YDAC). Both maps are simplified versions⁴ and there are missing links between the two conceptual maps.⁵ Nevertheless they illustrate that there are a variety of ways in which offenders can access drug diversion programs in the ACT.

For the police diversion programs:

- Referral routes are relatively streamlined with one route into and out of programs. The main exception is for cannabis offenders, who have two routes for diversion: through SCON or PED, or sentenced through the traditional court system, and even sent from one program to another if they are non-compliant. That said police directives from June 2010 prioritise the use of PED over SCON.
- For PED and EIPP, connections between police and health are fostered by an online referral system, SupportLink. This notifies diversion assessors in the Alcohol and Drug Services (ADS) of new referrals, often within hours of collecting an offender, and enables appointments to be swiftly established.

For the court diversion programs:

- Referral routes are more diverse, particularly for CADAS, with offenders able to be referred by the Magistrates Court, Supreme Court, Children's Court, Youth Justice, or from a pre-sentence CADAS option to a sentence CADAS option.
- There is some overlap in programs, mainly as CADAS is utilised to undertake assessments for YDAC and to case manage clients.
- Relative to the police diversion programs, getting into CADAS and YDAC programs requires many more steps, and contact with different stakeholders. This increases the potential that offenders will be referred but not engage with AOD treatment, but strong collaborative working relationships and close follow up in the ACT mean that the vast majority of referred offenders end up in AOD treatment.
- Unlike the police diversion programs, there are different models afforded to diverted clients – both in program length (e.g. a one off CADAS assessment or a 12 month period of CADAS assisted treatment and case management) and/or the nature of the program plan (e.g. whether it is AOD specific, or also addresses other offender needs).
- What is less clear, but also important to note, is that relative to the police system, time between referrals, assessment and treatment may be more delayed. Moreover, as noted on pages 29-30 our court key informants suggested the potential for delays has increased since June 2010 when due to the absence of a court facility that could meet OHS requirements CADAS assessors relocated offices outside the court complex. While historically the CADAS defendant could see the magistrate/judge, attend a CADAS assessment, return back to the magistrate/judge and be released on condition of CADAS-assisted treatment all on the same day, with the relocation of CADAS offices there is increased potential for a delay in these steps: particularly in the time taken to get back to see the magistrate/judge. Defendants who are in custody and cannot get bail appear at greatest risk of such delays.

⁴ For example, not included are steps whereby offenders may be bailed to undertake their CADAS assessment or assessed in custody cells.

⁵ Any offender who is not diverted through a police diversion program and/or fails to meet the conditions of their police diversion program (Figure 3) may be assessed for and diverted through CADAS (Figure 4).

Figure 3: Conceptual map of ACT AOD police diversion

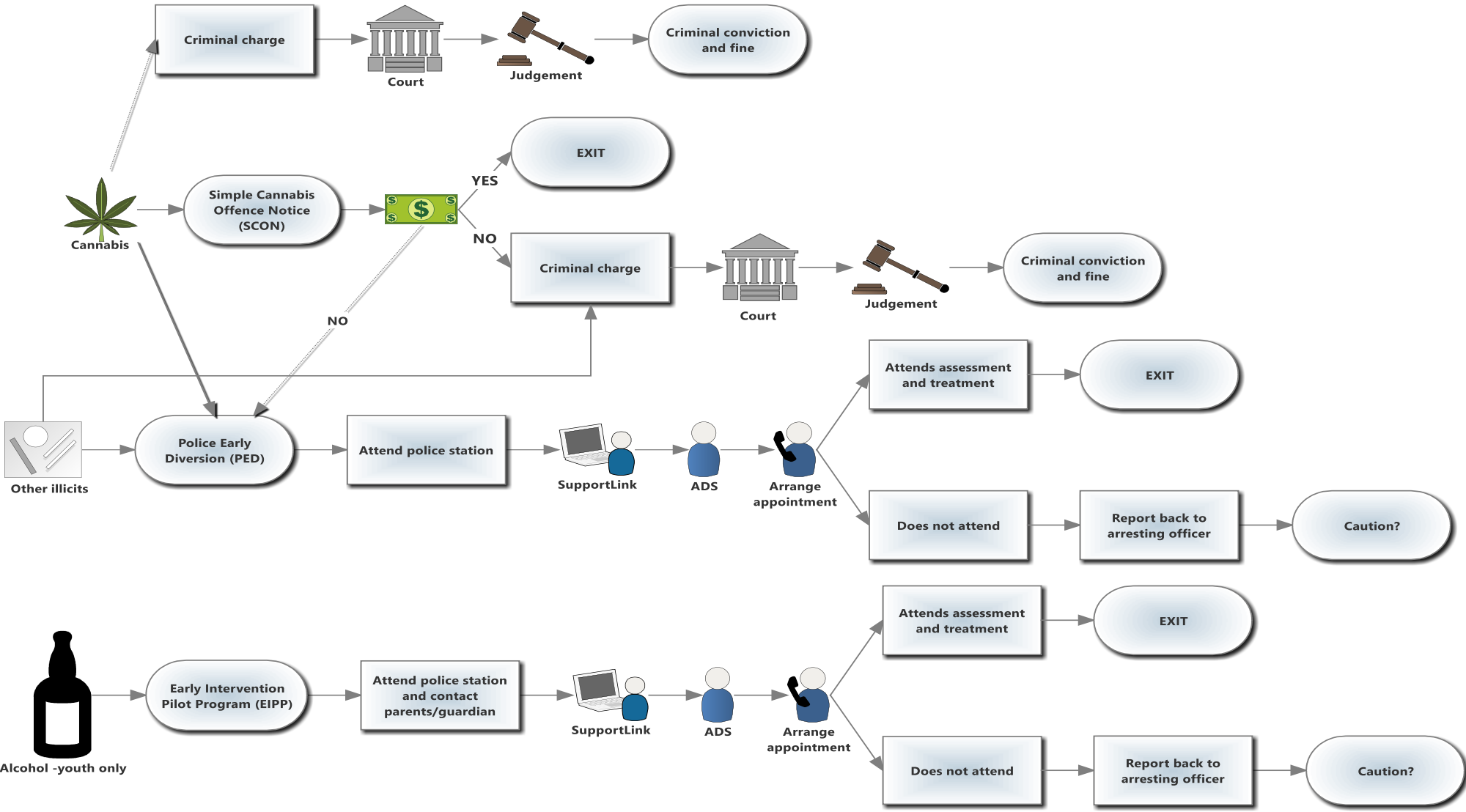
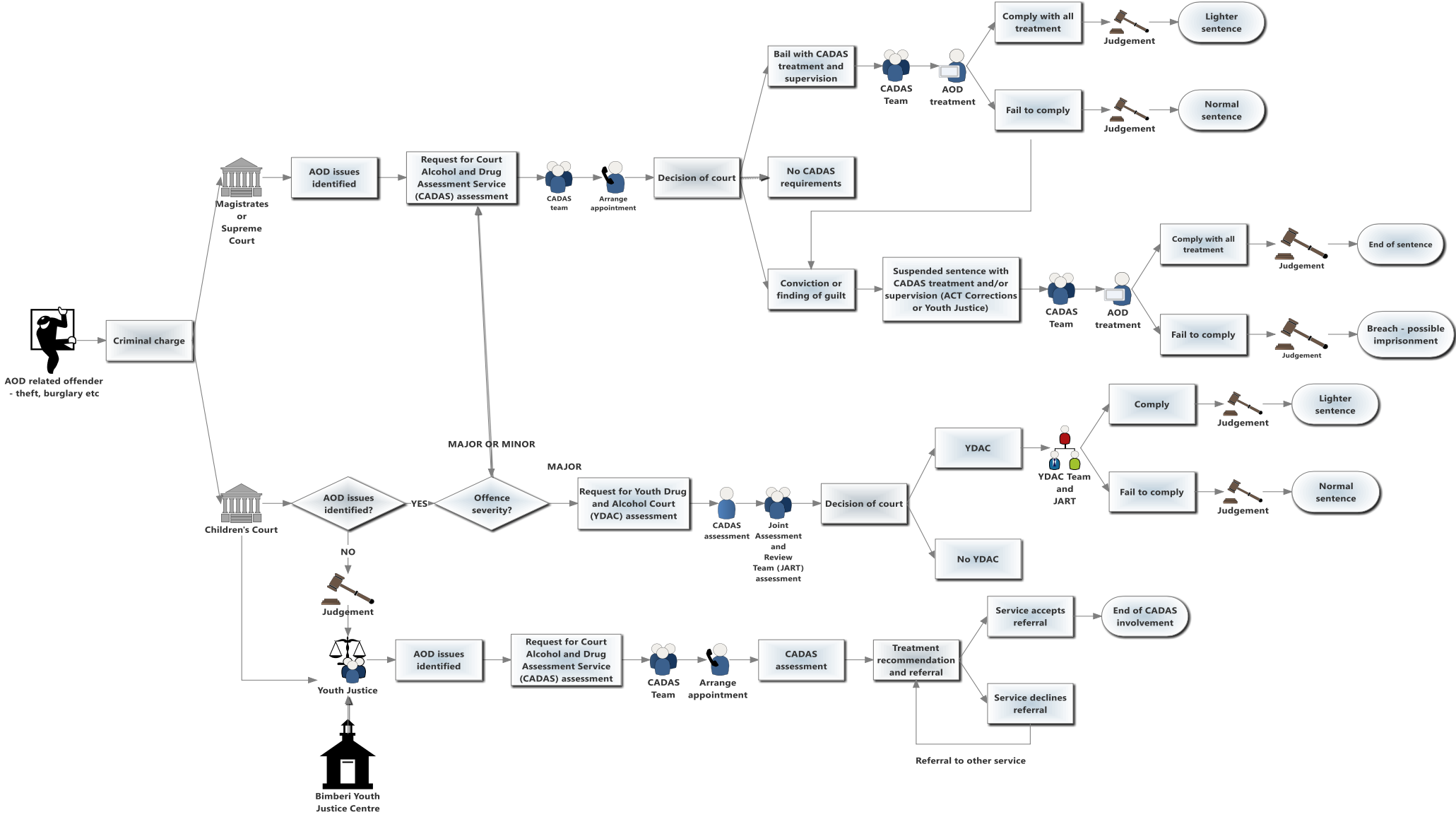


Figure 4: Conceptual map of ACT AOD court diversion



Data on program referrals and throughput in 2010/11

The following section summarises data on referrals and throughput in 2010/11. This provides a picture of the number of offenders flowing into the ACT AOD diversion system and the types of activities undertaken to those diverted. Given the period of analysis there are no data on offenders diverted through the YDAC program.

Program referrals

Number of referrals

Table 8 reports the total number of referrals to the ACT drug diversion system in 2010/11, by program. From July 2010-June 2011 there were a total of 555 referrals: with 60% occurring to the EIPP and CADAS programs. It is important to note that EIPP was still in a period of program commencement during this period, which may have reduced throughput. For example, from January to December 2011 there were a total of 227 referrals to EIPP.

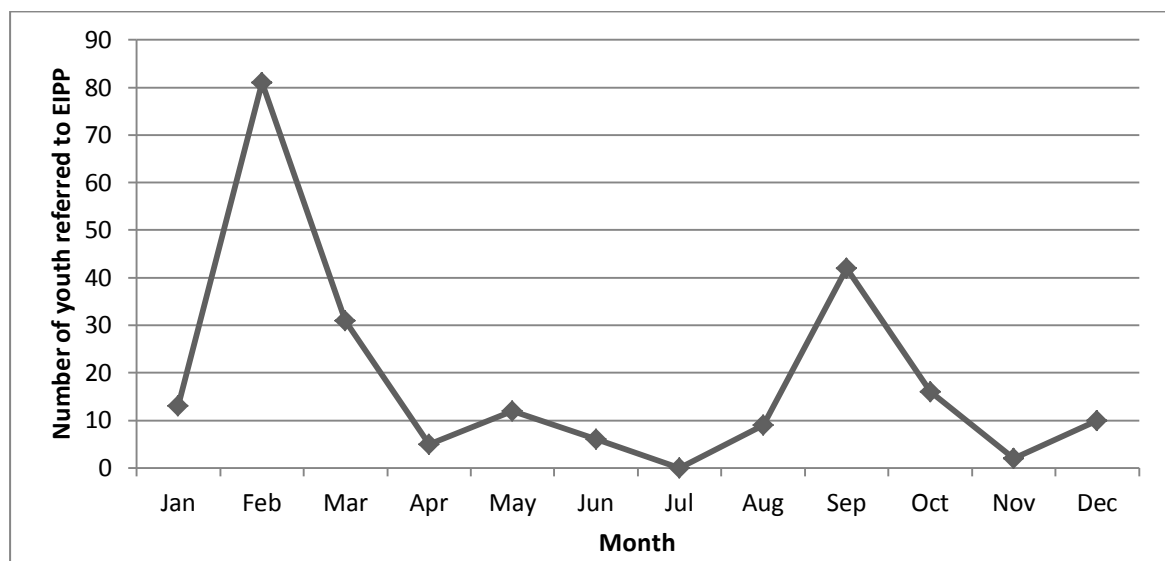
Table 8: AOD and AOD-related offenders referred to ACT police and court diversion programs in 2010/11, by program

Diversion program	No. of referrals	Percentage of referrals
Early Intervention Pilot Program (EIPP)*	157	28%
Police Early Diversion (PED)	107	19%
Simple Cannabis Offence Notice (SCON)	114	21%
Court Alcohol & Drug Assessment Service (CADAS)	177	32%
Total	555	100%

Source: ACT Drug Diversion Data Activity Report 2010-2011

* Referrals to EIPP were lower in the first half of this reporting period (Jul-Dec 2010), as EIPP diversion staff were employed in November 2010. There were only 6 referrals from the first half of this reporting period (Jul-Dec 2010), compared to 151 from Jan-Jun 2011.

Moreover, referrals to the EIPP program are highly variable, with 16 or fewer referrals during most months, and a large number of referrals from targeted youth events including the Australia Day Live concert and Skyfire (Australian Federal Police 2010; Australian Federal Police 2011; Australian Federal Police 2012). This is particularly evident from unpublished monthly PROMIS data on EIPP referrals from January to December 2011 (see Figure 5).

Figure 5: EIPP referrals by month, Jan-Dec 2011

Source: Unpublished PROMIS data.

Nature of offence/offender

Data on the nature of offence/offender is important to identify who is being referred through the ACT drug diversion system (and into different elements of the system). All data on the offence/offender is for the point of first referral. The characteristics of those who complete may differ from those originally referred. This is particularly true for CADAS. With that limitation in mind we begin by outlining the nature of the offence.

For EIPP for the period December 2010-December 2011 most EIPP offences constituted consumption or possession offences (see Table 9) (unpublished PROMIS data). This indicates that youth are as intended being diverted for 'alcohol offences' rather than 'alcohol-related offences' such as a property offence.

Table 9: EIPP offence at point of referral – Dec 2010-Dec 2011

Offence	Number	Percentage
Purchase		5.2%
• Child/young people buy liquor	11	
Possess		36.6%
• Child/young people possess liquor	31	
• Child/young people possess liquor in a public place	47	
Consume		56.8%
• Child/young people consume liquor	81	
• Child/young people consume liquor in a public place	40	
Possess/Consume		1.4%
• Child/young people possess/consume liquor	3	
Total	213	100%

Source: Unpublished PROMIS data.

Table 10 indicates that in 2010/11, 89.7% of offences that led to a PED involved cannabis. The data does not distinguish cases involving cannabis possession from cannabis cultivation, but unpublished seizure data for the subset of 83 of the 96 PED referrals involving cannabis,

indicates only 3 (3.6%) involved cannabis cultivation.⁶ After cannabis, the next most frequent offence type was possession of ecstasy (4.7%). Only 11 individuals were diverted for drugs other than cannabis across the whole system.

Table 10: PED offence at point of referral – 2010/11, by drug type

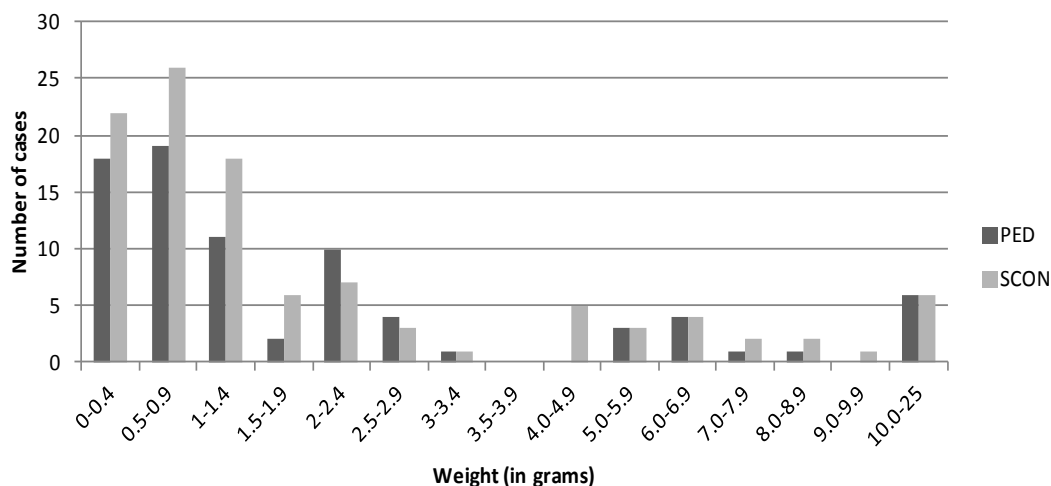
Offence	Number	Percentage
Cannabis	96	89.7%
Ecstasy	5	4.7%
Amphetamines	1	0.9%
Cocaine	1	0.9%
Hallucinogens	1	0.9%
Heroin	0	0.0%
Not stated	3	2.8%
Total	107	99.9%

Source: ACT Drug Diversion Data Activity Report 2010-2011.

Data on the offence type of SCONS issued is not routinely recorded, but unpublished seizure data was obtained for 113 of the 114 issued SCONS in 2010/11. This indicated that similarly with the PED scheme, the vast majority (93.0%) involved cannabis possession only, with 6.1% involving cultivation of cannabis plants.

Figure 6 reports the quantity of cannabis seized on offenders referred to SCON and PED for cannabis possession in 2010/11. A very similar pattern is evident from both schemes. Indeed, 45-46% involved possession of less than 1 gram of cannabis and 78-80% involved possession of less than 3 grams. This indicates that offenders are being diverted with extremely small quantities of cannabis.

Figure 6: Quantity of cannabis seized on offenders diverted to PED and SCON for cannabis possession in 2010/11, by program



Source: Unpublished ACT Police data. N.B. 1 joint=0.34 g (Mackenzie et al. 2010).

For CADAS offenders referred in 2010/11 unpublished data from the Health Directorate indicates that most were referred for theft/burglary, public order offences (e.g. offensive language, graffiti, property damage, public urination or public drunkenness) or road traffic

⁶ This may underestimate the total number of referrals involving cannabis cultivation as one seizure may have involved two referrals. Nevertheless, it indicates that the majority of cannabis referrals involve simple possession offences.

offences. Drug offences were a minority, accounting for only 9.1% of referred offences (see Table 11). This indicates that the CADAS population, at least at the point of referral, is as intended a ‘drug-related offender’ rather than a ‘drug offender’.

Table 11: CADAS offence at point of referral in 2010/11

Offence	Number	Percentage
Drug		9.1%
• Illicit drug offences (possess/use/traffic)	16	
Theft/Burglary		28.4%
• Theft and related offences (includes fraud)	33	
• Unlawful entry with intent/burglary, break / enter	5	
• Aggravated Robbery	12	
Assault		18.2%
• Act intending to cause injury (includes assault)	30	
• Sex Offence	2	
Public order/Road traffic		27.3%
• Public order offence	26	
• Road traffic and motor vehicle regulatory offences	20	
Other		17.1%
• Supreme court bail app	3	
• Unknown	27	
Total	176	100.0%

Source: Unpublished data – ACT Health Directorate.

Nature of the offender

Data on the demographics of SCON recipients was unavailable. Across all other programs, the majority of clients referred through the ACT drug diversion scheme were male. Indeed, 71.9% of all referred clients (for which data is available) were male. However, as shown in Table 12 there was variation across the programs. Most notably, males and females were almost equally likely to be referred into the EIPP program (55.4% male), while there were more males diverted to PED (83.2%). This appears to reflect the patterns of consumption of alcohol and drugs in the ACT (see pages 12 to 13).

Table 12: Gender of referrals, EIPP, PED and CADAS, 2010/11

Diversion program*	Male	Female	Total	Percentage male
EIPP	87	70	157	55.4%
PED	89	18	107	83.2%
CADAS	141	36	177	79.7%
Total for which data is reported*	317	124	441	71.9%

* Demographic data is unavailable for SCON recipients.

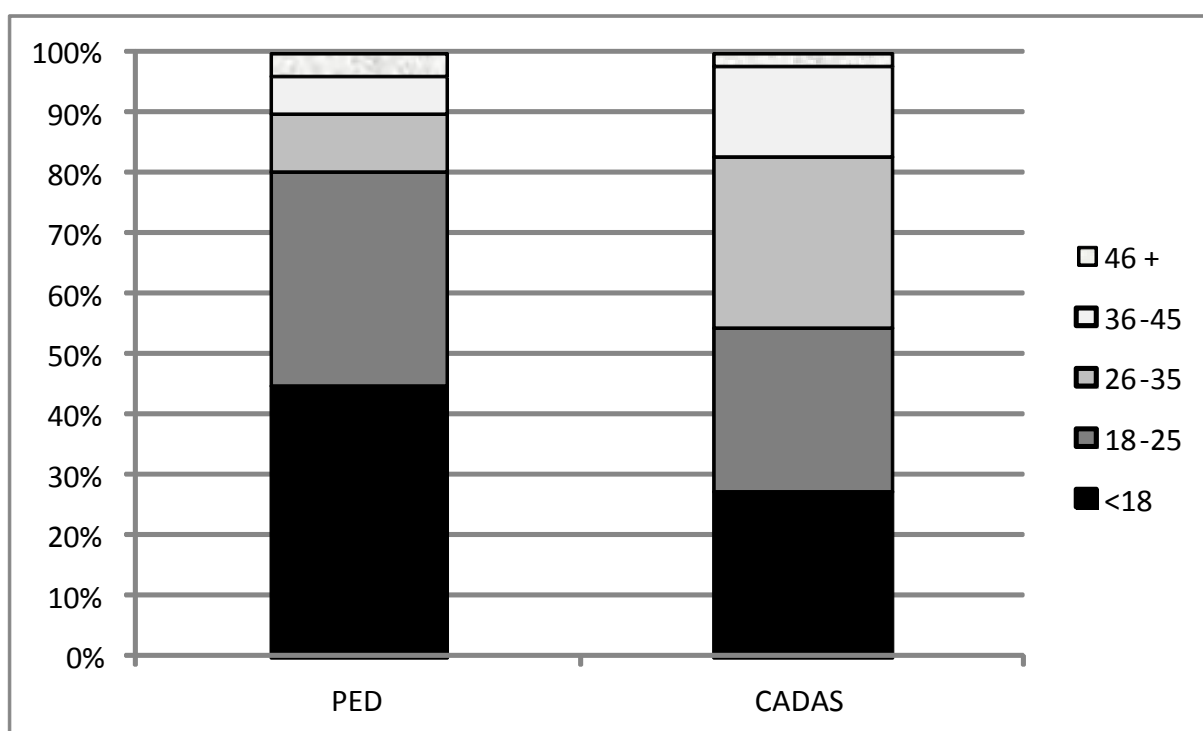
Although approximately 14.7% of all referred clients were Aboriginal and Torres Strait Islander (ATSI), as shown in Table 13 this differed markedly between the police and court programs. Indeed, one in four clients referred through CADAS were Aboriginal and Torres Strait Islander, compared to less than one in ten clients referred through the police EIPP or PED program.

Table 13: Aboriginal and Torres Strait Islander (ATSI) status of referrals, EIPP, PED and CADAS, 2010/11

Diversion program*	Number of ATSI clients	Total	Percentage ATSI
EIPP	14	157	8.9%
PED	5	107	4.7%
CADAS	46	177	26.0%
Total for which data is reported*	65	441	14.7%

* Demographic data is unavailable for SCON recipients.

In 2010/11 approximately 77% of offenders referred to the ACT AOD diversion system were aged less than 25 and 57.6% were aged less than 18 (data on SCONs is excluded due to lack of data). The average age of those referred differed across the programs: EIPP clients (average age=17) were on average six years lower than for those referred to PED (average age=23) and nine years lower than for those referred to CADAS (average age =26).⁷ Examining PED and CADAS more specifically (see Figure 7), CADAS received three times as many people aged 26-36 (28.6% compared to 9.3% of PED).

Figure 7: Age of PED and CADAS referrals, 2010/11

Reflecting the differing target populations the primary of drug of concern in 2010/11 varied across the programs. For example as shown in Table 14 alcohol was the primary drug of concern for 98.6% of EIPP clients, 28.4% PED clients and 31.0% of CADAS clients. Cannabis was the primary drug of concern for PED and CADAS clients, albeit with many more PED clients than CADAS clients nominating it as their primary concern (62.1% and 36.1% respectively).

⁷ These ages were recalculated based on data in the ACT drug diversion activity report.

Table 14: Primary drug of concern, EIPP, PED and CADAS, 2010/11

Diversion program	EIPP	PED	CADAS
Licit			
• Alcohol	141 (98.6%)	27 (28.4%)	48 (31.0%)
• Tobacco	0 (0.0%)	2 (2.1%)	0 (0.0%)
Illicit			
• Cannabis	2 (1.3%)	59 (62.1%)	56 (36.1%)
• Heroin	0 (0.0%)	2 (2.1%)	26 (16.8%)
• Opiates	0 (0.0%)	0 (0.0%)	3 (1.9%)
• Amphetamines	0 (0.0%)	0 (0.0%)	20 (12.9%)
• Ecstasy	0 (0.0%)	2 (2.1%)	0 (0.0%)
• Cocaine	0 (0.0%)	0 (0.0%)	1 (0.6%)
None identified			
• Nil	0 (0.0%)	3 (3.2%)	1 (0.6%)
Total for which primary drug of concern known	143 (99.9%)	95 (100%)	155 (99.9%)

* Unknown for 1 EIPP. * Unknown for 22 CADAS clients. Demographic data is unavailable for SCON recipients.

Throughput of diverted offenders

Data on throughput indicates the extent to which diverted offenders comply with the diversionary opportunity and for programs such as EIPP, PED and CADAS, the extent to which they received therapeutic intervention. As shown in Table 15 in 2010/11 a total of 68 of the 114 SCON recipients paid their SCON during the 60 day expiration period. This left 40.4% that were not paid. While data on responses to non-paid SCONS is limited there is evidence that 6 were withdrawn and converted into a PED and 17 were to be brought before the court.

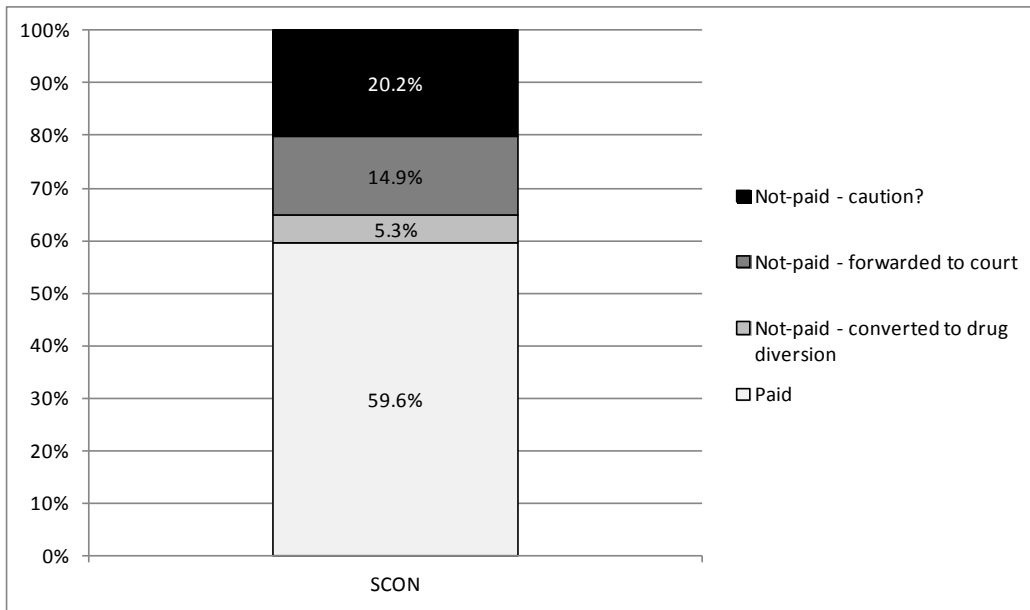
Table 15: Throughput of AOD offenders issued with SCONS, 2010/11

No. SCONS issued	No. paid	Number. not-paid	Response to non-paid SCONS (n=46)		
			No. withdrawn and converted to PED	No. to be brought before court for non-completion	No. unknown
114	68	46	6	17	23

Source: ACT Drug Diversion Data Activity Report 2010-2011 – updated to finalised period.

Overall, 59.6% of all issued SCONS were paid outright, 5% were withdrawn and converted to a PED and 14.9% were brought before court (see Figure 8). Data from 2011 indicates that of the 2008-09 SCON cohort who did not pay their SCON (n=33), only 7 cases have been finalised, with five still scheduled to attend court, 3 under warrants for arrests, etc. The consistency of reporting and follow up is questionable, but this does suggest there are long delays before non-paying SCON recipients are seen before the court and finalised. Moreover, it further suggests that of offenders that are finalised in court, they tend to be convicted and fined an amount equal to or less than the original SCON offence (\$100, \$60 or \$50). Indeed, a Supreme Court directive means that those in court should receive a 25% discount off the original offence (Roundtable 3).

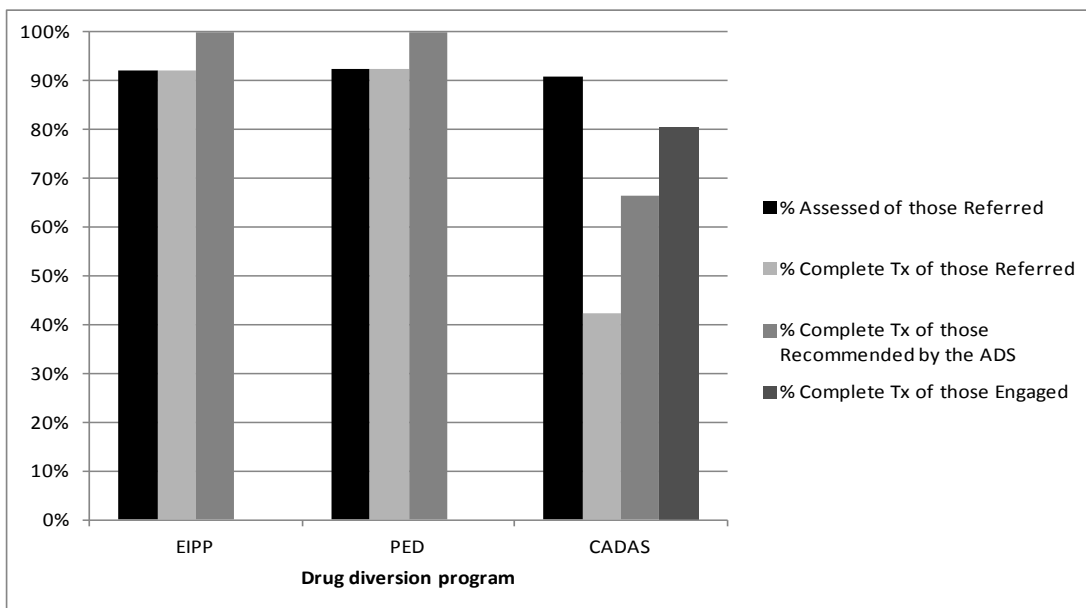
Figure 8: Response of AOD offenders issued with SCONs in 2010/11, by mode



Source: Unpublished PROMIS Data.

For the other AOD diversion programs which utilise referrals into treatment, all three programs showed high levels of compliance with the initial assessment by the ADS. Indeed, 91-92.5% of offenders referred to EIPP, PED or CADAS in 2010/11 attended an assessment (see Figure 9). For the two police diversion programs, EIPP and PED, 100% of clients who attended an assessment with the ADS were engaged in and completed their required treatment, with the net consequence that both programs had very high levels of treatment completion. Both programs had therefore a very similar throughput profile (albeit as shown subsequently, the type of treatment differed).

Figure 9: Percentage referrals/assessments/treatment completions for AOD offenders referred through EIPP, PED and CADAS, 2010/11



Source: ACT Drug Diversion Data Activity Report 2010-2011 – updated by unpublished ADS data.

In contrast for CADAS while 91% referred were assessed by the ADS, only 44.1% of all referrals to CADAS were deemed to have successfully completed treatment (see Table 16).⁸ At first glance this number appears low, but it is clear that CADAS offenders who are engaged in treatment have a very high likelihood of treatment completion: with 83.9% of all CADAS clients engaged in treatment, completing the treatment. This indicates that those who are successfully engaged fair well. But there are also a substantial number of CADAS clients who were either not recommended by the ADS as requiring or being ready for treatment (successful non-completions) and a substantial number who were recommended but then did not engage in CADAS facilitated-treatment. Both factors applied more to youth than adults. Without additional data it is not possible to say with certainty as to the reason however, it may be in part attributable to the use of CADAS by Youth Justice to undertake assessments only (Community Youth Justice et al. 2012; Youth Justice Services and Court Alcohol Drug Assessment Service Not officially adopted).

Table 16: No. referrals/assessments/treatment engagements/treatment completions for AOD offenders referred through PED and CADAS, by youth and adults, 2010/11⁹

Diversion program	Number of referrals	Number assessed by ADS	Number recommended for treatment	Number engaged in treatment	Number completed treatment
PED					
• Youth	48	44	44	44	44
• Adults	59	55	55	55	55
• Total	107	99	99	99	99
CADAS					
• Youth	52	50	38	23	19
• Adults	125	111	101	70	59
• Total	177	161	140	93	78

Source: Unpublished data from the ADS.

Treatment utilisation

In 2010/11 all 144 EIPP clients received assessment and education (see Table 17). Further counselling was received by 7 (4.8%) of EIPP clients. In accordance with the PED policy (all clients attend an assessment and one of the following: education or counselling) data provided by the ACT Diversion Activity Report indicate that all 95 PED clients in 2010/11 received one of these options: with 61 (64%) receiving assessment and education and 34 (36%) receiving assessment and counselling.¹⁰

Finally, CADAS clients often accessed multiple treatment options. Counselling was most commonly accessed (97.1% CADAS clients), but many clients also accessed residential rehabilitation and pharmacotherapy (40.9% and 24.7% CADAS clients respectively). There were noted differences in treatment utilisation between CADAS youth and CADAS adult clients. Of those assessed, young people in CADAS were much less likely to be referred to residential rehabilitation (see Table 17).

⁸ CADAS treatment completion figures do not include people referred to treatment who attended without court direction. This number only reflects people monitored by CADAS during their Court matters.

⁹ There has been some difference of opinion as to whether there were 99 or 95 PED clients assessed and completed: with assertions the data may have been incorrectly entered. The final figures were based on personal communication with the ADS (11.05.12). In either case, the proportion of referred clients who were assessed and completed PED treatment is very high.

¹⁰ Feedback on a draft report noted: "All PED clients receive assessment and education when they attend and then are referred for further treatment as required. In 2010/11 our stats may not have accurately captured that education always occurs as a part of the initial assessment."

Table 17: EIPP, PED & CADAS treatment utilisation in 2010/11, by treatment type and age

2010/2011	Youth	Adult	Total
EIPP			
• Education	144	-	144 (100.0%)
• Counselling	7	-	7 (4.8%)
PED			
• Education	31	30	61 (64.2%)
• Counselling	14	20	34 (35.8%)
• Case Management	1	1	2 (2.1%)
• Pharmacotherapy	0	2	2 (2.1%)
• Residential Rehab	0	1	1 (1.0%)
CADAS			
• Counselling	29	52	81 (87.1%)
• Residential Rehab	4	34	38 (40.9%)
• Pharmacotherapy	0	23	23 (24.7%)
• Education	2	11	13 (14.0%)
• Case management	2	10	12 (12.9%)
• Supported accommodation	0	4	4 (4.3%)
• Withdrawal	0	3	3 (3.2%)
• Not recommended for treatment	11	10	21 (22.6%)

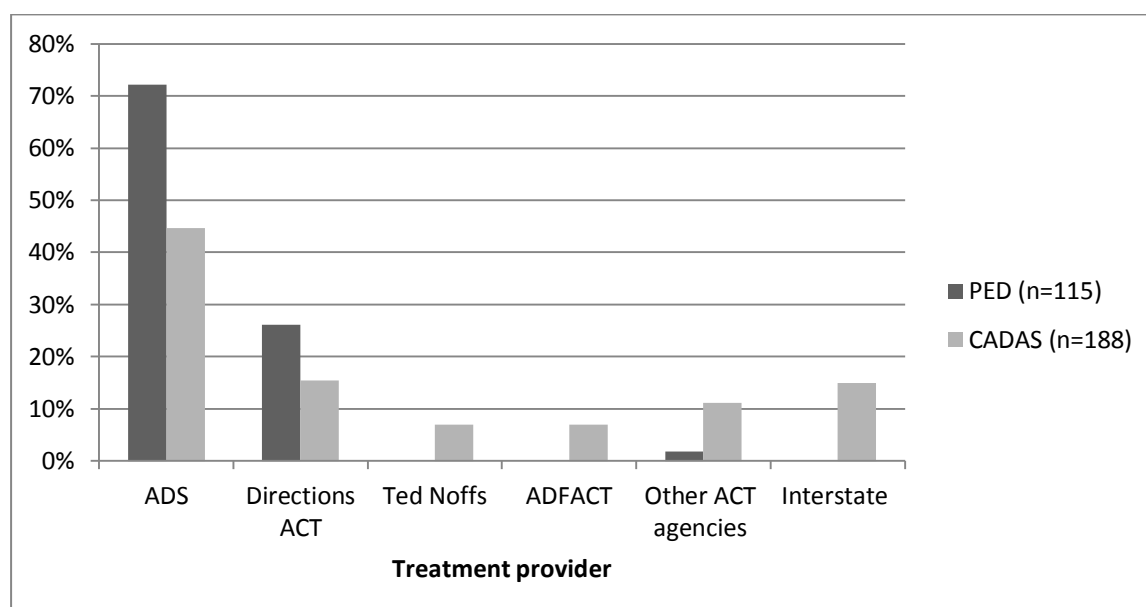
EIPP number of clients = 144 i.e. clients can be referred to more than one treatment type.

PED number of clients = 95 i.e. clients can be referred to more than one treatment type.

CADAS number of clients = 93 i.e. clients can be referred to more than one treatment type.

The majority of PED treatment was provided by the government funded Alcohol and Drug Services (ADS) (72.2%), either by the diversion team or the other ADS counsellors. But 26.1% was provided by the non-government treatment organisations, most notably Directions ACT (see Figure 10).

Figure 10: Distribution of treatment provision* for PED and CADAS, 2010/11



*Individuals may receive more than one form of treatment. ADFACT is now Karralika Programs Inc.

For CADAS, the ADS was again the major provider (44.7%) but non-government treatment organisations played a much greater role (38.9%). Interstate services moreover accounted for 14.8% of service provision. Differences in service provision across adults and youth are unclear.

CADAS knowns and unknowns

As outlined in the earlier section CADAS has undergone a number of substantial changes since its adoption. There continues to be ongoing flux as it appears that the pathways into CADAS have broadened. We also know that CADAS models have broadened, with assessment only, pre-sentence and sentence only. Yet there is an apparent lack of understanding of different models operating in the ACT, the scale of utilisation or implications for interpreting the referral and throughput data, costing the system or establishing avenues for improvement. For example, the individuals the evaluation team spoke to often had different views on how CADAS was operating, or alternatively, could not say what was happening. Thus, while we know the traditional pathway of referrals into CADAS and then out to treatment, this is not even close to encapsulating the complexity of CADAS. The best knowledge and data is on referral routes for the pool of CADAS clients referred for assessments with ADS (see Table 18).

Table 18: Referral routes for CADAS in 2010/11, by age, number and percentage

	Youth	Adults	Total
Number			
• Magistrates	0	77	77
• Children's Court	7	0	7
• Supreme Court	2	47	49
• Youth Justice	43	0	43
• Total	52	124*	176*
Percentage			
• Magistrates	0.0%	62.1%	43.8%
• Children's Court	13.5%	0.0%	4.0%
• Supreme Court	3.8%	37.9%	27.8%
• Youth Justice	82.7%	0.0%	24.4%
• Total	100.0%	100.0%	100.0%

Source: Youth: ACT Drug Diversion Data Activity Report 2010-2011. Adults: unpublished data from the ADS.

*Data on one adult is missing.

Table 18 indicates that 82.7% of referrals for CADAS youth were via Youth Justice. For adults, the major source of referral was Magistrates, accounting for 62.1% of referrals, but the Supreme Court made a still sizeable contribution to referrals (37.9%). Across all CADAS clients this therefore means that the major referral source is the Magistrates (43.8%), with the Supreme Court and Youth Justice both contributing about a quarter of all referrals in 2010/11.

Key unknowns remain: who of the referred stay in the system, who leaves, and why? We conjectured above that it appears that, in line with the existing protocols, many of the apparent CADAS 'drop outs' are the Youth Justice referrals. Yet the extent to which this is true is not currently verifiable as data on this is not collected nor even guessable. A further and very important unknown is to what extent CADAS is being utilised for assessment only, versus as a pre-sentence versus a sentencing option: to what extent this differs for young people and adults; and to what extent this varies across the courts. The different models (and relative mix of the models) have considerable implications for resource utilisation (see pages 54 to 63) and program impacts/effectiveness. For example, if CADAS is being used predominantly for assessment only this is likely to lead to cost savings (as it is undoubtedly cheaper than assessment and treatment provision), yet it may lead to reduced capacity to address AOD issues.

Trends from 2001/02 to 2010/11

Figure 11 illustrates the total number of referrals to the ACT drug diversion system from 2001/02 until 2010/11. Referrals during the start-up years did not reflect full capacity (start-up years were 2001/02 for CADAS and PED and 2009/10 for EIPP), but this nevertheless reveals a number of insights. First, the ACT drug diversion system has received about 400-500 referrals in any one year. Second, the number of referrals reduced during the early 2000s (from 2002/03 to 2005/06), stabilised during the mid to late 2000s. The trend from 2009/10 to 2010/11 appear to reverse this somewhat, with the peak levels seen in the system to date.

Figure 11: Trends in the total number of referrals to the ACT drug diversion system, 2001/02 to 2010/11

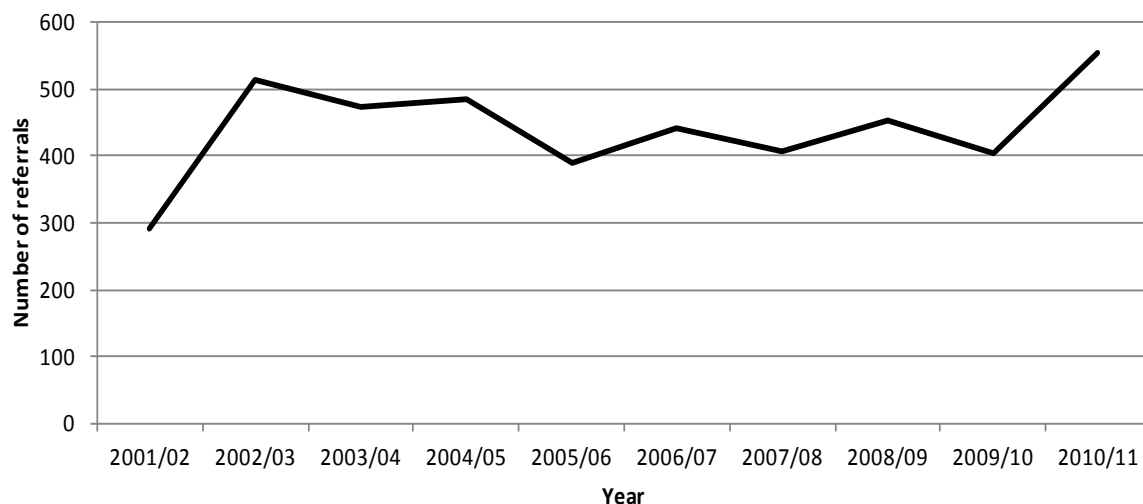
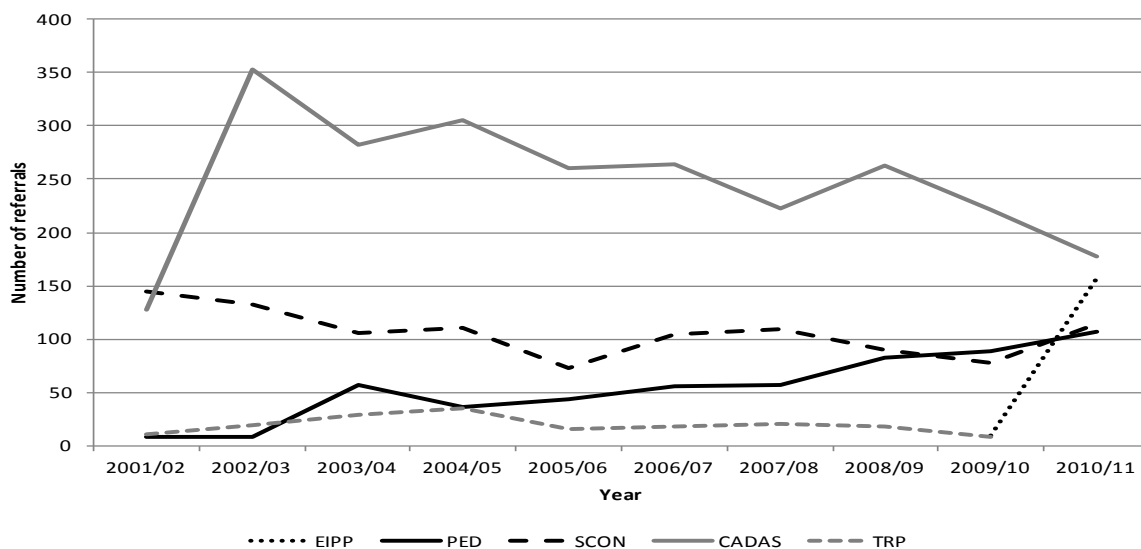


Figure 12 presents the number of referrals, by program. Two key trends are evident. First, CADAS referrals have steadily declined from 2002/03 until 2010/11. The reduction since 2008/09 is arguably even more marked, with for example 2010/11 being the first year since commencement that total referrals fell below 200 (a 50% reduction from the 2002/03 peak).

Second, PED referrals have increased markedly. Indeed, from 2003/04 to 2010/11 there was a 188% increase in PED referrals. Combined with the new EIPP referrals, this means that 2010/11 was the first year in which referrals via police outnumbered referrals via courts. Indeed, while over the entire time period 61.3% of referrals have been to the courts (57.2% to CADAS), in 2010/11 only 31.9% were through the courts, CADAS specifically. For discussion on the potential causes on the CADAS decline in referrals see pages 88-90.

Figure 12: Trends in the number of referrals to the ACT drug diversion system, by program, 2001/02-2010/11

N.B. Referrals in year of program commencement are incomplete. CADAS & PED commenced in 2001/02 and EIPP in 2009/10.

Data on the extent to which referred clients are assessed by ADS, recommended for treatment and complete treatment is depicted in Table 19 summarising the key points of interest: the extent to which those referred are actually assessed; the extent to which those referred complete treatment; and the extent to which those recommended by ADS as requiring treatment complete. The extent to which assessments actually take place, reflects the extent to which the offender is educated about their requirement, and efforts of ADS to contact the offender. The extent to which those diverted complete treatment can be shaped by a range of factors including, for CADAS, the extent to which Magistrates utilise CADAS as a route into treatment, versus for information only. The extent to which those recommended for treatment actually complete treatment is arguably the best indicator of CADAS success.

PED assessment and completion has remained high, albeit with the exception of the 12 no shows in 2010/11 (see Table 19). Added together with Figure 12 this indicates that even while PED referrals have increased, the percentage of clients who are assessed by ADS and complete treatment has remained high.

Trends regarding CADAS indicate that the percentage of CADAS referred clients who were assessed increased from 2007/08 to 2009/10 then dropped in the most recent year for which data is available (2010/11) indicating some decline in getting clients to turn up for an assessment. However, the proportion of offenders who are referred to CADAS who complete treatment has increased to 42% in 2010/11, reversing the drop during 2008/09 and 2009/10. Finally, and importantly, the percentage of CADAS clients who are recommended for treatment and complete it has increased, from 35-37% to 66% (see Table 19). This indicates that while the number of referrals to CADAS has decreased over time, there has been increased success in retaining those offenders that are assessed as needing AOD treatment.

Table 19: Trends in treatment completion for PED and CADAS, 2007/08 to 2010/11

Diversion program	Referrals			Recommended for treatment		Engaged in treatment	
	N	% Assessed	% Complete	N	% Complete	N	% Complete
PED							
• 2007/08	57	98.2%	94.7%	55	98.2%	55	98.2%
• 2008/09	83	97.6%	97.6%	81	100.0%	81	100.0%
• 2009/10	88*	98.9%*	98.9%*	87	100.0%	87	100.0%
• 2010/11	107	92.5%	92.5%	95	100.0%	95	100.0%
CADAS							
• 2007/08	222	94.6%	42.3%	203	46.3%	138	68.1%
• 2008/09	263	96.2%	30.4%	214	37.4%	118	67.8%
• 2009/10	221	97.7%	29.0%	182	35.2%	101	63.4%
• 2010/11	177	91.0%	42.4%	140	66.4%	93	80.6%

*100% if count referrals of 'offenders' only.

Program reach

A question that is often posed about the ACT AOD diversion programs is the extent to which more clients could be diverted, and a sense that there have often been low numbers of referrals (Hales and Scorsonelli 2009; ACT Government Department of Disability Housing and Community Services 2011). One way of assessing this is to examine the size of the potential eligible population, and compare this with the actual referral numbers into the programs.

Early Intervention Pilot Program (EIPP)

Potential EIPP clients are young alcohol users/mis-users. Data to identify the number of eligible offenders was extracted by ACT Policing from PROMIS. During the period December 2010 to December 2011 there were 257 juveniles picked up in the ACT by police for alcohol offences, defined as purchase, possession or consumption (see Table 20). Of these, 82.9% were dealt with by way of an EIPP referral. The largest other category was caution, predominantly for consumption offences. This indicates that the vast majority of those eligible for EIPP are being diverted through the scheme.

Table 20: Charges for juvenile alcohol offences – purchase, possession or consumption of liquor – by clearance mode, Dec 2010-Dec 2011

Drug	Number of charges	Relative coverage
EIPP	213	82.9%
Caution	42	16.3%
Summons	1	0.4%
Arrest	1	0.4%
Total	257	100.0%

Source: Unpublished PROMIS data.

Police Early Diversion (PED) and Simple Cannabis Offence Notice (SCON)

Due to the overlap in client pools of PED and the SCON scheme we consider the reach of these together. There were 405 arrests/detections for consumer drug offences in the ACT in 2009/10 (Australian Crime Commission 2011) and a total of 221 diversions through the PED/SCON programs in 2010/11 (Table 21). This suggests that the programs diverted the vast majority of cannabis consumers: 70.9%.¹¹ Yet, there were far more illicit drug users detected with heroin, cocaine or amphetamine-type substances such as MDMA than were being referred through the police diversion programs (7 out of a total of 105 offences).

Table 21: Number of consumer arrests versus number of diversions by drug type

Drug	Consumer 'arrests/detections' in 2009/10	ACT PED and SCON diversions in 2010/2011	Relative coverage
Cannabis	2961	210	70.9%
ATS	76	6	7.9%
Cocaine	8	1	1.3%
Heroin	21	0	0%
Any illicit	405	221	54.6%

¹¹Includes SCONS i.e. any legal action taken towards cannabis consumers.

Court Alcohol & Drug Assessment Service (CADAS)

CADAS clients can be detected for a large potential array of offences – this makes assessments of potential reach harder, particularly as CADAS eligibility is based less on the offence, and more on drug use patterns of the detected offender. We can however estimate the potential reach based on three factors:

- Knowledge of the current patterns of CADAS detected offences
- Estimates of the total number of offences that led to court within each category committed in the ACT in any one year
- Estimates of the likely pool of offences, committed by drug dependent individuals.

As listed in Table 22 CADAS clients in 2010/11 were detected for predominantly theft/burglary, assault, public order and road traffic offences. Data on the total number of offences (regardless of whether drug or non-drug related) that led to a court appearance in the ACT in each of these offence groups is available through the Australian Bureau of Statistics (ABS). The ABS data excludes offences for the unknown categories. Nevertheless, the available data covers 83.0% of the offences for which 2010/11 CADAS clients were detected with.

To account for the likely proportion of offences committed by drug-dependent offenders we have drawn upon the data of the Australian Institute of Criminology from their Drug Use in Monitoring in Australia (DUMA) program (Sweeney and Payne 2012). Data for DUMA is derived from police detainees at stations across Australia based on self-reported data on the extent to which their most recent offence was attributable to illicit drugs and/or alcohol. The 2009/10 data was derived from 7,761 detainees.

¹¹ A small number of minor cultivation offences are included in both the numerator and denominator.

Table 22 lists the number of CADAS offences at the point of referral, by offence, the total number of offences in the ACT in 2010/11 and the estimated number of offences committed in 2010/11 that were linked to AOD use. The second is based on the proportion of police detainees detected for each offence type that directly attribute their offending to the use of alcohol or illicit drugs. There were an estimated 890 offences committed in the 2010/11 that were directly attributable to the use of alcohol or illicit drugs, and thus were potentially eligible for CADAS referrals. It is unlikely that all would be deemed eligible for CADAS by the courts and the CADAS assessors but this suggest that of relevant offences committed in the ACT in 2010/11 CADAS currently captures 16.2% of the potential offences. The question that arises is whether this is a good or bad reach, i.e. what is the benchmark?

Table 22: Number of offences committed by CADAS clients, number of offences in the ACT courts in 2010/11 and estimated number of offences that were attributed to AOD use

Offence	CADAS offences in 2010/11 at point of referral ¹	ABS No. Offences in ACT in 2010/11 ²	Self-reported AOD Attribution ³	Estimated No. of Offences committed in 2010/11 that were linked to AOD use	Reach
Drug	16	115	60%	69	23.2%
Theft/Burglary	45	327	42%	137	32.8%
Unlawful entry with intent	5	140	42%	598	8.5%
Assault	30	540	45%	243	12.3%
Sex	2	31	45%	14	14.3%
Public order	26	34	50%	17	152.9%
Road traffic and motor vehicle	22	1,640	22%	361	6.1%
Total	146	2,827		890	16.2%

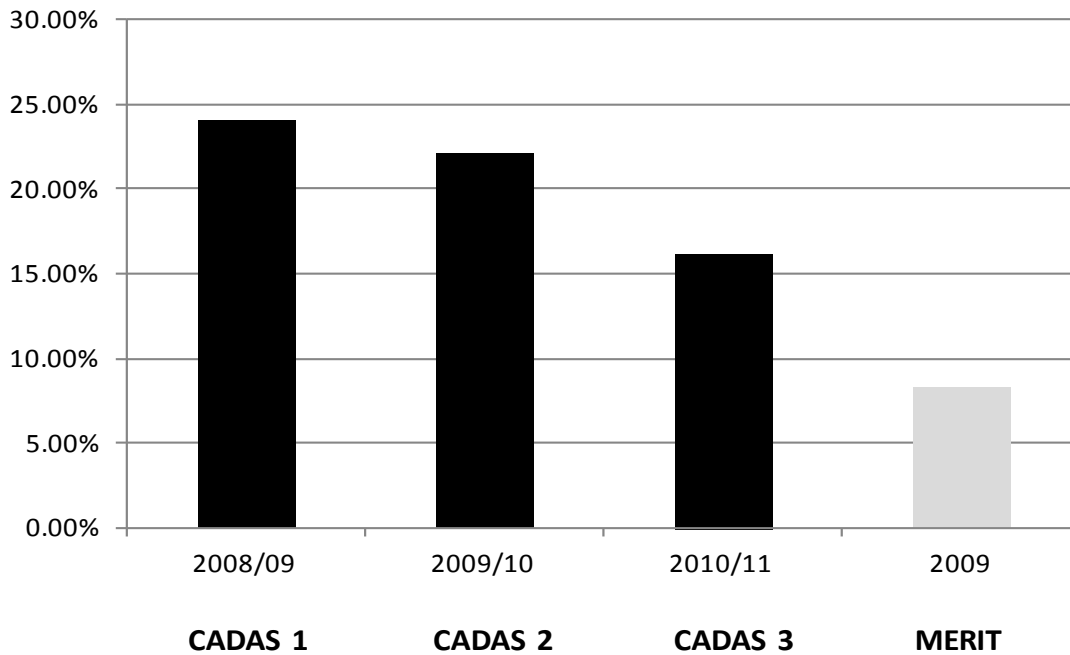
1 Accounts for 83.0% of CADAS offences in 2010/11. Excludes other offences (n=30) as no equivalent data was available from the ABS.

2 Australian Bureau of Statistics (2012). N.B. Accounts for 77.7% of all cases before ACT courts in 2010/11.

3 Attribution based on Drug Use Monitoring in Australia (Sweeney and Payne 2012) data from a national sample of 7,761 police detainees.

Figure 13 outlines the potential reach of CADAS under three different time periods: 2008/09 – a period of peak referrals in recent years, 2009/10 and 2010/11. It also compares it to the potential reach for the NSW Magistrates Early Referral Intervention Program (MERIT) program in 2009 (Martire and Howard 2011). Doing so indicates that across all time periods the reach of CADAS appears greater than for the MERIT program. However, the reach in 2010/11 is much lower than in the previous two years. This provides strong grounds for suggesting that the recent declines in CADAS referrals have reduced program reach: that is reduced the number of eligible offenders within the ACT that are being assessed and potentially treated.

Figure 13: Potential reach of court drug diversion to eligible AOD-related offenders, comparing reach of the ACT CADAS in 2008/09, 2009/10 and 2010/11, and the NSW MERIT program in 2009



Two further considerations are that that absence of 100% reach does not mean that 100% of offenders in these calculations would have been eligible, due in particular to additional eligibility criteria that we could not factor in. Of note, for EIPP an offender can have a maximum of two prior EIPP referrals and must accept the EIPP referral. For PED, an offender may only have a maximum of two PED referrals, must admit to the offence, and have less than the specified threshold quantity for each drug type: 2 pills of MDMA or methamphetamine or 25% of the trafficable amount. For CADAS the main additional criterion is that the referral must be made by the court and/or youth justice. This hinges in part on the extent to which AOD issues are identified and CADAS assessments are known of and supported by the court.

Impact on diverted clients

Data on subsequent offending and drug use of diverted offenders is very limited. Regarding the court diversion programs our key informant interviews indicate that there is no data on drug use or future offending of CADAS clients. Regarding the police diversion programs our key informant interviews indicated data on PED and SCON may be available for the incidence of subsequent offending in the 24 months post detection. Data on EIPP is available for the incidence of subsequent offending, but only for a shorter period (given the much later start up). For all police diversion programs there are no measures of the frequency of offending, and no pre-post comparisons, which are necessary to account for differences in pre-existing levels of recorded offending. With these limitations in mind Table 23 provides some insights. First, only 3% of EIPP clients were detected for a subsequent alcohol offence in the 10 months post detection. In contrast, 12.3% of PED and 13.7% of SCON clients were re-detected in the 24

months post detection. This suggests that EIPP clients may be less likely to re-appear for the same type of offence for which they were diverted.

Table 23: Incidence of any recorded subsequent offending for diverted clients, by program

Diversion program	Incidence	Reporting period
EIPP	3.0% (any alcohol offence) ¹	10 months post detection for a Jan-Jun 2011 offence
PED	12.3% (any drug offence) ¹ 37.0% (any offence) ¹	24 months post detection for a 2008/09 offence
SCON	13.7% (any drug offence) ¹ 53.0% (any offence) ²	24 months post detection for a 2008/09 offence
CADAS	N.A.	N.A.

Sources: ¹ Unpublished PROMIS data. ² ACT Drug Diversion Data Activity Report 2010-2011. Non-drug offence includes theft, public order offences, breaches etc.

Second, comparing the PED and SCON groups more specifically, we can see that while they had a similar incidence of a subsequent drug offence, they differed in terms of the incidence of any subsequent offence. Specifically, the incidence of any subsequent offending is higher following a SCON than a PED (53% compared to 37% in the 24 months post detection for a 2008/09 offence). The challenge is that the data on any offence includes detections for 'breaches' for failing to comply with the criminal justice conditions for a pre-existing offence. It may be that one reason for the difference is breaches for failure to pay the SCON. The likelihood of breach is known to be elevated amongst certain populations, particularly youth, and/or by the presence of unduly onerous criminal justice conditions, including bail conditions which are subject to ongoing review (ACT Government Department of Disability Housing and Community Services 2011). The available data thus means it is unclear whether PED or SCON clients do in fact differ in their likelihood of 'new offending'.

For drug use more specifically, while there have been a number of ad hoc studies conducted, e.g. asking clients about their reported incidence of drug use in the month post diversion, these have not been provided to the evaluation team. Equally importantly, stakeholders from the Health Directorate report there is no consistent data on the incidence of future drug use for diverted clients, by program.

Resource flows

This section of the report describes an attempt to document the resource flows in four of the five diversion programs in the ACT. Costings for YDAC were not attempted given the recent introduction of the program and the small client numbers to date. What is being documented here are the inputs and throughputs, not how effective or efficient the programs are at decreasing drug use or improving recidivism rates. It is important to understand what this section is not. It is not an economic evaluation as there were no effectiveness measures collected consistently across the diversion programs, thus it is not possible to undertake a cost effectiveness analysis which requires costs, consistent outcome measures and a comparator. Additionally, as there has been no attempt to adjust for the characteristics of the individuals in the various programs care should be taken when comparing across programs. This is particularly true for the CADAS program where offenders may be engaged for a longer period, and these offenders may be more complex in terms of their drug and alcohol and criminal histories.

This section is also not a strict cataloguing of budgetary expenditures as the use of only budgeted expenditures might over-allocate true costs to some areas, and under-allocate to others, for example, it also does not account for underspending due to delays in hiring staff nor would such a method reflect the sharing of resources, or the use of resources outside of the diversions

program budget. Here the assessment of resources begins from the point of referral into one of the diversion programs. For SCON, EIPP and PED this is at the point when police have intercepted the individual; for CADAS it is at the point where a request for a referral is made. As described elsewhere, the point at which this occurs varies by and within programs. In the courts, only the magistrate or judge can make a request for a referral however the offender's advocate, the DPP or the offender may request a referral from the judiciary. This may occur at either a bail hearing, or at sentencing. A referral may also be received from Youth Justice when, for example, a sentence includes a good behaviour bond conditional on receiving treatment.

Resources included are police time, diversion staff (police and health), other treatment costs where relevant, and any additional court or corrections involvement. There may be the temptation to compare the costs across the programs but this is only a valid comparison if the program objectives and clients of the programs are comparable. This is unlikely to be true of CADAS, but may be valid for PED and SCON.

Although the original intent was to allocate the salary and wages of staff to specific activities and offenders, the data with which to undertake this task is unavailable. Such an exercise would require detailed data on referral patterns, various types of activities and the length of time spent in the program. For programs such as CADAS where the clients and the situations are diverse and follow-up may be extensive this would be a challenging exercise and is not currently feasible given the data made available to the research team.

The methods, sources of data, and assumptions will be described in more detail for each program but there are some common methods.

- Costs to the offender/client or their family are not included.
- Where possible resource flows are presented for adults and juveniles separately.
- The assessment of resources flow utilise a number of sources such as practice directives (ACT Magistrates Court 2000; Supreme Court of the Australian Capital Territory 2010; Children's Court of the Australian Capital Territory 2011); interviews with various diversion team members; the three Roundtables (February 20, 2012; March 7, 2012; May 1, 2012), various Memorandum of Understanding (AFP and ACT Health 2010; Australian Federal Police and ACT Health 2010; ACT Health and ACT Corrective Services 2011; Youth Justice Services and Court Alcohol Drug Assessment Service Not officially adopted), and contracts and other information as provide by the ADS.
- All expenditures are reported in 2010-2011 AUD and where necessary updated using the CPI (Australian Bureau of Statistics 2011).
- Based on interviews with members of the diversion team some allocations, by type of activity (directly related to offenders, education, school based activities) have been made, but ultimately total salary and supporting costs are reported.
- In addition to the designated staff in each of the programs there are individuals, in the ADS and ACT Policing, who are directly involved in the diversion programs. One ACT Police Officer, a Sergeant, Team Leader, Youth Liaison Team spends approximately 25% of their time providing oversight of the EIPP program and promoting diversion programs amongst senior police colleagues. This is part of an ongoing effort to entrench diversion programs into regular police practice.
- There is also a Diversion Service Manager, Alcohol and Drug Service, Health Directorate. The role involves managing health resources for diversion, managing the diversion Service staff including the Aboriginal and Torres Strait Islander Liaison Officer, as well as reviewing and allocating EIPP, PED and CADAS referrals. The role

includes client contact as well as participating in broader service management. PED/EIPP referrals are received via SupportLink. CADAS referrals are received via email from the Magistrates and Children's Courts, and by fax from the Supreme Court. Additionally referrals are received from Youth Justice. In addition to oversight responsibilities the role entails educating and informing the stakeholders including the Magistrates and Judges of the potential of the CADAS program.

- There are additional support staff within the Alcohol and Drug Service: an Aboriginal Liaison Officer and a Data Manager who work across all ADS diversion programs (EIPP, PED and CADAS). Costs are allocated accordingly.
- For 2010-11 specifically there were also some service establishment costs: most notably SupportLink, the online referral system between police and the Alcohol and Drug Service. This cost was shared across the relevant programs (EIPP and PED).
- For each program, the total cost estimates the average cost per person referred and the average cost to the program to achieve one completion. The second average cost is reported as the programs have different completion rates.

General sources of funding

The CADAS program and the PED programs were funded under the Commonwealth's Illicit Drug Diversion Initiative (IDDI). However, as of June 2009 the funding of the IDDI programs is included in the base funding provided to the States and Territories through the Healthcare Special Purpose Program funding and is no longer identified separately. This funding from the Commonwealth is to the ACT Treasury who then allocates to the ACT Health Directorate. Previous KPIs and reporting requirements remain obligatory. The funding for the SCON IDDO is a component of the PED funding.

The funding for the Early Intervention Pilot Program (EIPP) arose from a federal government initiative under the National Binge Drinking Strategy. The national framework was endorsed by the Ministerial Council on Drug Strategy in April 2009, the ACT EIPP Agreement in December 2009, and the MOU between the AFP and ACT Health in June 2010 (see Appendix B).

YDAC was introduced September 2011 by the Chief and Childrens Court Magistrates (Children's Court of the Australian Capital Territory 2011). While there are expectations around the maximum case load for case workers, and potential implications for court resources, at the time of writing this report there have been no specific resources attached to this program.

Resource costs by program

Simple Cannabis Offence Notice (SCON)

An Illicit Drug Diversion Officer (IDDO) is employed within the ACT Policing Drug and Alcohol Policy Unit of the AFP. Funding for this position is provided to the AFP through an MOU between ACT Health and the APF at \$105,554 AUD2009 with allowances for indexation (AFP and ACT Health 2010). Fifty percent of this position's time is allocated to the SCON program (personal communication, March 28, 2012). The PED and SCON IDDO responsibilities are currently allocated to the same individual. The role of the IDDO in the SCON program is to manage data entry, track payments, to follow-up with those whose SCONs remain unpaid and to inform case officers of the status of unpaid SCONs. A combination of reminder letters and telephone contacts are used to contact those whose SCONs remain unpaid one to two weeks prior to SCON payment due date, and again a month after due date if the SCON remains unpaid. If payment does not occur, the IDDO notifies the case officer. The

IDDO is also responsible for compiling reports as required by the funding agreements. If the SCON remains unpaid after the reminders, the IDDO notifies the case officer who is required to pursue alternative actions. These alternate actions include initiating drug diversion (PED) or prosecution. It is evident in examining the data for the three most recent years (see Table 24) that the response to unpaid SCONS varies over time.

Table 24: SCONS compliance and subsequent responses

Year	SCONS Issued	SCONS Paid	Referred to PED	To be brought before the Court	Response Unknown
2008/09	90	59	6	27	0
2009/10	78	41	4	4	29
2010/11	114	68	6	17	23

The estimated number of minutes of police time for issuing, recording and lodging the SCON were obtained from a survey of NSW Police (n=99 officers) where officers were requested to provide the time, on average, they spent undertaking various tasks related to issuing warnings, cautions, summons and arresting individuals found with a small amount of cannabis (Shanahan 2011). Separate times were obtained for managing adults and juveniles to account for time waiting for a parent or guardian.

In 2010-2011 there were 114 SCONS issued, 96 to adults and 18 to persons under the age of 18. It was estimated that this requires 86 and 153 minutes respectively of police time to stop and search an individual, to determine identity, assess for eligibility for a SCON, issue the SCON, complete the necessary documentation and records in PROMIS, and secure the drugs as legally required (Shanahan 2011). The cost of police time was obtained by dividing the total expenditure on policing in the ACT by the total number of officers, and then converted into a cost per minute (Steering Committee for the Review of Government Service Provision 2012). This was then multiplied by the number of minutes.

The court costs for the 17 to be brought before the court (see Table 24) were estimated by multiplying the average cost per finalised matter in the Magistrate's Court in the ACT (Steering Committee for the Review of Government Service Provision 2012) by the number to be brought before the courts. The data on throughput, referrals to the PED scheme, and back to the courts are sourced from the ACT Drug Diversion Activity Report. The costs for those referred to PED are sourced from work for Table 26 but exclude the original police costs.

Table 25 provides a summary of the costs in 2010/11 for SCON. Not included are offenders' personal costs other than the fines, the costs related to collecting the fines, or any costs related to the approximately 20% of SCONS issued which are neither paid, nor diverted to PED or to be brought before the courts. The estimated total expenditure on SCON for one year was \$121,655, when this amount was averaged over the total number of referrals the average is \$1067, while averaged over the total number who complete the average is \$1337. The largest expenditure was the cost of employing the IDDO officer while the court costs for the seventeen who are subsequently referred to court following failure to pay their SCON was the next largest expenditure category.

Table 25: SCON resource flows, 2010/11 AUD

SCON	N	Minutes per activity	Total minutes	Total cost (2010-2011)	Source
Policing issuing/ recording/ lodging SCON (adult)	96	86	8279	\$7,625	Survey of NSW Police, Shanahan, 2011; Report on Government Services
Policing issuing / recording/ lodging SCON (youth)	18	153	2696	\$2,483	Survey of NSW Police, Shanahan 2011; Report on Government Services
SCON IDDO (50% Full Time Equivalent (FTE)*)				\$54,595	Interview, CW contract
Case officer updates PROMIS /withdraws original offence	52	60	3,120	\$2,873	Interviews
Diversion	6			\$14,007	ADS data
Magistrates court	17			\$31,654	ADS
Police prepare and attends court	17	240	4080	\$3,758	ADS
Police oversight				\$4,660	ADS
Total	114			\$121,655	
Average cost per SCON issued	114			\$1,067	
Average cost per SCON finalised (paid, PED, Court)	91			\$1,337	

* Based on personal communication

Police Early Intervention and Diversion (PED)

As above, the time police required for the assessing individuals for suitability of diversion under the PED scheme were reported separately for youth and adults (Shanahan 2011). Included are the time to determine identity, to explain the PED scheme, waiting for and having discussing with a parent and guardian where relevant, completing necessary documentation on PROMIS and SupportLink, and securing the illicit drugs.

The Illicit Drug Diversion Officer (Police Early Diversion officer) is a 0.5 FTE position. The IDDO is responsible for overseeing and maintaining the PED program, collecting and recording statistical data, providing necessary reports, providing training to Police about the PED program, and liaising between Police and the ACT Health Directorate diversion staff.

The PED referral to the health diversion team by the police officer with carriage of the case occurs through SupportLink, and any non-compliance is reported back to the case officer through that same mechanism. Once the clinician receives notification of the referral an appointment is made with the offender for assessment. The clinical staff also provide brief treatment or education intervention session at this assessment. Some offenders are further referred elsewhere for treatment and or education and these costs are included below and are separate from the PED Clinician costs. Costs of treatment were obtained from the ACT Diversion Treatment Referral Form.

In addition there were start-up costs for the establishment of SupportLink between Alcohol and Drug Service and ACT Policing (\$9,500: split across PED and EIPP).

The total expenditure on PED is \$215,148 with the largest expenditure categories being the PED clinician, and the IDDO officer. When the total was averaged over the total number of referrals the average is \$2011, while averaged over the total number who complete the average is \$2173 (see Table 26).

Table 26: Costs related to PED, 2010/11 AUD

PED	N	Average Minutes or % of time	Total cost (2010-2011)	Source
Policing – Assessing/ recording/ lodging (adult)	73	76	\$5,093	Survey of NSW Police
Policing – Assessing/ recording/ lodging (youth)	34	127	\$4,011	Survey of NSW Police
IDDO Maintain databases, liaise with clinical staff (0.5 FTE minus time spent on education/training)		90%	\$40,946	Interview, CW contract
Health PED Clinician - Assessments /education sessions for those not referred elsewhere / record keeping/ SupportLink/ Treatment referrals		90%	\$70,626	Interviews, CW contract, PED Data, Health Policy
Treatment (other than provided by PED staff)			\$14,862	
Health: Education (Police, Schools)		10%	\$8,375	
IDDO: Education (Police training, Schools)		10%	\$13,649	Interviews, Report on Gov Services
Health: Diversion Manager Oversight			\$15,801	PC, CW contract, ADS budget
Data manager (100% FTE pro-rata over EIPP, PED, CADAS) 12			\$32,375	PC, CW contract, ADS budget
Aboriginal Liaison Officer (0.5% FTE pro-rata over EIPP, PED, CADAS) 13				
Police: Diversion oversight			\$4,660	PC, CW contract, ADS budget
SupportLink establishment (split between PED and EIPP)			\$4,750	Interview, ADS budget
Total			\$215,148	
Average cost per referral	107		\$2011	
Average cost per completion	99		\$2173	

Also included in these cost are a proportion of the employment costs of the Diversion Service Manager, Alcohol and Drug Services, Health Directorate; the Police Sergeant with oversight of the police diversion programs; the Aboriginal Liaison Officer at the Alcohol and Drug Services, Health Directorate; and a Data Manager. This was done based on discussions with the relevant individuals, and the staff numbers in the various programs. For example, it was suggested that the Aboriginal Liaison Officer would spend 50% of her/his time with clients in the various diversion programs, as there was no data available and the number of Aboriginal and Torres Strait Islander clients may vary year to year, this salary was allocated based on the number of

¹² Advice received on a draft of this report indicates the data manager position may not be a full-time allocation across the three programs. This would reduce the total program cost, but as the position is equally allocated across EIPP, PED and CADAS, it would not affect the relative rankings of the three programs.

¹³ Advice received on a draft of this report indicates the Aboriginal Liaison Officer position may be 0.3 FTE, rather than 0.5 FTE. This would reduce the total program cost, but would not affect the relative rankings.

staff in the various programs (EIPP, PED and CADAS). All salary costs include the additional costs of employing staff such as long service leave and superannuation.

The total costs were estimated at \$215,148 the financial year of 2010/11. This is an average cost per referral of \$2,011.

Early Intervention Pilot Program (EIPP)

As above, the time police required for the assessing individuals for suitability of diversion under the EIPP scheme are included (Shanahan 2011). Included are the time to determine identity, to explain the EIPP scheme, waiting for and having discussing with a parent or guardian, as well as completing necessary documentation on PROMIS and SupportLink. However, evaluating the resource flows for the EIPP program required several additional assumptions. The agreement between the Commonwealth Department of Health and Ageing and the ACT Health Directorate, and the Memorandum of Understanding between the Australian Federal Police and the ACT Health Directorate documented the budgeted expenditures, along with KPIs and reporting requirements. Funding and initial recruitment was for three Drug and Alcohol Diversion Officers within ACT Policing for the EIPP program, however delays in recruiting meant that there was only three people for a short period of time and the program has operated with two officers the majority of the time (Australian Federal Police 2010; Australian Federal Police 2011; Australian Federal Police 2012; Australian Federal Police 2012). As actual expenditure data was not provided upon request, the primary estimates below adjust the budgetary data based on detailed information on staffing from the Progress Reports. Thus, rather than the budgeted expenditure of \$314,000 for Drug and Alcohol Diversion Officers for 2010/11, an expenditure of \$183,166 was used based on seven months of operation.

Additionally, based on the previously mentioned Agreement funding was for two FTE EIPP clinicians. However, within the ADS funding for one FTE position from EIPP was designated for a Data Manager for the Alcohol and Drug Service (Personal Communication, 3/05/2012; 7/05/2012). In the primary analyses presented in Table 27, the costs of this second FTE were apportioned across all the diversion programs based on the numbers of FTE. In addition a proportion of the costs of the Aboriginal Liaison Officer employed within the Diversion Service were allocated to the program. It was estimated that approximately 50% of this individual's time was spent with Diversion clients and the salary costs were allocated across all diversion programs according to FTE. As with the PED police oversight and diversion manager costs are apportioned to the EIPP funding. As with PED a portion of the costs of the Diversion Service Manager, Alcohol and Drug Service, Health Directorate was also included. In addition there were start-up costs which included the purchase of a car (\$60,000)¹⁴ and the establishment of SupportLink between Alcohol and Drug Service and ACT Policing (\$9,500).¹⁵

¹⁴ The start-up costs for the car were not included in the resource assessment for EIPP.

¹⁵ The cost of Supportlink was included in the resource assessment: and equally split between EIPP and PED.

Table 27: EIPP resource flows, 2010/11 AUD

EIPP	N/ %	Totals	Source
Police – detect, identity, eligibility	157	\$14,040	Survey of NSW Police, Report on Government Services
EIPP Officers	100%	\$183,166	Interviews, CW contract, AFP Progress Reports
Health EIPP Clinician (1) – offender related activities AND SupportLink establishment	90%	\$70,626	Interviews, CW contract
Health EIPP Clinician (2) – education related	10%	\$8,375	Interviews, CW contract
Police oversight		\$18,630	Interviews, Report on Gov Services
Health Management		\$15,801	Pro-rata based on staffing
Data manager (100% FTE pro-rata over EIPP, PED, CADAS)		\$32,375	Early Intervention Pilot Program (alcohol, youth); Interviews
Aboriginal Liaison Officer (0.5% FTE pro-rata over EIPP, PED, CADAS)			
SupportLink establishment (split between PED and EIPP)		\$4,750	Interview, ADS budget
Total		\$347,763	
Average cost per referral	157	\$2,215	
Average cost per completion	144	\$2,415	

In discussions with the Health EIPP Clinician and Manager, it appears clear that approximately 10% of the clinician's time is spent providing education to police and within schools on diversion with the remainder of their time directly related to offenders (assessments, education, referrals to treatment and follow-up). It is less clear as to how the time of the Drug and Alcohol Diversion Officers is allocated between informing and training police on EIPP, providing community and school based education about the EIPP. Estimates of the proportion of time spent on educational activities ranged from five to fifty per cent of the time (Personal communications, 5/03/2012, 8/05/2012). Given this range no attempt was made to allocate the resource flows to various types of activities.

The total costs were estimated at \$347,763 for the financial year of 2010-2011. This is an average cost per referral of \$2,215 and an average cost per completed assessment and treatment of \$2,415. Approximately 10% of referrals do not complete their assessment or treatment and the costs related to any subsequent follow-up is not known. When all the budgeted expenditures (three FTEs for the AFP and two for ADS) were included, the average costs rise to \$3,688 and \$4,021 respectively.

Court Alcohol and Drug Assessment Service (CADAS)

CADAS is a program based in the Diversion Service, Alcohol and Drug Service, Health Directorate. There are three FTE clinical staff, a manager, and an Aboriginal Liaison Officer with the last two positions having responsibilities across other programs as well. As described elsewhere this program operates across a number of pathways with responsibilities for providing assessments to both youth and adults in the Supreme, Magistrate and Children's courts. Assessments are also provided at the pre-plea court hearings and at the point of sentencing. In addition to providing assessments and developing treatment plans case management may be provided by CADAS staff.

The costs of treatment provided based on referrals by the CADAS staff are included in Table 28, along with the costs for the CADAS staff, a portion of the managers time as wells as that of the Aboriginal Liaison officer. The treatment costs are based on 65% of those who are engaged into treatment complete (Alcohol & Drug Service (Health Directorate) 2011)

Not included in the costs below are other potentially important costs to government of the diversion program such as the costs of incarceration while waiting for assessment, treatment or a subsequent court case post assessment. These data were not available and would require individual unit record data. Also not available are the resource implications for other departments such as Community Youth Justice and ACT Corrective Services. If the full costs of the diversion programs were to be document these would need to be considered as they have responsibilities for monitoring and reporting to the court of progress, and breaches.

The total costs, of CADAS staff and treatment in 2010/11 were \$558,387.

Table 28: Court Alcohol and Drug Assessment Service resource flows, 2010/11 AUD

CADAS	N	Totals	Source
3 CADAS staff (assessment, referrals, case management, consulting with Youth Justice, Corrections Staff)	177	\$251,252	ADS Budget,
Treatment episodes (those not provided by CADAS Staff)	115	\$210,608	Health Department
Health Management		\$47,402	Pro-rata based on staffing
Aboriginal Liaison Officer (0.5% FTE pro-rata over EIPP, PED, CADAS)		\$25,125	Pro-rata based on staffing, Personal Communication, ADS budget
Data manager (100% FTE pro-rata over EIPP, PED, CADAS)		\$24,000	PC, CW contract
Total		\$558,387	

Summary of resource flows

This section has presented the resource flows for one year as they were identified through the three Roundtables, reviewing agreements, MOU, and in direct conversations with staff in the various programs. As discussed each of the assessments was challenging due to lack of availability of some data and to contestation about some particular costs/time allocations. The total overall costs for 2010/11 are \$694,500 for the three police AOD diversion programs and a total of \$1,242,900 if CADAS were included. Limitations aside, the costs per referral vary across the police diversion programs, and in spite of the allocation of EIPP resources to other activities (data management, etc.) it is still the most expensive police diversion program (see Table 29). And while arguments may be raised about time to start up, recent data would suggest the referral rates are not increasing over time. This adds to the insights garnered above.

Table 29: Total program cost and cost per completed referral in 2010/11 (SCON, PED and EIPP)

Program	Total program costs	No. referrals	Cost per completed referral
SCON	\$121,655	114	\$1337
PED	\$215,148	107	\$2173
EIPP	\$347,763	157	\$2415

The question might then be asked – what did this money purchase? It is hard to answer such a question without data on outcomes. However, it is likely that, without such a scheme, many of those diverted through the police diversion program may have faced Court. This presents a counterfactual. The average cost in 2010/11 AUD for a finalised case in the ACT Magistrate's Court was \$1,295 and in the Children's Court was \$1,550 (Steering Committee for the Review of Government Service Provision 2012). If an additional cost of \$200 to \$250 for police preparation and court attendance and \$100 for police detection was included the total cost per case is approximately \$1,640 to \$1,900. These costs are not directly comparable with the averages for SCON, PED and EIPP as they do not include any penalty costs. It is also likely that if the diversion programs did not exist not all offenders would be arrested (e.g. given caution or warnings instead). Nevertheless they suggest that costs would be somewhat greater than a SCON, but less than either of diversion into education programs (PED or EIPP).

While some questions may have been answered key gaps remain. If a more complete understanding of resource flow is felt to be important to the ACT and stakeholders in the AOD diversion system there are some essential data to be collected and collated. Having data by individual on source of referral, type of referral (bail hearing or sentencing), the types of treatment, case management history, time in treatment, compliance and breaches is essential to understand the resource flows and efficiency of programs such as CADAS and YDAC. It will not be possible to ever evaluate them completely as programs with complex clients, multiple pathways and many stakeholders if one is not able to appreciate the various components and their relationships. For programs where the inputs are brief, there is may be less need for complex analysis of the inputs but for both types of programs information on longer term outcomes, whether this is problematic alcohol and drug use or recidivism, are necessary.

An Evaluation Roadmap

Purpose

The purpose of this Evaluation Roadmap to provide evaluation designs and indicators that can be established so as to assess implementation, outputs and outcomes (positive and negative, intended and unintended) from the ACT drug diversion system at the system and individual program levels. It includes proposed plans for a prospective evaluation of YDAC.

We point out what we believe should be done—the minimum to get the flow of evaluative information that is needed—and also suggest opportunities to engage in other evaluation projects dealing with specific, perhaps time-limited, evaluation questions.

Evaluability assessment

Before embarking on an evaluation roadmap of the ACT diversion program it is helpful to explore, and make decisions about, the extent to which it is amenable to evaluation. This is because effort can be wasted if an evaluation is designed for a program that fails the tests of evaluability. We have assessed the evaluability of the diversion program against four criteria (Wholey 2004):

1. The program goals and priority information needs are well defined

As discussed above, widespread agreement exists about the overarching goals of the diversion program at the system level (see pages 24-25). With regard to the five individual programs, the core policy documents provide a reasonably clear indication of their goals. The information needs on the part of the policymakers and program managers have become reasonably clear through this project.

Conclusion: the program goals and priority information needs are well enough defined for evaluation to proceed.

2. The program goals are plausible

The goals of the program overall, and of its components, have a fair degree of plausibility in that they focus on diverting people out of the criminal justice system and/or into helping services which are, in turn, known to have a reasonable degree of success.

Conclusion: the program goals are plausible enough for an evaluation that includes goal attainment to proceed.

3. Relevant performance and outcome data can be obtained at reasonable cost

Elsewhere in this report we have discussed some of the challenges that program managers and us, as evaluators, have faced in producing relevant performance data in some areas. That said, key data are either available now or could be brought into existence. Although significant costs could be incurred in establishing and/or improving some data sets, others will be less resource-intensive. There are varying levels of performance and outcome data that can be obtained, from the bare minimum to the ideal, to suit the ACT's preferences and resources.

Conclusion: data availability now and in the foreseeable future is good enough for evaluation to proceed.

4. Intended users of the evaluation results have agreed on how they will use the information

Although the intended users of the evaluation results have not formally agreed how they will use the information derived from program evaluation, a clear commitment exists, across agencies, for this to happen. The evaluation strategy proposed here, which emphasises the usability of evaluation findings for decision-making relating to policy and program management, enhances the likelihood that the products of the evaluation will be used.

Conclusion: A strong enough commitment exists to using the evaluation findings for it to be viable for the evaluation to proceed.

We conclude, then, that the diversion program at both the system level and the level of the five components meets these core criteria for evaluability. The ACT has the capacity to build a sustainable evaluation system for its diversion program and to implement this into the future. A range of options exist with varying degrees of costs to implement. Part of that implementation process will need to include evaluability assessments of any one-off studies that are proposed to answer specific evaluation questions that may arise.

Outline of the Evaluation Roadmap at the system level

This Roadmap has 10 components, as follows:

1. Specifying the model for evaluating the ACT AOD diversion system: developmental evaluation within a broader utilisation-focused evaluation model
2. Clarifying who are the key stakeholders for each evaluation, and engaging them
3. Focusing the evaluation: clarity about the purpose, users and uses of the evaluation
4. Clarifying what is the entity within the ACT AOD diversion system being evaluated
5. Describing the program theory that underpins the design and implementation of the diversion system
6. Identifying the specific evaluation questions
7. Specifying the indicators that will enable the evaluation questions to be answered
8. Identifying the data collection methods that, if implemented properly, will deliver the required indicators data
9. Developing the evaluation findings from data analysis/synthesis, interpretation and judgment
10. Using the evaluation's findings.

We refer to these as components rather than steps as the process is not linear. Instead, they are the components of a comprehensive evaluation strategy that can be implemented into the future with the aim of meeting diverse information and decision support needs. Some components require more work than others to implement effectively, and it may not be necessary to implement all the components. Nonetheless, we are confident that the ACT has the capacity to implement such an approach.

Component 1: Specifying the evaluation model: developmental evaluation within a broader utilisation-focused evaluation model

This Roadmap is based upon the utilisation-focused evaluation model. From the many evaluation models available we have selected this one because of its focus on clarifying and meeting the needs of those commissioning evaluations, in this case people needing to make

decisions about the diversion program. This may be contrasted with other approaches in which evaluators adhere to specific models or approaches that they routinely use, regardless of the commissioners' needs. The utilisation-focused model has been defined as "evaluation done for and with specific intended primary users for specific, intended uses" (Patton 2008:39). This approach will give the ACT the scope to decide, in an informed manner, about what evaluation approaches to use.

The Evaluation Roadmap aims to deliver the decision support information needed at the right time and in a readily-usable form. As demonstrated in this evaluation, policy and program goals and implementation modalities tend to change over time, making evaluations focusing only or primarily on goal attainment problematic. The Roadmap has to deal with the reality that program and broader contextual factors influence program outcomes, and that the programs produce diverse outcomes depending on time and changing contextual factors.

The implication of this is that the evaluation approach—the Roadmap—is not based upon one-off evaluation studies. Instead it is an approach that produces a continual flow of usable evaluative information. This approach incorporates the most useful features of monitoring, but it includes producing information that goes beyond monitoring to assist program managers, decision-makers and other stakeholders to make evaluative judgements about what is going on in the programs and what changes are needed in the light of changing circumstances.

This is in line with a developmental evaluation which contributes to program and organisational development. It "...involves changing the [evaluation] model by adapting it to changed circumstances and emergent conditions. Developmental evaluation is designed to be congruent with and nurture developmental, emergent, innovative, and transformative processes" (Patton 2011:127).

Component 2: Clarifying who are the key stakeholders for the evaluation, and engaging them

The diversity of potential stakeholders involved in the ACT AOD diversion system (see in particular Table 7) means that identifying the most affected/relevant for the particular evaluation is essential. This is because of the barriers to the use of information flowing from the evaluation if key stakeholders fail to acknowledge the relevance of it to their work. Furthermore, early engagement of key stakeholders often facilitates access to data for which they are gatekeepers.

For the purposes of this Roadmap it will be useful to identify different stakeholders for the diversion program as a whole, for its five individual components, and for future one-off evaluation studies. This is because different parts of the diversion system have different stakeholders.

A practical handbook on stakeholder engagement in evaluation (Preskill and Jones 2009) identifies five key steps:

- Step 1: Prepare for stakeholder engagement
- Step 2: Identify potential stakeholders
- Step 3: Prioritise the list of stakeholders
- Step 4: Consider potential stakeholders' motivations for participating, and identify incentives that will encourage participation
- Step 5: Select a stakeholder engagement strategy.

A useful process of stakeholder analysis, addressing steps 1 to 4, is to get together a small group of people who have a good understanding of the issues to be addressed through the evaluation and having them engage in a dialogue process. The discussion can identify the many stakeholders of the evaluation and classify them on the criteria of interest and power. Interest measures the extent to which they are likely to be affected by the evaluation and the levels of interest and concern they have about it. Power is concerned with the capacity that particular stakeholders have to help facilitate or impede both the conduct of evaluation and the use of the information that it produces.

Drawing a two-by-two matrix of power-by-interest identifies the following categories of stakeholders:

- High power and high interest: these stakeholders need to be closely engaged in the evaluation.
- High power and low interest: these stakeholders need to be kept satisfied that the process is not potentially problematic for them. It is usually worth putting effort into trying to raise their level of interest so as to have them actively engaged in the evaluation.
- High interest and low power: these stakeholders need to be kept informed of what is happening.
- Low interest and low power: little effort is required with these stakeholders (Start and Hovland 2004).

Component 3: Focusing the evaluation

Focusing the evaluation entails clarifying its purpose, users and uses. This component of the Roadmap links to the stakeholder analysis discussed above, in that the implementation of the evaluation, and the use of the information that it produces, is likely to be facilitated if the high power stakeholders have been engaged have reached a reasonable degree of agreement about the purpose, users and uses evaluation.

It is useful to document the results of discussions on focusing the evaluation, and to review the document at intervals to help avoid ‘project creep’, i.e. subtle changes in what people understand the evaluation to be about and the implications of that for evaluation implementation. For example, it might be possible for people conducting an evaluation of YDAC that is designed to identify the program’s penetration (i.e. the proportion of young offenders who could benefit from the program who are actually admitted to it) to be asked (during the course of the evaluation) to also report on the extent and nature of repeat offending among program participants.

Component 4: Clarifying what is the entity being evaluated

It is crucially important that the entity being evaluated is explicitly identified. It became clear in the first Roundtable used in this project that many different perceptions exist as to what the ACT diversion system actually encompasses. For some, the system is limited to people with some form of engagement with alcohol and other drugs being diverted out of the criminal justice system entirely or coming to attention through the criminal justice system and being diverted into education and/or treatment. For others, however, the diversion program is much broader, encompassing other activities such as community education, police officers providing education in the schools about drug law, and health promotion initiatives, all of which aim to help people reduce their problematic drug use and hence reduce the likelihood that they will become involved in the criminal justice system.

This demonstrates that, within the five components of the ACT drug diversion program, there is a lack of clarity about the boundaries. This was particularly highlighted in page 49 with regard to CADAS: some of its work entails conducting AOD assessments of people brought before the courts even though these assessments are not for the purpose of determining whether or not they should be diverted from the criminal justice system into treatment interventions. While these assessments probably make valuable contributions, they divert resources from diversion as such. Furthermore, the data we have been able to elicit during this project has not been adequate to clarify the proportions of different types of CADAS activity, including the proportion of services that operate on a pre-sentence basis compared to a sentence basis. The implication of this is that, if CADAS is construed as a pre-sentence program only, its evaluation will be somewhat different from what it would be if it were construed as a sentence program only, and different again from what it would be if it were construed as a combined assessment, pre-sentence and sentence program.

These examples are given to emphasise the need for clarity as to just what is being evaluated and for this to be systematically documented. Part of this is a boundary analysis. Attention can be given to the needs that the program fills, who is expected to benefit from the program, other stakeholders, the expected effects of the program, the resources allocated to it, its stage of development, factors in the broader environment that impact upon it, any competing perspectives about the program, how the program is intended to operate, what are seen as the key active ingredients in goal attainment, etc.

Component 5: Describing the program theory that underpins the design and implementation of the diversion system

This component of the Roadmap focuses upon the program theory that underlies the diversion system as a whole and the various programs that compose it. Program theory has been defined as “...an explicit theory or model of how an intervention, such as a project, a program, a strategy, an initiative, or a policy, contributes to a chain of intermediate results and finally to the intended or observed outcomes” (Funnell and Rogers 2011:xix).

It is important to be explicit about the program theory as doing so assists both the managers of the programs and external observers to understand not only what is happening in the diversion program, but also what it is about the program that actually produces the intended (and sometimes unintended) outcomes. In other words, it makes explicit the causal linkages that connect inputs, activities, outputs, intermediate outcomes and longer term outcomes.

The program theory for the diversion system as a whole could be described as follows:

Alcohol and other drugs are involved in criminal behaviour in many and complex ways, constituting both a cause of crime and the consequence of it. The criminal justice system provides many opportunities for identifying offenders experiencing problems related to alcohol and other drug use, and to provide educational, treatment and other interventions with high potential to assist the offenders to deal with their alcohol and other drug problems and reduce their risk of reoffending. In contrast, the standard approaches of processing offenders with alcohol and other drugs problems through the criminal Justice system are largely ineffective in resolving their alcohol and other drug problems and in reducing the risk of reoffending.

The diversionary programs aim to divert certain categories of offenders away from the criminal justice system entirely, or to divert them into assessment, educational, treatment and/or other

interventions aimed at assisting the offenders to resolve their alcohol and other drug problems and to reduce the risk of subsequent reoffending.

The core assumptions underlying this, with regard to those offenders diverted from the criminal justice system through the SCON program, are that:

- the program has sufficient penetration to reach a large proportion of cannabis offenders
- the SCON option is attractive enough for offenders to pay their SCONs rather than to opt for the normal criminal justice system processing through the courts
- the conditions that apply to those diverted are not more onerous than those applying to offenders not diverted.

The core assumptions underlying the parts of the diversion system that divert people into helping services (PED, EIPP, CADAS and YDAC) are that:

- the programs have sufficient penetration to reach a large proportion of drug-involved offenders
- the diversion option is known and attractive enough for police, Judges, Magistrates and Youth Justice to accept it, rather than to opt for the normal criminal justice system processing
- the diversion option is attractive enough for offenders to accept it, rather than to opt for the normal criminal justice system processing
- there are sufficient assessment resources available to meet the level of need and demand
- the assessment processes are of high enough quality to be able to successfully match offenders with appropriate interventions
- the assessment processes are timely
- there are sufficient treatment resources available to meet the level of need and demand
- the case management processes are effective enough to ensure that offenders diverted into helping services actually receive the intended interventions
- the interventions that are delivered are effective in achieving their behaviour change goals relating to problematic alcohol and other drug use and lower levels of re-offending
- the interventions are not more onerous for diverted offenders than are the traditional criminal justice responses.

The program theory underlying each program commences by consideration of the goals, as per the policy and practice documents relating to each of the programs (see pages 25 to 31). The managers of these programs may care to refine these statements of their program theory and document them more fully including, for example, the outcomes hierarchy, success criteria, assumptions about factors within control of the program, assumptions about factors outside control of the program, the program's activities and resources, etc. A useful approach is, through discussion with stakeholders, to create a series of if-then-because-as long as statements. Doing so makes explicit the program inputs, activities, outputs and outcomes, demonstrating the causal links between them and the influences of contextual factors. Funnell & Rogers (2011) provides details on how this can be done.

Component 6: Identifying the specific evaluation questions

The evaluation questions that will be answered through the implementation of this Roadmap need to be specified. In accordance with the utilisation-focused evaluation approach, it is not our

role to predetermine, for the diversion program policy-makers and managers, just what the evaluation questions should be. Indeed, the questions will change over time with changing contexts, opportunities and threats, along with the development of the individual programs within the diversion system. Nonetheless, we draw attention to some of the important evaluation questions that have arisen during the course of this project. Some evaluation questions apply at the level of the diversion system as a whole, whereas others apply to the specific programs that compose it. Some apply on an ongoing basis whereas others are the evaluation questions for one-off, time-limited studies.

Illustrative evaluation questions at system level

- *Goal attainment*
 - To what extent, and in what ways, is the ACT's diversion system achieving its primary goals of 1) diverting certain categories of drug offenders out of the criminal justice system and 2) diverting certain categories of drug and drug-related offenders into contact with the ATOD assessment, education and treatment services?
 - To what extent, and in what ways, is the ACT's diversion system achieving its secondary goals:
 - To minimise harms associated with unnecessary involvement in the criminal justice system
 - To strength partnerships
 - To educate police and courts regarding the appropriate responses to AOD issues
 - To fulfil community expectations of community protection and the punishment of offenders
 - To educate young people and families
 - To deter encounters with the system
 - To reduce AOD use and/or AOD-related harms
 - To reduce cost to the criminal justice system and reduce social cost of AOD
 - To reduce AOD and AOD-related crime
- Does the diversion system produce any unintended consequences, both positive and negative? (Examples include problematic net widening, labelling/ stigmatisation particularly of young people, breaches of due process rights, inappropriate referrals to education and counselling, building distrust in and disrespect for the criminal justice system, etc.) If so, what is the level of intended to unintended consequences, and how does this vary across programs?
- To what extent are the goals being attained for different sub-populations: young people versus adults, ATSI versus non-ATSI offenders?
- What needs to be done to build on the positives and minimise the impacts of the negatives?
- *Program descriptive information*
 - Numbers and characteristics of clients including flow data: police contacts – courts – clients assessed – clients entering treatment – clients completing treatment, and those who fail to attend/complete etc.
 - The services that diverted offenders receive: what types of therapeutic/educational interventions, how many of each type, client characteristics.

- *Penetration*
 - To what extent does the program reach the people who could benefit from it, and how could its reach be extended without the adverse consequences sometimes associated with net-widening?
- *Resourcing and service considerations*
 - What personnel and other resources are used in implementing the ACT AOD diversion system, for all programs, and at what costs?
- *Process considerations*
 - How coherent and comprehensive are the five components of the program? How do they inter-relate and with what consequences? (Dealt within this evaluation, but will need to be reviewed in the future.)
 - What are the impacts of the current eligibility criteria and what changes to them (if any) are desirable? (Dealt within this evaluation, but will need to be reviewed in the future.)
 - How effective are the management/coordination structures and processes for the system; how could it be improved? (Dealt within this evaluation, but will need to be reviewed in the future.)
 - To what extent are the performance indicators currently being collected useful, and how can they be improved? (Dealt within this evaluation, but will need to be reviewed in the future.)
- *Outcomes (additional to the goal attainment questions above)*
 - What opportunities exist within the program to improve outcomes for clients with special needs (e.g. Aboriginal and Torres Strait Islander people and clients with substance abuse/mental health co-morbidity)?
 - How successful are the treatment/education interventions that clients receive (with respect to physical & mental health, drug use, social functioning, criminal behaviour, subsequent contact with the criminal justice system, etc.)?
 - To what extent is the diversion system as a whole, and its individual components, delivering value for money? To what extent is a cost-effective? To what extent could be it be made more cost-effective? e.g. To what extent are the resources being allocated for diversionary, rather than other, purposes?

Illustrative evaluation questions for specific one-off, time-limited studies (not part of Roadmap implementation)

- How do the public and opinion leaders see diversion generally, and the ACT program specifically?
- How effective is the system overall, and its individual components, at minimising recidivism?¹⁶

¹⁶ One-off analysis of recidivism would supplement the system flow data on reoffending. For example, the roadmap recommends adoption of consistent reporting on levels of subsequent offending post diversion (by program), but detailed recidivism analysis would provide much greater insight into recidivism. For example, extraction of unit record offending data for each offender's entire pre-diversion criminal history and at least one year after diversion, and key demographic criteria (see for example Payne, Kwiatkowski and Wundersitz, 2008), could enable assessments of change in offending pre and post diversion, and identification of sub-groups diverted who are most and least likely to reoffend. Other one-off studies could be used to establish control groups, and match offenders on key offending characteristics to examine difference in offending between diverted and non-diverted clients.

- What are the impacts of the diversion system on the health and criminal justice systems, and on their interactions?
- Do individual programs within the diversion system produce any adverse unintended consequences, particularly problematic net-widening? (This applies particularly to the SCON and EIPP components.)
- What are the flows of individuals in the CADAS program: who are referred but not engaged, and how do they differ from those who are referred and engage? What is the relative use of different CADAS models, especially pre-sentence versus sentence? To what extent are individuals cycling through CADAS on multiple occasions?
- How do the characteristics of the cannabis users who receive SCONs and PED differ?
- What are the characteristics of the people who receive SCONs and pay them compared with those who fail to pay and receive a caution or are diverted to PED, or fail to pay and are dealt with by the courts?
- What factors, other than the formal eligibility criteria, determine whether or not an offender is diverted, and how do those factors vary in different component of the diversion system?
- Is it possible to establish ongoing record linkage systems that will facilitate the tracking of offenders through the health and criminal justice systems, producing a continual flow of information about recidivism rates and patterns?
- On the basis that some people claim that educational programs about drug laws and their implementation provided by ACT Policing in education institutions can have a preventive impact, to what extent is this outcome actually produced, if at all?

Component 7: Specifying the indicators that will enable the evaluation questions to be answered

Having sound indicators is a key to success in the utilisation-focused evaluation approach that aims to produce a continual flow of usable evaluative information.

Paraphrasing Peter Drucker, a prominent leader in the management discipline (“What gets measured gets managed”), Serrat (2010:5) provides the instructive warning that “What is important cannot always be measured and what can be measured is not necessarily important”. This is illustrated in the epigraph to a classic paper on the topic: “In Poland under communism, the performance of furniture factories was measured in the tonnes of furniture shipped. As a result, Poland now has the heaviest furniture on the planet” (Perrin 1998:368).

A performance indicator has been defined as

...an observable change or event that provides evidence that something has happened, be that an output delivered, an immediate effect occurred, or a long-term process observed. To such discerning interpreters, indicators do not offer proof so much as reliable clues that the change or event being claimed has actually happened or is happening: rather, evidence from several indicators will make a convincing case for claims being made (Serrat 2010).

Eight different managerial functions of performance indicators have been identified: to evaluate, control, budget, motivate, promote, celebrate, learn, and improve (Behn 2003). Because no single performance indicator can meet all eight purposes, managers need to select those what will be most suitable for their primary purposes, in this case evaluating, celebrating, learning and

improving. Indicators can be used for either performance proving or performance improving, to cite another familiar distinction (O'Shaughnessy 2001).

Both direct indicators (e.g. the number of people referred for a CADAS assessment) and indirect indicators (e.g. the number of people completing treatment as a proxy for the number who may have increased their knowledge of AOD service provision and/or reduced their level of drug use) have been applied.

As noted on pages 18 to 20 the recent Human Rights Commission report to the Legislative Assembly on juvenile justice in the ACT (Roy and Watchirs 2011:195) recommended that the ACT's diversion system operate on a plan that includes a vision for diversion in the ACT, objectives, outcome measures, performance indicators and a "commitment to continuous improvement through evaluation, action learning and innovation".

The recommendations regarding performance indicators, including ensuring that they have an outcome component, apply across the whole of the diversion system, not only the youth justice component.

The characteristics of high quality performance indicators

UK Treasury Department has, in the past, been prominent in developing performance systems for public sector programs, and in doing so have identified the characteristics of high quality performance management processes under the acronym FABRIC:

- **F**ocused on the organisation's aims and objectives
- **A**ppropriate to, and useful for, the stakeholders who are likely to use it
- **B**alanced, giving a picture of what the organisation is doing, covering all significant areas of work
- **R**obust in order to withstand organisational changes or individuals leaving
- **I**ntegrated into the organisation, being part of the business planning and management processes
- **C**ost-effective, balancing the benefits of the information against the costs (HM Treasury 2001)

Another set of criteria, perhaps more widely known, are the SMART criteria (**S**pecific, **M**easurable, **A**chievable/attainable, **R**ealistic/Relevant and **T**imely), and the CREAM criteria: **C**lear, **R**elevant, **E**conomic, **A**dequate and **M**onitorable (Kusek and Rist 2004).

The core criteria for sound individual performance measures, in the HM Treasury approach, that we propose be used for monitoring and evaluating the diversion system, are:

- **Relevant** to what the organisation is aiming to achieve
- Able to **avoid perverse incentives** - not encourage unwanted or wasteful behaviour
- **Attributable** – the activity measured must be capable of being influenced by actions that can be attributed to the organisation, and it should be clear where accountability lies
- **Well-defined**, with a clear, unambiguous definition so that data will be collected consistently, and the measure is easy to understand and use
- **Timely**, producing data frequently enough to track progress, and quickly enough for the data to still be useful

- **Reliable** - accurate enough for its intended use, and responsive to change
- **Comparable** with either past periods or similar programmes elsewhere
- **Verifiable**, with clear documentation behind it, so that the processes which produce the measure can be validated (HM Treasury 2001).

Indicators for monitoring and evaluating diversion

Many indicators are available that, if collected, collated and communicated effectively, will create a continual flow of evaluative information. In this section we list some of the most significant of them, at the system level. Appendix D and E contains more comprehensive lists of possible indicators for the individual diversion programs.

Our aim is to provide a list of indicators—though not an exhaustive list—from which program managers can choose when developing their information systems. The indicators selected will differ depending on the program: the diversion program at the system level, SCON, PED, EIPP, CADAS or YDAC. Furthermore, any future one-off evaluations developed to answer specific time-limited evaluation questions will need to have their own purpose-designed sets of indicators. Nevertheless, we list below the bare minimum that ought to be collected in order to be able to assess the attainment of system and program goals, including the key elements that were not assessable in the current evaluation including the benefits derived from resources expended (such as the level of crime averted per diversion, and per diversion program) and whether the intended outcomes outweigh the unintended outcomes.

Note that here ‘treatment’ refers to any type of helping intervention the diverted person may be offered or receive, including education, counselling, case management, withdrawal support, opioid substitution therapy, residential rehabilitation, etc.

A note about recidivism: Future recidivism amongst those diverted through the programs is of critical importance for evaluating program worth. But this is a complex concept, one that is challenging to operationalise and measure as it has many different components, including the offender sample, the indicator events, the time period involved and the counting rules. Criminologists have given close attention to the topic and have produced conceptually sound, and practically useful, definitions and indicators (for example Payne 2007). It is usually necessary to have information on offenders’ criminal history prior to the diversion, as well as offending after the diversion, as a history of past offending is a strong predictor of subsequent offending. Although it is beyond the scope of this report to explore recidivism indicators in detail, these are some of the more useful:

- Self-reports of detected and undetected crimes
- The proportion of offenders with any recorded subsequent offence using police, court and/or corrections data
- The proportion of offenders whose new offences are the same and/or of a more serious nature
- Time to re-offending
- Pattern of changes in offending from before the diversion to after it (e.g. offender with no priors: offences stable, increased; offender with priors: offences increased, stable, decreased)
- Frequency of offending in a specified period before and after diversion.

We suggest that the minimum that is needed to assess recidivism in the ACT is that reoffending is recorded and reported upon in terms of incidence (the number who reoffend in a specified time period), the frequency of reoffending (how many times individuals reoffend within a specified time frame) and the severity of the offences. The most reliable means of doing this is against the ANZ Standard Offence Classification (ANZSOC), as is done in CADAS.

There should also be a commitment where possible to assess and compare incidence, frequency and severity for those diverted and not diverted. We reiterate the finding of this evaluation that the many inconsistencies in diversion system data collection limit the ACT's current capacity to measure recidivism. A consequence is to establish a goal of increasing the systematic collection of recidivism data and, by doing so, increase ACT's capacity to assess impacts at the system and/or program level.

Some key system level indicators

Inputs

- Change in number of places per program (to assess changes in system capacity)
- Dollar costs overall, by program and by program element

Activities

- SCONs issued, paid, not paid, converted to caution or PED, dealt with by the court
- Referrals into the diversionary system by program
- Recommended for treatment (where relevant)
- Engaged in treatment (where relevant)
- Completed treatment (where relevant)
- Utilisation of other services (where relevant)
- Demographics of people diverted: gender, age, juvenile/adult, ATSI status, prior diversion history (ever/for individual program)
- Demographics of people diverted who complete their diversion: gender, age, juvenile/adult, ATSI status, prior diversion history (ever/for individual programs)

Outputs

- Program penetration, e.g. numbers diverted of numbers eligible for diversion
- Balance of diversionary efforts: police versus courts; young people versus adults, ATSI versus non-ATSI
- Principal drugs of concern for people diverted, by program
- Type of offence for which diverted (e.g. theft/burglary, assault, public order, traffic, drug offence (purchase (alcohol), possess, self-administration, manufacture, cultivate, supply), justice procedures, other)
- Dollar costs per referral and per completed treatment (where relevant) by program
- Extent to which programs are being utilised for diversion versus non-diversionary activities

Outcomes

- Rates and patterns of re-offending of people diverted, for those diverted who do not comply and comparable offenders not diverted, for the system as a whole and by program
- Client knowledge of AOD treatment services pre- and post-diversion
- Client knowledge of AOD harms
- Levels and patterns of drug use pre- and post-diversion among treatment completers and ideally non completers and/or comparable offenders not diverted
- Cost of diversion versus traditional criminal justice response, by program
- Level of net-widening and net-deepening

Other

- Level of knowledge about drug diversion options amongst key stakeholder groups e.g. police and courts
- Level of support for drug diversion amongst key stakeholder groups

Component 8: Identifying the data collection methods that, if implemented properly, will deliver the required indicators data

Once the evaluation questions and related indicators have been properly identified and agreed-upon, it is usually a reasonably straightforward, albeit technical, task to identify the methods of data collection that are required to produce the indicators and hence answer evaluation questions. The data collection methods will also be shaped by the availability of resources for designing and conducting evaluation and the intended uses of the information that the process delivers.

This Roadmap focuses on both (a) producing a flow of useful evaluative information and (b) on undertaking one-off studies to answer specific evaluation questions. The first of these roles will largely use administrative by-product data, i.e. data collected for both administrative and evaluative reasons through the routine operation of the program. As discussed above, it is important that these data (indicators) are of high enough quality to be readily usable. The issue is that the data collection methods will need to be robust enough, and sufficiently resourced, to deliver information that decision-makers can trust, that they find useful, and that are delivered in a timely manner.

The second set of data collection methods will be those for one-off studies designed to answer specific evaluation questions that arise from time to time. In some cases experimental or quasi-experimental research designs will need to be employed, rather than simply observational methods. The particular data collection methods will be largely dependent upon the research design. Since these one-off studies will be conducted to answer questions that cannot be answered by the data routinely produced within the diversion system, new data collection approaches will be needed for each individual study, and this will have significant resource implications in some cases. The cost of data collection will have to be budgeted for as part of the evaluation research design.

Component 9: Developing the evaluation findings from data analysis/synthesis, interpretation and judgment

A key feature in policy and program evaluation is that, contrary to the popular aphorism, the data do not speak for themselves. Instead, they have to be analysed and synthesised and then interpreted by the evaluation's stakeholders in the light of their understanding about the programs being evaluated and the contexts within which they operate.

The process of making judgements lies at the heart of evaluation. For example, if the number of participants in a diversion program falls, is that good because fewer people with drug-related problems are coming into contact with the criminal justice system? Or is it bad because people are being processed in the traditional manner through the courts rather than being diverted into helping services?

As highlighted throughout the evaluation, the capacity to collect and analyse the available information in the ACT is variable. Data is collected by different people, using different methods. Some data is collected but never analysed; some other data has required re-analysis as it was improperly coded the first time. Another aspect is the need for data to be analysed at the system and program levels, as changes within one program may occur in the context of, and be a consequence of, changes in the system.

Rubrics can be used as analytical tools to promote transparency and the reliability/replicability of the data analysis process. A rubric '...is a tool that provides an evaluative description of what performance or quality "looks like" at each of two or more defined levels' (Davidson 2005:137). Here is a simple example:

Table 30: A generic rubric for converting descriptive data into absolute determinations of merit

Rating	Explanation
Excellent	Clear example of exemplary performance or best practice in this domain; no weaknesses
Very good	Very good or excellent performance on virtually all aspects; strong overall but not exemplary; no weaknesses of any real consequence
Good	Reasonably good performance overall; might have a few slight weaknesses but nothing serious
Barely adequate	Fair performance; some serious (but nonfatal) weaknesses on a few aspects
Poor	Clear evidence of unsatisfactory functioning; serious weaknesses across the board or on crucial aspects

Source: Davidson, 2005, p. 137.

It can be a useful process to develop rubrics through discussion among stakeholders so as to incorporate into the analytic process their understandings of the program, including (especially) what 'success' and 'failure', would look like. This was done, for example, as part of the 2012 evaluation of the ACT Workplace Tobacco Management Program.

Component 10: Using the evaluation's findings

Reflecting the principles underpinning the utilisation-focused evaluation strategy, it is important to ensure that systems are in place for disseminating the information brought into existence through the evaluation, and the evaluations findings, to the people and organisations who can make most use of them. Passive dissemination, though, is of limited value. Far better is to have

in place known and agreed-upon structures and processes for reflecting on the meanings and implications of the evaluation findings. Ideally, this implies that people responsible for making decisions about the programs and their underlying policies should be those who engage in the process of reflecting upon the evaluation's products and identifying their implications for the future of the programs and policies. Similarly, explicit processes are needed for ensuring that the decisions that are made are, in fact, implemented, and to track the outcomes of the resulting changes.

For those components of the Roadmap that are ongoing, processes and structures will be needed to reflect on its continuing usefulness and to modify its design in the light of changing contexts, changes to the diversion programs being evaluated, the type of information flowing from the evaluations needed, etc. For example, the broadly based Territory Reference Group that was established some years ago under the provisions of the MOU between the ACT and Commonwealth governments provided a framework for reviewing the flow of data, reflecting on their meaning, making decisions about any changes to the programs that were called for, etc.

We discuss elsewhere in this report the value of a coordinating mechanism for the diversion program overall. Within that mechanism could be processes for managing the evaluative data in the ways outlined here. Attention is drawn, however, to the fact that we have identified in this report some data collections that appear to have some inherent errors. This implies that sound quality control processes are needed to ensure that decision-makers are presented with data and information that are both valid and reliable.

STRENGTHS AND CHALLENGES WITH THE ACT DRUG DIVERSION SYSTEM

Relative to other states and territories, the Australian Capital Territory (ACT) has been a leader in drug diversion provision; the first jurisdiction to introduce a court drug diversion program (1989) and the second to introduce civil penalties for cannabis possession (1992). In this section we collate the strengths and challenges with the system as it currently operates. This draws upon the feedback from the roundtables and key stakeholder interviews and the data outlined previously.

Strengths

1. Breadth of diversionary options

The ACT now employs five different diversion programs: SCON, PED, EIPP, CADAS and YDAC. The utilisation of multiple opportunities for diversion, at the police and court ends, and targeting different groups of drug and drug-related offenders, follows best practice principles of drug diversion (Bull 2005; Hughes and Ritter 2008). With only some exceptions (highlighted below) the ACT drug diversion system thus places a strong emphasis upon maximising opportunities to divert drug offenders. Moreover with a large number of referrals into this system, 500-600 per year, or 4,705 since 2001/02 (see Figure 11), this is a further indication that drug diversion has become core business in the ACT. Given the known harms from a criminal justice intervention, this is a good policy response.

2. Adaptability of the system/system players to perceived gaps/need

The ACT diversion system has undergone considerable change (see Appendix B for a summary). Some programs have closed (TRP), others have not only been adopted, but also rapidly and widely utilised (EIPP). Many of the programs have moreover adapted over time in response to perceived gaps and needs. Notable examples are the expansion of CADAS to fill the TRP type role in the courts, CADAS expanding to different courts, and to different client groups (e.g. young people) and the emergence of the new YDAC. Moreover, there have been numerous adaptations made to processes for PED and EIPP to increase police training efficacy etc. The strength is the adaptability of the system and lack of resistance to change. Yet, as noted below the flexibility/adaptability can also at times pose a potential problem.

3. Good will and enthusiasm of key stakeholders

The roundtables and interviews highlighted a high level of enthusiasm for diversion. This is not something that can be created overnight but is critical to dealing with complex clients, high workloads and system challenges. The enthusiasm is tempered at times by a desire for more sustainability of programs and program funding. Nevertheless, the commitment to this policy and to the ACT system is a real credit to those within it.

4. Streamlined referral process between police and health

A key challenge in drug diversion is building effective means for different stakeholders to work together. Both police and health praised the utilisation since late 2010 of SupportLink - the online referral system for referring PED and EIPP clients into the health system. From a police perspective it enables much easier referrals ("just jump on SupportLink") and from a health perspective it enables better management and prompter appointments to be established with

diversion clients. Attaining a streamlined referral process between police and health is thus a huge success. It is moreover no doubt a key reason why, in spite of a massive rise in referrals, there has been a very high level of assessments and completions for these two programs (see Table 16 and 19).

5. A centralised assessment and treatment agency

Looking at the conceptual maps (see Figure 3 and 4) and the different, albeit simplified, flow routes from police and courts the ACT Drug Diversion system can at times appear complex. Yet, the actual process is streamlined by having a centralised assessment and treatment agency in the ACT: the ADS. Having one central agency responsible for all health referrals builds into the system flexibility and responsiveness, particularly given staff willingness to shift roles as needs arise. An excellent example of this is documented below, namely the system's capacity to respond to a timely manner to a very large influx of EIPP referrals (82) at an Australia Day Live event (Australian Federal Police 2011).

Case study: Diversion through Australia Day Live – 25 January 2011

Police role

On the evening of 25 January 2011 an Australia Day Live concert was held at Parliament House. Due to problems in the past with underage drinkers, the ACT police EIPP officers managed a Youth Reception Team to process and refer youth to the Alcohol Diversion Program (Australian Federal Police 2011). A total of 82 young people were apprehended for alcohol related offences and referred to the Alcohol and Drug Service.

Health role

At the time of the 82 referrals there was only one clinician involved in the PED and EIPP role. The CADAS clinicians (also part of the ADS Diversion team) were enlisted to process clients: set up a new client file, contact clients, arrange appointments, conduct assessments and education, complete administrative reporting requirements and follow up on non-attending clients. As noted by the PED/EIPP clinician “the process ran surprisingly smoothly and we were able to see the clients in under 4 weeks”.

The net result was while the ADS were usually seeing a maximum of 16 EIPP clients per month, they were able to assess and treat within 4 weeks the vast majority of the 82 young people (5 were non-compliant). Moreover a new tool was developed to reduce time spent writing case notes, which both helped in this and future processing of EIPP clients.

6. High rates of treatment assessment and completion

The level of assessment for all programs requiring AOD assessments is high (above 91%) (see Table 16). The rate of completion, even amongst CADAS, is moreover notable, particularly for often difficult populations. It is thus not surprising that the stakeholders we spoke to expressed a high level of trust in the Alcohol and Drug Service diversion clinicians and AOD treatment providers. This is a credit not only to the ADS but also to the other agencies that the ADS engage with.

Challenges

1. Gaps in system knowledge and siloed knowledge

There are some parts of the system for which there are clear gaps in understanding, for which no stakeholder was able to provide the answers. An example of this concerns non-compliant offenders in the police diversion programs, with no known criminal justice outcomes (i.e. whether they were charged or not) were available on 9% of EIPP, 7.5% of PED and 20.2% of SCON referrals. We suspect that they receive a caution, but this was not verifiable through any means, which makes it impossible to assert that they are not being prosecuted (as per the police directives) (see Appendix C), nor the full cost or efficacy of responses. The second major gap in knowledge concerns CADAS, particularly as outlined in page 47 concerning the flows, the types of service responses provided, resource utilisation etc. The rapid changes in recent years make gaps perhaps understandable. Yet, the large number of questions remaining, make it hard to provide surety about why CADAS referrals have declined, or what constitutes the optimal means for reversal of this trend.

The evaluation team also encountered a number of potentially resolvable concerns/frustrations, which can be attributed to siloed knowledge. For example, a number of concerns were made about Magistrates making their own rules about CADAS through, for example, ignoring CADAS assessor recommendations to provide treatment and/or ordering CADAS for longer than 3-6 months. Still others highlighted their concern regarding the decline in CADAS referrals from the Children's Court. Yet, analysis of the patterns of referrals, and the newly established protocols, suggests overall referrals of young people have not declined, merely shifted in line with the newly established protocols. The query that arises is why gaps in system knowledge exist?

Related to this is that much of the knowledge about program operations, data availability and data extraction is either siloed within segments of the system, and/or one individual within that segment. All of this reduces the capacity to know what is and what is not working, the ability to resolve problems rapidly. It also reduces potential resilience of the system to unforeseen events.

2. Gaps in working as a system

Related to the point above is that there are some parts of the system that are not necessarily working as a coherent drug diversion system. For example, whether considering the number of referrals, the resourcing, or identified problems, it is hard not to perceive a real increase in problems regarding the court system. At the time of the previous evaluation of the system, CADAS was praised for being the most well-known and most utilised diversion program, with PED (or PEID as it was known at the time) very poorly understood (Hales and Scorsonelli 2009). The almost complete turnaround in only a few years is startling.

As noted in challenge no. 11 below the cause of the increase in problems regarding the court system appears attributable in large part to systemic factors beyond the control of the CADAS program or the broader AOD diversion system. But, one potential factor that has been within control of the AOD diversion system is inequity in investment in training support. While there has been a huge investment in police training, which appears to have paid off, particularly for PED, as documented by increased referrals over time, there remains a lack of dedicated funding for CADAS training. While focusing on the front-end of the ACT AOD drug diversion system may be beneficial, the lack of training for the back-end may have ramifications not only for CADAS but also the future capacity of the system to address AOD issues.

A further challenge is that some stakeholders who could be working together are currently not. A real strength of the ADS diversion clinicians is the sharing of staff and resources as needs arise. This appears to be less evident within the Police, with lines maintained between programs, particularly between EIPP, PED and SCON, but also between EIPP and PED, that ought not necessarily be there. One example is in regards to police training. There are a large number of training sessions conducted, some for EIPP alone, some combined EIPP/PED (see Appendix C). When combined, these utilise an EIPP officer, a PED officer and often a member from the ADS. It is obvious that police training is important, and has no doubt fostered the rise in PED referrals, but one drug diversion officer could arguably undertake all the training, perhaps with an ADS representative, and speak about all three programs.

3. Increasing use of diversion programs for 'non diversionary' activities (program creep)

As noted earlier the goals of drug diversion are fundamentally either to divert away from the criminal justice system or to divert into education/treatment. Yet there is clear evidence of program creep around most of the drug diversion programs; that is diversion programs being utilised for a number of different, non-diversion activities. Key examples include assessments of young offenders under Youth Justice protocols as the tertiary service for people aged under 18 years in the ACT (CADAS), school drug diversion education (EIPP and PED), and programs being utilised to undertake community education through (in particular) stands and pamphlet distribution at big events (EIPP).

This is clearest in regards to EIPP. For example, there has been a lack of clarity of the roles of the EIPP diversion officers since inception as evidenced by the position description (Australian Federal Police 2010). The role of the EIPP officer, under the supervision of the Sergeant of the Youth Liaison Team, would be to:

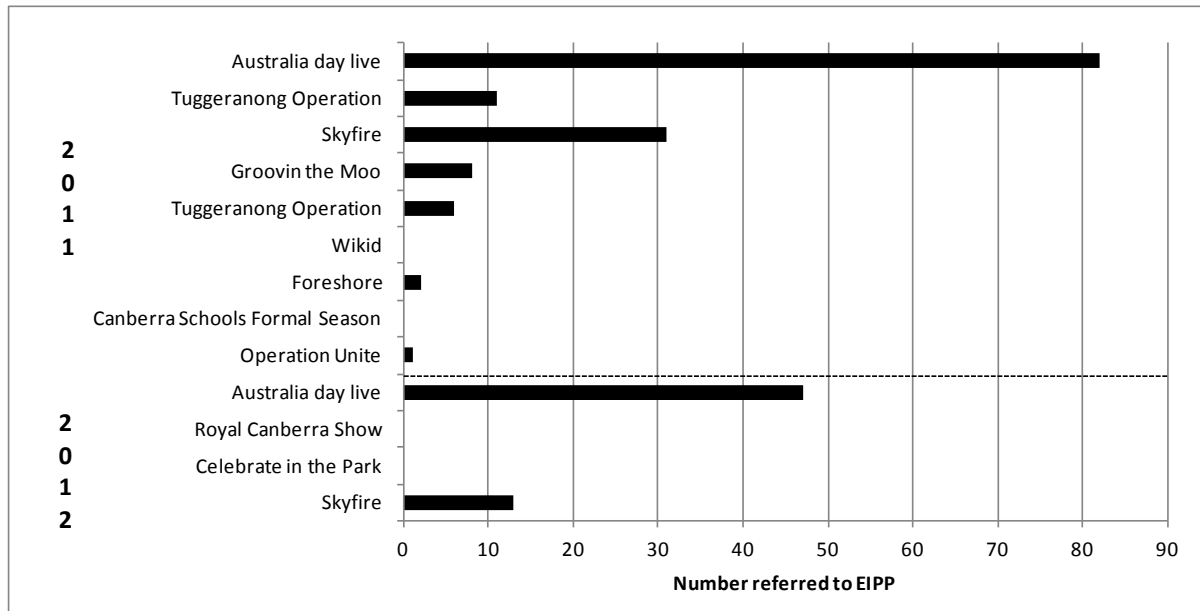
- i. Engage with the ACT Community and Youth in the context of COAG concerns and with a focus on reducing harm, binge drinking and associated social and health problems in the community
- ii. Conduct alcohol harm reduction education in ACT Schools in partnership with stakeholders
- iii. Conduct alcohol harm reduction education and promotion at public and targeted events
- iv. Initiate and develop effective partnerships with agencies and organisations, which can support the project in line with COAG principles
- v. Promote and develop appropriate referral processes using Supportlink® and other methodology to ensure best practice
- vi. Provide training and support for ACT Policing members to assist them in making correct referrals, appropriate considerations and processes
- vii. Track, record and report on the progress of the project
- viii. Contribute to the broader Crime Prevention strategies in support of initiatives, events and engagement opportunities; and
- ix. Contribute to the broader ACT Policing Strategic Plan and objectives

It is clear that points ii, iii, and viii are not primary objectives of a drug diversion program as described elsewhere.

A considerable amount of EIPP time is thus devoted to education and marketing to parents, the public and schools. For example, large amounts of time are spent attending major operations/events (see Figure 14). Indeed, from January 2011 to April 2012 there have been 13 major events attended (Australian Federal Police 2010; Australian Federal Police 2011; Australian

Federal Police 2012; Australian Federal Police 2012). Some events have resulted in large numbers of EIPP referrals but others have not. Some events moreover have taken a considerable amount of time, including the Canberra schools formal season (4 weeks during which EIPP officers scheduled their shifts to patrol the formal venues) and Operation Unite (a 2 day event), with little or no diversions.

Figure 14: Major events to which EIPP diversion officers have attended versus number of young people referred from the event during 2011 and 2012



In a small jurisdiction such as the ACT program creep may be somewhat inevitable when the size of programs requires those in many positions to wear many hats. Moreover, while there may be a clear need for all such activities to be undertaken, expenditure of scarce drug diversion resources on such activities is questionable at best. Indeed, as outlined on page 27 to 28 the Commonwealth EIPP funding agreement explicitly supplemented funds for EIPP with funds for community initiatives and public marketing, recognising that police should divert young people into education/health while other stakeholders educate the public at large about the potential harms from binge drinking (Department of Health and Ageing 2009).

There are three further reasons why program creep is of concern. First, it reduces the potential capacity of the system to do other tasks: particularly when CADAS referrals are declining, the expansion to be the tertiary assessor appears questionable to say the least. Second, it may be poor policy. As outlined in Appendix F the evidence base about school drug education does not support the effectiveness of police officers providing information, education or psychosocial interventions in schools. Nor do the policy documents, as evidenced by both the ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014 (Alcohol and Other Drug Policy Unit 2010:50) and the National Drug Education Strategy (Department of Education Training and Youth Affairs 1999). Third, if diversion staff undertake the tasks, it reduces the onus on others in the system to do them (i.e. to show gaps that are needed to be filled).

4. Lack of adequate data collection/skills in analysis

Data collection and skills in analysis are critical for well-designed diversion systems. Yet routine data on drug use and offending was provided for only a limited number of programs, and existing data was often reported for non-comparable offences and time periods (see page 53 to

54). It has become clear throughout the evaluation that there is more data being collected, but that there are not necessarily the people with the skills or time to analyse that which is being collected (or to analyse with sufficient quality assurance). Hence the challenge is not only what is collected, but also the usability and accessibility of that data. This has led to a number of side effects.

First, it has fostered a focus on referrals, rather than referral outcomes. Whether diversion through these programs is eliciting intended impacts, whether it be knowledge of services, changes in attitudes or in behaviour is critical to be able to measure and demonstrate. Equally important is the need to provide assurance that these programs do not unwittingly increase the likelihood of future harm, such as future criminal justice contact. Finally, for the most expensive programs, it is important to be able to assess whether the community is getting more for that expenditure. This applies particularly to the police programs, PED and EIPP, which are considerably more expensive than the SCON response (see Table 26-28), and indeed than provision of a standard criminal justice response.

Second, the lack of adequate data collection also fuels potentially erroneous assumptions. One such example is that SCON offenders are much more likely to reoffend than PED offenders, something for which the evaluation team do not feel there is sufficient evidence to say with surety.

Third, it stymies capacity to demonstrate success, something that stakeholders frequently asserted they want to be able to do.

Finally, it contributes towards system changes often having occurred without any evidence-informed assessment. The expansions regarding CADAS and YDAC are prime examples: responding to perceived needs, but without necessarily consideration of resourcing implications of whether this dilutes potential capacity/efficacy of the system. Particularly for a system that is now 10 years old this is a risky approach.

5. Lack of adequate goals and direction for the ACT drug diversion system

Goals and direction are important for any system, particularly when there are a large number of stakeholders, and programs within the system that potentially compete. Key examples include whether programs should be used to divert away or into education/treatment. Policing directives have clearly shown that diversion into education/treatment is to take precedence for cannabis users. Whether this is necessarily desirable or the optimal use of resources warrants attention at a broader system level, particularly as the ACT system is increasingly slanted towards therapeutic models of diversion, and police support for SCON is waning (see challenge no. 8).

Indeed, of all the 555 diversions in 2010/11, 79.5% were diversions into education/treatment; or looking specifically at the police diversion (n=378) 70% were therapeutic. The resource assessment clearly shows that a SCON is the cheapest response, even when costs for prosecuting some individuals are included. Given the lack of evidence to assert whether diversion into education/treatment is necessarily better, that is whether drug use or reoffending would be the same, better or worse (see challenge no. 4), this raises legitimate queries of what the system may look like with greater utilisation of a SCON-type response. For example, even assuming a similar rate of non-compliance for SCONS if 100% of referrals received a SCON-type response the costs of responding could be almost \$200,000 less, or \$42,000 less if all cannabis users were processed through SCON rather than PED (see Table 31).

Table 31: Hypothetical costs of increasing use of non-therapeutic police diversion in the ACT

	Status quo	100% SCON for cannabis offenders	100% SCON for all AOD offenders (assuming legislative changes)
No. police referrals	378 (157 EIPP, 107 PED and 114 SCON)	378 (157 EIPP, 11 PED and 210 SCON)	378 (0 EIPP, 0 PED and 378 SCON)
No. AOD assessments	243	168	0
Total cost of police diversion	\$694,500	\$652,436	\$505,386 (assuming similar rate of non-payment)
Impacts on drug use	?	?	?
Impacts on reoffending	?	?	?

The point of this exercise is not to say whether the current balance is right or wrong, but to firstly highlight the different ways of attaining the current ACT AOD diversion goals and, secondly, the absence of policy direction as to how these should best be attained and/or the space to engage in debates about optimal design.

6. Confusion in communication about some programs

Clear communication about programs is an essential step in building awareness and appropriate use. Yet there is confusion in the public domain about what programs operate (and don't). For example the ACT Health Directorate website continues to list TRP as an operational program. Most public domain accounts (including ACT Health Directorate again) still refer to CADAS as a pre-sentence option. There is further confusion about the relationships between some programs, and in the names. For example, the 2010 ACT Policing Annual Report lists drug diversion (PED) as an option under the EIPP scheme (Australian Federal Police 2011). There is moreover inconsistent use of terms for the PED and EIPP programs: For example the PED program has been variously called PEID, PED and even the AFP Police directive refers to the program as the 'Early Intervention and Diversion Program (the Drug Diversion Program)', and never formally uses the term PED or PEID (Australian Federal Police 2010).

Further examples of confusion arise in the training. For example in the police training, the message being conveyed is that the SCON scheme has high rates of non-compliance. This is of concern, particularly given data shows rates are high relative to other fine schemes (see Appendix G). It may also contribute towards police resistance to using this scheme. On the other hand, training on the PED program refers to 90% not-reoffending (ACT Policing 2010). As shown in Table 23 this is largely true if the metric is the extent to which those in the PED program are detected in the future for only drug offences. However, in reality the likelihood of being detected for any form of offence is considerably greater. Only reporting reoffending for drug offences may give a misleading impression of program efficacy.

7. Disconnect between drug diversion and broader system changes

There are a large number of changes occurring in the ACT system, many of which pertain to issues of diversion. One troubling observation in ongoing discussions about the youth justice system in the ACT was a lack of recognition of the role of drug diversion for many young offenders (Alcohol Tobacco & Other Drug Association ACT (ATODA) 2011). Given the large number of referrals through this system this is of concern.

The broader system changes moreover provide both potential opportunities for the drug diversion system and challenges. The opportunities include increased attention across the whole of government to the need for optimal diversion design, and for greater strategic direction and expenditure on diversion and early intervention (Youth Justice Implementation Taskforce 2011). Yet at the same time there are potential challenges, not least of all because the models proposed for young people differ to the models that drug diversion utilise for adults and young people.

Additional, more specific problems with particular programs

8. *SCON: Low police support/Low compliance with SCON scheme*

Data gathered throughout the evaluation suggest two principal problems with the SCON scheme: the level of non-compliance with the scheme and low police support. Levels of non-compliance continue to remain of concern for the scheme, particularly due to their much greater resource utilisation. That said, as shown in Appendix G, compliance with SCON appears higher in the ACT than for many other equivalent schemes. Moreover, recent data suggest some improvements in compliance relative to previous years. Of perhaps greater concern is that the roundtables and stakeholder interviews revealed low support within police for the scheme,¹⁷ due to the perception it creates extra work. Indeed, our discussions revealed that SCONS are now seen as a last resort for some Sergeants and that they actively discourage their use by their teams. This is a real concern if the scheme is to be maintained.¹⁸

Our discussions highlighted a number of mechanisms to increase compliance that have been tried, on an informal basis. While the practice directives state offenders must elect to pay their \$100 fee either at a shopfront or by cheque, a small number of offenders have been allowed to pay the \$100 fee by instalments but it remains up to Canberra Connect as to whether or not this occurs. Further the IDDO must approve this action, both of these militate against this option being utilised. The evaluation team has also been informed the option of BPAY was considered at some point, but never came to fruition. All of this indicates there has already been experimentation with different forms of payment, however in a very unsystematic way.

9. *PED: Low referrals for possession of drugs other than cannabis e.g. ecstasy*

There are very low referrals though the PED scheme for individuals found to possess drugs other than cannabis e.g. only 11 offenders total in 2010/11 (see Table 10). Our estimates of the program reach show that there is a very low percentage of offenders diverted through PED for drugs other than cannabis; 0% – 7.9% of all detected heroin, MDMA use/possess offenders are currently being diverted (see Table 32). This compares to a current rate for cannabis use/possess offenders of 70.9%, and a historical rate of between 74% and 100% of those referred from 2003-04 to 2006-07 being diverted for cannabis offences (Hales and Scorsonelli 2009).

The consequence is that of all types of drug and drug-related offenders in the ACT system, individuals found in possession of ecstasy, cocaine, methamphetamine or heroin are the least likely to be diverted. This is startling and stands as a big anomaly against the goals of providing diversionary opportunities and the success in providing it across most of the system. Moreover, it is arguable that it is the individuals who most warrant a health assessment and access to treatment, namely users of heroin and methamphetamine, who are missing out under the current approach.

¹⁷ See for example the comment from Roundtable 1: 'we don't like SCON.'

¹⁸ In response to a draft of this report the evaluation team was advised that: "There is support for the scheme in Police. We try to encourage police to use diversion, but where diversion is not suitable we do encourage SCONS."

Table 32: Summary of ACT diversion program reach, by target AOD population

Target population	Reach
Young alcohol user/mis-user	82.9%
Cannabis use/possess offenders	70.9%
Drug-related offender before the courts	16.2%
Ecstasy, methamphetamine, or cocaine use/possess offenders	1.3-7.9%
Heroin use/possess offenders	0%

Research conducted by the Drug Policy Modelling Program suggests that the cause is likely to be the threshold criteria. This work has shown that the current legislative thresholds in the ACT are low relative to many typical patterns of use within the ACT, particularly typical patterns of use of ecstasy and cocaine (Hughes and Ritter in press). The existence of thresholds for the PED program that are even lower again, 2 pills or 25% the legal threshold, is thus likely to exclude many users of drugs other than cannabis from being eligible for drug diversion. Indeed, the specification of thresholds for drug diversion is not universal, with many states opting to not provide a threshold of maximum quantity of heroin, ecstasy possessed – leaving this up to police discretion to decide whether the drugs were intended for personal use (Hughes and Ritter 2008).

Coupled with evidence that the amounts of cannabis that people are being diverted for is very low (see Figure 6), this suggests that not only are the eligibility criteria too low for the other drugs, but that ACT police are being very conservative, and desiring to avoid making a mistake in terms of whom they refer.

10. EIPP: Most expensive and resource intensive

EIPP is undoubtedly the most expensive of the policing programs. Moreover it also the program for which the number of diversion referrals vary the most, not only by quarter, but also by month. This makes it hard to justify when compared against the PED and SCOP program. Indeed, data for 2011/12 indicate that in spite of having EIPP officers operational for the entire period (not 7 months as per 2010/11) the number of referrals was lower than during 2010/11. A major reason appears to be that the referrals are driven largely by the big events, and that over time the number of referrals at these is declining.

All such factors make how resources are allocated within EIPP that much more important. As noted in challenge no. 3, compared to the other police diversion programs, there are many more areas where resources are directed towards non-diversion activities, including community education and school drug diversion education. Moreover, while EIPP was theoretically modelled on PED and there are some similarities between the PED and EIPP referral process, during the pilot EIPP adopted a much more hands off approach of PED. For example, PED has always relied on police officers to detect and refer eligible offenders – and refer via SupportLink. In contrast the EIPP process relies on the EIPP officers to undertake more of the responsibilities, the arresting officer often brings the young person to the station and the EIPP diversion officers then take over and contact parents/guardian and sit down and explain to young person and parent/guardian the options and process and enter the referral into SupportLink. All such actions increase the resource intensive nature of the program.¹⁹

¹⁹ Feedback received on the draft report noted that: “It remains ACTP’s position that EIPP has not moved away from the more hands off approach of PED. As EIPP was being established during the pilot, it appeared to be more resource intensive. The idea is that eventually once the officers are aware of how to process EIPP they would take over all the processing of the referrals. EIPP officers would only take over all paperwork and referrals during major events where the influx of diversions became excessive (e.g. like Australia Day Live 2010 where 82 young people were brought into the station). Our ultimate aim for EIPP is to have it work exactly like PED”. There is thus some lack of clarity regarding the extent to which EIPP officers versus sworn police process offenders for EIPP. This may be in part due to variations in offending loads. Figure 5 and Figure 14 demonstrate that most offenders are detected at major events: points at which

Equally importantly, this resource intensive model appears to conflict with building a sustainable diversion culture, that is a culture in which sworn officers will utilise diversion (whether EIPP, PED or SCON) as part of their day-to-day policing practice. For example, if EIPP is to be an ongoing and well utilised program it is unlikely to be feasible to have an EIPP officer in all police stations and to cover all the various shifts when police bring a young person in.

11. CADAS: Lack of awareness in the courts, DPP and Legal Aid, geographical barriers to using assessors and lack of clarity over what is and is not CADAS

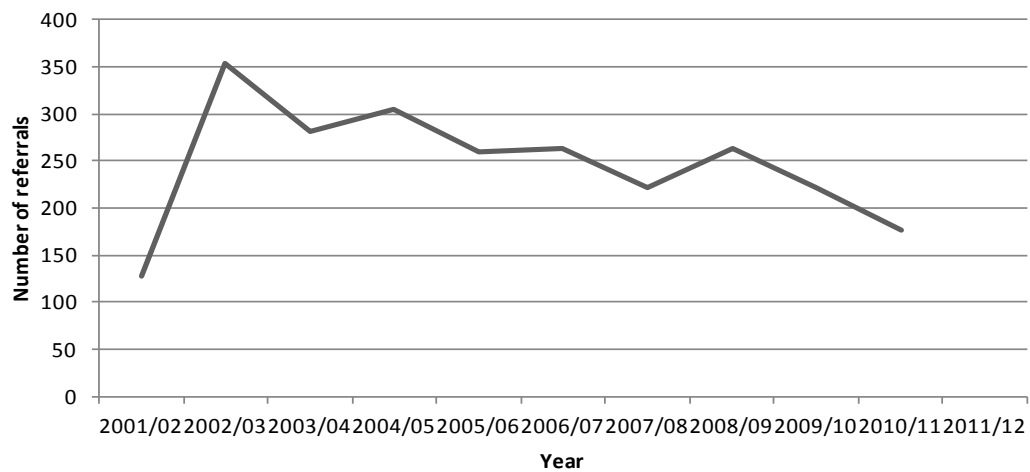
As outlined throughout the report there are a number of very real concerns with CADAS. The most notable reason is that referrals for CADAS have been consistently declining; and that what was the most praised program in 2009 has become the program about which there is very varying profile/utilisation, and confusion. For example as shown in Figure 12 referrals declined by 50% since 2002/03, more so in 2010/11. Moreover, as shown in Figure 13 the decline in referrals has also reduced CADAS reach to drug and alcohol-related offenders who have AOD problems in the ACT (most notably from 24% in 2008/09 to 16% in 2010/11). This is a real concern as across all metrics (levels of offending, drug use, harm or social cost, etc.), drug-related offenders cause significant burden on society. If not resolved, reduced utilisation of diversionary opportunities in the court system may therefore unwittingly contribute to problems for police and other stakeholders.

The causes of the decline in CADAS referrals are complex and we were not able to assess all possible causes within the evaluation. But, given treatment completion rates for CADAS clients have remained high it appears clear that the decline is attributable in large part to systemic factors beyond the control of the CADAS program itself.

One common suggested reason for the decline in CADAS referrals was changes within the Magistrates – loss of key champions and rise of new Magistrates who are unfamiliar and/or not big proponents of CADAS. Evidence to support this is key stakeholders noted that the CADAS profile has waned considerably within some ACT courts. CADAS was identified as having a high profile in the Supreme Court, but a low profile in the Magistrates Court. Yet as shown by Figure 15 this appear to be only a partial reason at best, as most of the changes have occurred in 2010/11 and 2011/12, at the end of the long-term decline in CADAS referrals. Such data also indicate that the number of Magistrates who could refer eligible offenders has not declined.²⁰

there is no contention that EIPP officers process offenders. However, the interviews with the EIPP officers (see page 111) also indicate they do much of processing at non-event times.

²⁰ Also potentially relevant are changes in the overall number of court cases. While not examined from 2001/02, the number of drug-related court offences was estimated from 2008-09 to 2010-11 (see pages 51-53) and showed minimal declines in the number of potentially eligible drug-related court cases.

Figure 15: Number of referrals to CADAS, compared to changes in Magistrates (2001/02 to 2011/12)

CADAS REFERRALS	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Number	128	353	282	305	260	264	222	263	221	177	
MAGISTRATES IN OPERATION											
CAHILL, Ronald John											
BURNS, John Dominic											
SOMES, Michael Anthony											
MADDEN, Shane Godfrey											
DOOGAN, Maria Krystyna											
DINGWALL, Peter Geoffrey											
FRYAR, Karen Margaret											
CAMPBELL, Lisbeth Ellen											
LALOR, Grant Chrysostom											
WALKER, Lorraine Anne											
MOSSOP, David											
MORRISON, Peter John											

Other pertinent causes for the decline in CADAS referrals include the lack of suitable court facilities to house CADAS assessors and the absence of dedicated training about CADAS within the courts and other stakeholder groups that utilise the courts, particularly Legal Aid ACT and DPP.²¹

A key barrier identified by those from the courts as well as the Alcohol and Drug Service team has been the absence of CADAS assessors within the courts. This has impacted on visibility of CADAS within the courts. Court key informants also suggest that not having CADAS in the building may have increased the time of responding to defendants, from an on the spot assessment that took half an hour to half a day, after which the court could make a ruling up on the same day, to a process that can take up to 3-6 weeks. While there is contestation about the extent and size of delay (see page 33), this indicates either a real or perceived delay in accessing CADAS. This conflicts with one of the CADAS objectives, that of capitalising upon the moment of first court appearance.

Another concern highlighted throughout the evaluation, was the perception that CADAS was 'identifying not solving problems' and that it had limited link with mental health, employment services. Whether it thus provides the option that the courts and others want is thus unclear. In this regard it is worth noting the CADAS remains the only one of the court drug diversion

²¹ This is by no means a reflection of the lack of good will or work of the diversion manager, but of systemic issues that need to be addressed: including as noted in challenge no. 2 dedicated funding for CADAS training.

programs in Australia to primarily if not exclusively focus on AOD assessment and treatment. Many have shifted to much more therapeutic models, in efforts to better increase the capacity to meet client needs and reduce reoffending. For example, services provided through the Victorian CREDIT scheme include:

- Assessment; treatment & support plan
- Referral to short term crisis accommodation.
- Passport photos for identification & medical purposes.
- Referral to outreach services for clients requiring intensive support.
- Referral to employment programs for training/ employment assistance.
- Travel cards, food vouchers and access to material aid, payment of keypass where required and court date reminders/diaries (Magistrates' Court of Victoria 2008).

The final challenge is that CADAS has changed considerably since adoption (ACT Magistrates Court 2000), with multiple pathways into and out of CADAS, and multiple ways that CADAS can and is used by the courts (see page 47). It is important to note that many of the changes have been in response to identified gaps or need. The changes are not therefore in themselves problematic. Yet, as noted above, the lack of understanding about the changes and the implications for the system are arguably a key contributor to the decline. For example as noted above many of the key players were unaware of the different models, and were frustrated by the apparent changes they could see. This is most undesirable for maintaining support for a program.

Such changes can have considerable impacts on resource implications. As outlined in Appendix H a number of IDDI funded court drug diversion programs have shifted from a pre-plea only focus, again suggesting there may be similar demands on providing a more multi-pronged program. This can increase the resource utilisation quite substantially and/or reduce the potential outcomes from programs. The clearest example of this is in reference to the Tasmanian court mandated drug diversion program (CMD), which provides the court with three different categories of orders ranging from diversion as a condition of bail to a sentencing option (a drug treatment order) of up to 18 months. Evaluators showed that between 2007-2008 53% of offenders were placed on the bail only option and 21% on the suspended sentence option (Success Works 2008:59), and that while the former took 118 days, the latter took an average of 134 days (Success Works 2008:59). Clients on the latter option were 10% more likely to reoffend.

12. YDAC: Lack of performance indicators and comprehensive data collection

There have only been a handful of YDAC clients to date. Large numbers are not expected (5-15 per year). For example there are approximately 130-150 young offenders on supervised justice orders in the ACT at any one point. The concern is that while individual programs are collecting some data on YDAC, there is no specified set of performance indicators for YDAC, nor way of knowing if all the requisite data is being collected.

WAYS FORWARD AND RECOMMENDATIONS

The Australian Capital Territory (ACT) has long been a leader in drug diversion provision. Drug diversion is a good thing. It should be maintained and funded as a priority activity within the ACT. In line with best practice principles of maximising opportunities for diversion we recommend that all programs be maintained. It is clear that there are avenues for improvement, at both the system and individual program level. Many of these areas of improvements intersect. Adoption of this set of recommendations will cement the ACT at the forefront of Australian drug diversion.

System level recommendations

1. Document a comprehensive AOD diversion strategy

The ACT needs a comprehensive AOD diversion strategy to provide vision and direction for the AOD drug diversion system. Eleven years post the COAG-ACT IDDI agreement the strategy would serve as a reminder to all stakeholders within the system, and to new players that enter it, why AOD diversion is important, the key players within it, how it operates (e.g. by way of the conceptual maps), the primary objectives (divert away and/or divert into education/treatment), stakeholder roles and key performance targets for the next years. The strategy document would provide clarity of current and future directions and expected outcomes from the diversion system in the ACT.

New performance targets should be outcome oriented – that is in terms of changes in behaviour (whether that be drug use and/or offending behaviour) rather than focussed solely on process targets, such as ‘increasing the uptake of drug diversion’. They should also focus on the system of diversion, for example increasing the proportion of police, Judges, Magistrates and Youth Justice workers who are aware of drug diversion options in the ACT.

Benefits/outcomes:

- Vision
- Renewed commitment
- Goal clarity
- Performance targets
- Stakeholder engagement
- Improve capacity for system improvement
- Promotion of the ACT drug diversion system

2. Establish a facilitator position for the whole ACT AOD diversion system

While there is an existing ADS Diversion Manager who works well across 4 of 5 programs, there are an increasing number of protocols, procedures and program changes that warrant a facilitator position for the ACT AOD diversion system. The facilitator position would be responsible for facilitating system improvements: enabling information exchange across the system about new protocols; orienting new drug diversion staff (across health, police and justice) to the ‘big picture’ of ACT AOD diversion; facilitating the review of trends in referral patterns and other relevant data; and establishing discussion forums to highlight successes or discuss or problem solve common challenges. Given the critical role of training in the system, this person would also manage a training calendar—a central resource which documents all training activities by various

stakeholders in the system—to ensure that training is being undertaken across the whole system. The goal will be principally one of information facilitation, not line management or program accountability.

The ACT AOD diversion facilitator will also take on the role of ensuring drug diversion gets the recognition it warrants in ongoing and future ACT policy discussions. They will ensure that there is at least one person who can keep abreast of these and think about potential opportunities to leverage the drug diversion system. The facilitator could for example, ensure broad feedback into the drug diversion strategy (recommendation 1). As an advocate for ACT drug diversion, they would also minimise the chances that other policy activities do not unwittingly get introduced that reduce the capacity of the ACT AOD diversion system (see for example pages 24 to 25).

To aid the AOD diversion facilitator, we recommend introduction (or re-introduction) of an ACT Diversion Working Group, which would include representatives from each program, and from stakeholders and non-government organisations.²² This would then serve as a resource to the facilitator when issues/opportunities that arise.

Benefits/outcomes:

- Better informed clients and stakeholders
- Better understanding of system implications of changes
- Streamline communication channels
- Development of common understanding
- Improved implementation, through discussion forums and training, of the evidence on what works
- Minimise duplication
- More efficient resource use
- Increase leverage about drug diversion
- Enhance the capacity for innovative and superior responses

3. Re-focus all programs on drug diversion

Our evaluation has revealed examples of ‘program creep’ across many different parts of the system. One example is school-based information sessions. This has meant that ‘diversion’ resources have been diverted away from the central and agreed objectives of the ACT drug diversion system: diverting away from the criminal justice system and/or diverting into education and treatment. This is not to say that drug diversion officers cannot do these tasks, but if they do, then separate funds should be made available such that diversion resources are utilised exclusively for the central and agreed objectives.

This re-focussing of resources on the central goals of diversion will entail a renewed commitment to why drug diversion is being utilised, what it is and what it is not (hence the benefit of also doing recommendation 1). It also demands attention to the role of drug diversion vis-a-vis other activities in the ACT: youth diversion, crime prevention, social marketing campaigns etc.

²² This could be along the lines of the previous Territory Reference Group (TRG), which included representation from ADS, AOD Policy Unit, NGO representation, DoHA, ACT Policing, DPP, JaCS, DHCS, both Court administrations, and ADCA and met on a quarterly basis, but membership may need to be broader.

We are mindful that this will necessitate careful consideration of gaps that may be created in the broader ACT response to drug and drug-related issues, and that other avenues may be needed to support these. Indeed, this is why adopting this in concert with recommendation one and two are important, so as to both re-assert the vision, and to have someone to lead advocacy for the drug diversion system to be recognised and build off where possible broader policy changes.

Benefits/outcomes:

- More efficient resource use
- Goal clarity
- Lack of ‘program creep’

4. *Establish an improved capacity for data management and evaluation of the AOD diversion system in the ACT*

Our evaluation has revealed the gaps in outcome data that prevent many key questions from being answered, or answered in a less than satisfactory manner. Putting together an evaluation roadmap was thus a critical component of this current process. There is now a need to implement the evaluation roadmap. This will necessitate a number of decisions to be made, including deciding who are the most relevant stakeholders who ought be involved, the purpose, users and uses, the questions that the ACT want to be able to answer, and the requisite indicators to be established and/or improved upon. The stakeholder group and facilitator (recommendation 2) are likely to be key resources in this process, and in ongoing evaluation of the AOD diversion system. Added to this is a final requirement, to build capacity to utilise the data within and across the ACT AOD diversion system. A key benefit of this is ensuring not only increase capacity, but more systematic capacity so that both system and program level questions can be addressed now and into the future.

Benefits/outcomes:

- Increase capacity to demonstrate effects at the system and program level
- Increase capacity for more cost-effective responses
- Increase capacity to predict and be ready for current/emerging problems
- Reduce capacity for unintended consequences from the system

Program level recommendations

5. *Reform the Simple Cannabis Offence Notice (SCON) payment system to bring it in line with other infringement schemes in the ACT*

We note that there are continued instances of non-compliance and some police resistance to the SCON scheme, particularly due to the extra work required in following up unpaid SCONs. Nevertheless, we note that in many regards the SCON scheme is operating well: it is the least expensive of all police programs and has a higher level of compliance than other cannabis expiation notice schemes in Australia. The scheme also plays a unique role in providing one diversion option: it is the only program to divert offenders away from the criminal justice system. For all these reasons the SCON scheme should be maintained.

Key changes are warranted to the payment system. Specifically we recommend that as a first step the payment system be dealt with as per other ACT infringement notices, particularly Criminal Infringement Notices which are issued for criminal actions such as “defacing public or private

property or premises, urinating in public, supplying liquor to an intoxicated person, consuming liquor in prescribed public places, abusing, threatening or intimidating staff, failure to leave premises when directed and failing to comply with noise abatement directions” (Canberra Connect 2012). All such actions are payable through Canberra Connect, using a range of payment options: online, phone or in person (<http://www.canberraconnect.act.gov.au/>). Attention should also be paid to ongoing changes in the infringement schemes, and the avenues that may be opened up for payment of drug diversion infringement notices.

There is also a need to better inform officers about the SCON scheme. At the minimum, once changes are made this should be advertised to police, using advocacy as per PED and EIPP, about the ease of issuing a SCON and benefits (in terms of time and resources) of using SCON over a traditional criminal justice response.

Benefits/outcomes:

- Increase rate of payments
- Increase speed of payments
- Reduce police time spent following up non-compliant offenders
- Reduce cost to system: cost for paid SCONS is considerably less than the cost associated with chasing up SCONS in court (\$1067 versus \$1337)

6. Increase Police Early Diversion (PED) thresholds for maximum quantity of heroin, methamphetamine, ecstasy and cocaine that can be possessed

The very low number of referrals for users of drugs other than cannabis (0 – 7.9% versus 70.9% for cannabis use/possess offenders), and very conservative use of the thresholds, demands attention so that users of drugs other than cannabis do not miss out on diversionary opportunities. There is a need to increase the threshold on the maximum quantity of heroin, methamphetamine, ecstasy and cocaine that can be possessed. Alternately, given many states do not provide a threshold of maximum quantity of heroin, ecstasy, etc. possessed the threshold could be entirely removed. If retained, threshold changes should be considered in the context of the Attorney General’s review of thresholds.

The low rate of diversions for illicit drugs other than cannabis also speaks to a need for greater education and information for police about the intent of the program: that the purpose of PED is to divert users into assessments and treatment, regardless of the drug type, and that PED is well-suited to injecting drug users, amphetamine and ecstasy users.

Benefits/outcomes:

- Increased access to treatment/education for people who use illicit drugs other than cannabis
- Increased understanding of the purpose of the PED program by police
- Reduced load on the courts

7. Build a less resource intensive and more sustainable Early Intervention Pilot Program (EIPP)

EIPP has been an important contribution to the ACT AOD diversion system, expanding both responses to young people and for alcohol specifically. Nevertheless, Commonwealth funding for the EIPP was not continued in the 2012-13 budget, meaning it is currently funded only until 30 June 2013. The decline in EIPP numbers, and continued drop in referrals at youth events, along with the funding constraint means that a less resource intensive and more sustainable EIPP is required. One obvious aspect, consistent with recommendation 3, is to refocus EIPP solely on alcohol diversion activities that occur at the point of police detection. The school-based information session and community education activities reside outside the primary goals and objectives of the ACT diversion system.

The second suggested change is that, under normal day to day practices, EIPP police diversion officers adopt a more liaison role of training police and monitoring implementation, rather than processing young offenders for sworn officers. The exception to this is large inflow periods e.g. youth events where the demands on sworn officers are likely to remain considerable.

Benefits/outcomes:

- Reduce cost per referrals
- Increased sustainability of program
- Increased ability to share load with PED/SCON officer as need arises

8. Redefine and relaunch the Court Alcohol and Drug Assessment Scheme (CADAS)

The declining referrals to CADAS, confusion amongst key stakeholders and large number of changes in recent years demands efforts to rebuild legitimacy of the program. Key to this is establishing some definitional clarity about current and future utilisation of the program. This necessitates consideration of whether all current CADAS models are to be retained. The evaluation research team supports their continued use, as it clearly increases potential pathways into CADAS. Yet, we are also mindful that this adds to the complexity of system. The second requirement is clarifying goals and processes for each CADAS model. Given no directive covers all models, thought must also be given to whether a new directive is needed to encompass all.

To ensure the new goals and processes are known of, as well as to counter some of the current gaps in knowledge, frustrations and facilitate a re-renewed commitment to CADAS, there is then a need to relaunch CADAS in the ACT courts, DPP, Legal Aid ACT, and with CADAS assessors themselves. This will not only reduce confusion across the court and health systems, but also streamline future referrals and reporting.

Benefits/outcomes:

- Increase clarity and consistency of expectations for all stakeholders
- Provide more effective processes and responses to offenders
- Increase ability to assess resource utilisation/direct resources
- Address confusion in the system
- Increase perceived legitimacy of program

9. *Adopt short and long term solutions to get the Court Alcohol and Drug Assessment Scheme (CADAS) assessors into the court*

Getting CADAS assessors back into the ACT Courts is a top priority. There is almost unanimous support for this across all stakeholders we spoke to: Magistrates, Judges, ADS, DPP, and Legal Aid ACT, etc. Without it the CADAS system is clearly not functioning well.

Both short and long term solutions are needed to rectify this: long term - getting a space added to the new plans for the Supreme Court in the ACT; and short term - CADAS to team up with ACT Mental Health Court Assessment and Liaison Service and/or follow their model. The long term solution is that there is a proposal to develop a new Supreme Court within the ACT. Discussions with the designer have highlighted that spaces within the current plans are at a premium – but there may be the opportunity to attain space for a CADAS team if this is deemed a high enough priority. This will not be operational until 2018, but it is of immediate importance if a space is to be added to the plans. To demonstrate need will require rapid input from the Diversion team, Magistrates and Judges and other key stakeholders to demonstrate the need as well as their requirements. Key pieces of evidence to utilise are the declining CADAS reach in the courts.

The short term solution is for CADAS to team up with ACT Mental Health Court Assessment and Liaison Service and/or follow their model. The Forensic Court Liaison Service provides mental health assessments and court liaison services within the ACT Children's Court, the ACT Magistrates Court and the Supreme Court of the ACT. Assessments are conducted on a daily basis in the court cells for both the ACT Children's Court and the ACT Magistrates Court. In 2010/11 this service assessed approximately 300 individuals prior to their court appearances (ACT Government Health Directorate 2011). Representatives of the service also attended court for approximately 50 mental health consumers per month.

Clinicians in this team undertake comprehensive assessments and provide written reports for the court or tribunal (ACT Health 2011). Court liaison staff can also provide brief verbal reports to the court for people appearing in court on an ongoing basis, or for people who may be detained in custody receiving mental health care. While they can refer people on to community mental health teams they do not provide ongoing mental health care. But at present this team only asks about alcohol or drug use but does not enquire as to whether this use is problematic and/or causal to offending. There is the potential that a CADAS team member could either alternate with the mental health team or if this is not possible ensure AOD issues are incorporated into the mental health assessments to identify the potential need for CADAS.

It is important to note that the short-term solution will not cater for every eventuality, for example offenders not in cells. This is why the long-term solution warrants prioritisation.

Benefits/outcomes:

- Provide more effective processes and responses to a greater number of offenders
- Increase ability of CADAS assessors to be utilised rapidly
- Provide a public face of CADAS
- Increase perceived legitimacy of program
- Address urgent concerns of multiple stakeholders

10. Establish by the end of 2012 performance indicators and data systems for the Youth Drug and Alcohol Court (YDAC), and initiate work on developing an evaluation strategy for implementation in the second half of 2013

Given the importance of establishing optimal utilisation of programs from commencement, and to enable quality improvement where necessary, there is an urgent need to determine the evaluation framework and comprehensive set of performance indicators for YDAC. This will shed light on whether the currently collected data is sufficient: or more probably, whether additional data and systems are required. Although small, YDAC is likely to be the most resource intensive per referral of any of the ACT drug diversion programs. Establishing a comprehensive framework for assessment will thus guarantee capacity to appraise outcomes, and the potential costs and benefits of funding this as part of the ACT AOD diversion system. Given challenges with even some earlier clients it will also enable insights now into the program, what is working or could be improved.

Furthermore, work could commence now to develop a strategy to implement the ACT Government's commitment to evaluate the two-year pilot program.

Benefits/outcomes:

- Increase capacity to assess effects
- Increase capacity to adapt processes, in an evidence-informed manner
- Provide more effective processes and responses to offenders
- Increase ability to assess resource utilisation/direct resources
- Ability to implement the Government's undertaking to evaluate YDAC.

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APPENDIX A: ROUNDTABLE PARTICIPANTS**Roundtable 1**

No	Name	Role ¹
1	Helene Delany	Manager, Alcohol and Other Drug Policy Unit, Health Directorate Diversion Service Manager, Alcohol and Drug Service, Health Directorate: Oversees EIPP, PED, CADAS, YDAC and reviews/allocates all EIPP, PED and CADAS referrals
2	Kate Gardner	
3	Clare McGettrick	Drug and Alcohol Diversion Officer, ACT Policing, AFP
4	Sergeant Sue Smith	Early Intervention Pilot Project, ACT Policing
5	Clare Purcell	EIPP/PED Coordinator, Alcohol and Drug Service, Health Directorate
6	Camilla Rowland	Chief Executive Officer, Karralika Programs Inc
7	John Couto	Alcohol and Drug Service frontline youth counsellor A/g Assistant manager, Community Youth Justice - Acting Assistant Manager of Diversionary Program
8	Sarah McAuley	
10	Tamara Schwarzaugl	Court diversion coordinator, Alcohol and Drug Service, Health Directorate
11	Ronia McDade	Manager, Community Youth Justice

¹ Some roles have overlap due to job-sharing.

Roundtable 2

No	Name	Role
1	Helene Delany	Manager, Alcohol and Other Drug Policy Unit, Health Directorate Diversion Service Manager, Alcohol and Drug Service, Health Directorate: Oversees EIPP, PED, CADAS, YDAC and reviews/allocates all EIPP, PED and CADAS referrals
2	Kate Gardner	
3	Renate Moore	Manager, Social Policy and Implementation, Chief Minister and Cabinet
4	Nicole Wiggins	Manager, Canberra Alliance for Harm Minimisation
5	Carrie Fowlie	Executive Officer, Alcohol Tobacco and Other Drug Association ACT (ATODA)
6	Carmel McBride	Manager, Counselling and Treatment Service, Drug & Alcohol Service
7	Richard Davies	Legal Aid ACT/Head of Criminal Practice
8	Sam Hills	Drug and Alcohol Diversion Officer, ACT Policing, AFP Women's Information, Resources and Education on Drugs and Dependency (WIREDD) Coordinator
9	Paulina Hellec	
10	Vivienne Pearce	WIREDD Human Rights & Discrimination Legal Policy Adviser, Human Rights Commission
11	Sean Costello	
12	Roger Butcher	Justice Health Services
13	Ronia McDade	Manager, Community Youth Justice

Roundtable 3

No	Name	Role
1	Helene Delany	Manager, Alcohol and Other Drug Policy Unit, Health Directorate
2	Clare Purcell	EIPP/PED Coordinator, Alcohol and Drug Service, Health Directorate
3	Carmel McBride	Manager, Counselling and Treatment Service, Drug & Alcohol Service
4	David Ridley	ACT Policing, PED and SCON
5	Clare McGettrick	ACT Policing, EIPP
6	Magistrate Karen Fryar	Magistrate, ACT Children's Court
7	Richard Davies	Legal Aid ACT/Head of Criminal Practice
8	Renate Moore	Manager, Social Policy and Implementation, Chief Minister and Cabinet
9	Nicole Wiggins	Manager, Canberra Alliance for Harm Minimisation
10	Carrie Fowlie	Executive Officer, Alcohol Tobacco and Other Drug Association ACT
11	Paulina Hellec	Women's Information, Resources and Education on Drugs and Dependency Coordinator
12	Camilla Rowland	Chief Executive Officer, Karralika Programs Inc
13	Kate Pensa	Executive Director, Directions ACT
14	Victor Martin	Senior Legal Policy Officer, Legislation and Policy Branch, ACT Department of Justice and Community Safety

Interviews

No	Name	Role
1	Amanda Jubb	Prosecutor, ACT Office of the Director of the Public Prosecutions
2	Helene Delaney Jennifer Taleski	Manager and Financial officer, Alcohol and Other Drug Policy Unit, Health Directorate Diversion Service Manager, Alcohol and Drug Service, Health Directorate: Oversees EIPP, PED, CADAS, YDAC and reviews/allocates all EIPP, PED and CADAS referrals
3	Kate Gardner Clare McGettrick, Sergeant Sue Smith,	
4	Sam Hills	ACT Policing, EIPP
5	David Ridley	ACT Policing, PED and SCON
6	Ronia McDade, Sarah McAuley	Manager and A/g Assistant manager, Community Youth Justice
7	Judge Refshauge	Judge, ACT Supreme Court
8	Magistrate Karen Fryar	Magistrate, ACT Children's Court
9	Victor Martin, Nikki Bensch	Senior Legal Policy Officer, Legislation and Policy Branch, ACT Department of Justice and Community Safety Manager, Capital Works and Infrastructure, Justice and Community Safety
10	Mr Luke Jansen	Directorate

APPENDIX B: TIMELINE OF KEY DIVERSION RELATED EVENTS IN THE ACT

Date		Event
Year	Month	
1989	Mar	Drugs Of Dependence Act (DODA) 1989 adopted prohibited possession, supply and cultivation of all illicit substances in the ACT
1989	Mar	The Treatment Referral Program (TRP) post sentencing diversion program for illicit drug-related offenders commenced under the DODA.
1992		Simple Cannabis Offence Notice (SCON) expiation scheme introduced – enabled cannabis offenders possessing < 25 grams of cannabis or < 5 plants to avoid a criminal conviction by payment of a \$100 fine
1995	Sep	First ACT AOD strategy adopted: ACT Drug Strategy 1995-97.
1999	Sep	Second ACT AOD strategy adopted: ACT Drug Strategy 1999 - From Harm to Hope.
1999	Nov	Council of Australian Government-Illicit Drug Diversion Initiative (IDDI) signed off including an agreement for a nationally consistent approach to the diversion of minor drug offenders to education & treatment. Prime Minister John Howard allocated \$110 million to stage one.
2000	Oct	Court Alcohol and Drug Assessment Service (CADAS) introduced, following discussions between Chief Magistrate and ACT Health: Practice Direction: No. [] of 2000 CADAS.
2001	Jun	ACT COAG-IDDI agreement signed.
2001	Dec	ACT Policing and Early Intervention Diversion Program (PEID – later called PED) introduced.
2001		CADAS extended to Children’s Court.
2003		Memorandum of Understanding between Youth Justice Services and CADAS developed for responding to young offenders. Protocol was never formally signed off. Further attempts to have signed in 2007.
2003	Jun	CADAS evaluation completed by Morgan Disney and Associates – key recommendation to increase program access and services for Aboriginal and Torres Strait Islander people.
2004	Mar	Human Rights Act adopted in the ACT.
2004	Jul	Third ACT AOD strategy adopted: ACT Alcohol, Tobacco and other Drug Strategy 2004-2008.
2005	May	Criminal Code (Serious Drug Offences) Amendment Act 2004 came into force, reducing eligibility criteria for the Simple Cannabis Offence Notice (SCON) scheme. The new criteria included a maximum of 5 to 2 cannabis plants and excluded all hydroponically grown plants.
2005	Jun	ACT COAG-IDDI agreement 2004-2007 signed. Included change in treatment brokerage funding – to exclude ACT Health treatment services from eligibility for diversion funds. Also increased funds to expand CADAS eligibility criteria for alcohol-related offences for those aged under 18.
2008	Nov	COAG approved new National Health Agreement (NHA) for 2008-09 to 2012-13 – Special payment funds for all jurisdictions including for the COAG IDDI was rolled into this.
2009	Mar	The Alexander Maconochie Centre (AMC), the ACT’s first adult prison commenced operation.
2009	Apr	Early Intervention Pilot Program (EIPP) national framework 2009-2013 endorsed by the MCDS – key goal – to divert underage drinkers to targeted health interventions (and lead to sustained reductions in alcohol intoxication). Two models: Option 1 – informal caution. Option 2 – diversion/intervention. Funded under the National Binge Drinking Strategy (\$18.1 billion).
2009	Sep	Evaluation of the ACT Illicit Drug Diversion Initiative Programs by Health Outcomes International evaluation. This highlighted that CADAS was the best known and used diversion scheme, but that PEID suffered from low referrals due to poor police awareness.
2009	Dec	ACT Health Commonwealth EIPP Agreement.
2010	Jan	Expansion of police marketing/training surrounding PED: from new recruits to include all operational members.
2010	Feb	MOU between Legal Aid ACT and Directions ACT to enable Legal Aid ACT to provide regular legal information and clinical advice sessions to many of DIRECTIONS’ clients.
2010	Jun	CADAS assessors relocated offices outside court complex due to OHS requirements.
2010	Jun	Adaptation of SupportLink internet based referral system for PED and EIPP referrals between ACT Policing and ACT Health’s Alcohol and Drug Service (ADS) - provided police with on the spot referral through to the ADS. System became operational 6 December 2010.

EVALUATION OF AUSTRALIAN CAPITAL TERRITORY DRUG DIVERSION PROGRAMS

2010	Jun	MOU between the AFP and ACT Health regarding the ACT Illicit Drug Diversion Program and Early Intervention Pilot Program.
2010	Jun	Fourth ACT AOD strategy adopted: ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014.
2010	Aug	Repeal of Part 9 of the Drugs of Dependence Act 1989 led to end of the Treatment Referral Program (TRP) program.
2010	Aug	New MOU between ACT Health and ACT Corrective Services for the Supreme Court use of CADAS introduced formalising that, following the closure of the TRP program, CADAS will operate in the Supreme Court as both a pre plea (bail) and sentencing option (Supreme Court of the ACT Practice Directive No. 1 of 2010: Using CADAS in the Supreme Court).
2010	Nov	2 x ACT Police EIPP Diversion Officers commenced in Nov and Dec.
2010	Dec	The ACT Legislative Assembly asked the Attorney-General to direct the ACT Human Rights Commission to conduct an inquiry into the youth justice system, and to undertake a Human Rights Audit of Bimberi Youth Justice Centre.
2010	Dec	Diversion in-box was set up to facilitate CADAS referrals. Utilised by the Magistrate Court for submission of reports from December 2010 and receipt of orders from September 2011.
2011	Feb	The Minister for Community Services released a discussion paper "Towards a diversionary framework for the ACT" with two months for consultation.
2011	Apr	Diversionary Framework Consultation feedback was summarised in a report by Noetic Solutions: 'Consultations: Towards a Diversionary Framework for the ACT Discussion Paper.'
2011	Apr	Six month trial where all youth justice AOD treatment referrals went through CADAS. CADAS will undertake all AOD assessments and determine which treatment agency is best suited. Trial developed in partnership between DHCS, ACT Health, Gugun Gulwan Aboriginal Corporation and Ted Noffs Foundation. Final protocol signed 2012.
2011	Apr	Burnet report released: "External component of the evaluation of drug policies and services and their subsequent effects on prisoners & staff within the Alexander Maconochie Centre."
2011	Jul	ACT Human Rights Commission Report released: 'The ACT Youth Justice System 2011: A Report to the ACT Legislative Assembly by the ACT Human Rights Commission.' This included 224 recommendations for improvement.
2011	Jul	Practice directions for a new ACT Youth Drug and Alcohol Court (YDAC) adopted. The program, started as a two year trial on 1 Dec 2011, to provide a pre-sentence diversionary opportunity for children and young offenders with a demonstrable AOD problem.
2011	Oct	ACT Government response to the HRC Report released. Recognised need for a stronger focus on diverting young people from the youth justice system, and the intent to address this through the prioritisation of diversion in the Blueprint for Youth Justice in the ACT.
2011	Nov	Street Law Report – "The Downward Spiral: How a fine can cause homelessness in the ACT" - identified that the ACT infringement system was having a disproportionately negative impact on vulnerable populations, including those with serious AOD issues.
2011	Dec	Blueprint for Youth Justice in the ACT Consultation Paper released. Consultation period: December 2011 - 30 March 2012. Key recommendation included diversion.
2012	Feb	Greens bill introduced for reform of infringement system relating to road traffic offences - Road Transport (General) (Infringement Notices) Amendment Bill 2012 – to enable infringement notice penalties to be paid by instalments or discharged by attending an approved community work or social development program
2012	Mar	Government bill for reform of infringement system relating to road traffic offences - Road Transport (General) (Infringement Notices) Amendment Bill 2012.
2012	Mar	ATODA paper argued that reform of the multiple infringement systems in the ACT be extended to cover all infringements and fines, including infringements made for ATOD-related behaviours, such as smoking, drinking alcohol, or possession of illicit drugs.
2012	May	Unspent ACT EIPP funding rolled over until June 2013.
2012	May	Greens bill for reform of infringement system - Road Transport (General) (Infringement Notices) Amendment Bill 2012 approved with the support of the Government.
2012	May	Australian Government's Department of Health and Ageing announced it had reduced funding drug treatment and support services in the ACT. ATODA estimated the overall funding cut amounted to \$1.4 million.
2012	May	Commonwealth Budget announced no new funding for EIPP from 2013.
2012	May	ACT Property Crime Strategy 2012-15 adopted.

APPENDIX C: PROCEDURES FOR ACT AOD DIVERSION PROGRAMS

Simple Cannabis Offence Notice (SCON)

June 2010 ACT Policing practice directives note officers must firstly determine whether or not to issue a SCON or PED: 'before a SCON may be issued, the case officer must first determine if the offender qualifies for the Drug Diversion Program. If the Drug Diversion Program can be utilised it will take preference over the issue of a SCON' (Australian Federal Police 2010).

When a SCON is to be issued, the case officer must:

- Explain the terms and conditions of the infringement
- Ensure the person, and in the case of a young person, the parent or guardian agree to these conditions, including payment within 60 days at a designated shopfront
- Distribute copies of the SCON to the offender and Illicit Drug Diversion Officer (IDDO)
- Enter the incident into PROMIS, and clear the offence by 'SCON'
- Record in PROMIS the reason why a Drug Diversion was not issued
- Lodge the drug seizure

According to the police directive payment/non-payment of a SCON is then monitored by the Illicit Drug Diversion Officer (IDDO). If the SCON is paid in full within 60 days the IDDO will advise the case officer that the matter is finalised and to contact the ACT drug registry to authorise destruction of the drugs. If however, a SCON is unpaid after 30 days, the IDDO will post reminder notices to SCON recipients. If it remains unpaid with 7 days to go, the IDDO will post reminder notices to SCON recipients. If it remains unpaid the IDDO must then telephone the SCON recipient and record the reason for non-payment. Finally if it remains unpaid after 60 days the IDDO must inform the case officer who must then pursue alternate action. In this instance the case officer must update the PROMIS apprehension record accordingly by: withdrawing the original offence cleared by SCON; creating a new apprehension record using the original statement of facts; clearing the offence by the new course of action e.g. a drug diversion.

Other details that have become clear through the evaluation

- SCONS are issued on the street.
- Once the copy of the SCON is sent to the IDDO, the IDDO enters all SCONS onto a spreadsheet in order to monitor compliance and to comply with reporting requirements.
- Methods for compliance are somewhat broader than the practice directives: offenders have a few different payment options: offenders can elect to pay the \$100 fee at a shopfront or by cheque. The option of BPAY was considered at some point then dropped. Moreover, a small number of offenders have been allowed to pay the \$100 fee by instalments. But it remains up to the individual officer to enquire as to whether the offender would like this option and for the IDDO to approve this, both of which err against this option being utilised.
- Responses to non-payment have also changed. While they are notified by telephone of their non-payment, reasons for non-payment are not asked or recorded. Response to non-payment is not fully monitored. It appears that while some offenders are sent to

court to be convicted and some are withdrawn and converted into a PED, most officers will issue a caution as it is the easiest option.

Police Early Intervention and Diversion (PED)

The police directives note that when a Drug Diversion Caution Notice is to be issued, the case officer must:

- Explain the terms and conditions of the PED
- Record incident on PROMIS, clearing the offence as 'Drug Diversion'
- Enter all details of the diversion into the SupportLink referral network e.g. offenders name, date of birth, gender, if of ATSIC descent,
- Ensure the offender (or for a young offender, the parent or guardian) signs the Drug Diversion Caution Notice.
- Lodge the drug seizure.

If a drug diversion caution notice is not to be issued, the case officer must: specify on PROMIS why the offender did not meet the eligibility criteria and can consider alternate actions e.g. a SCON.

The police directive notes that the case officer will be notified of an offender's compliance or non-compliance, by the PED Clinician, and that if compliant, the case officer can arrange for the drugs to be destroyed. If non-compliant, the case officer is advised to seek alternate action via the court (in this case however the directive says SCON and cautions are both non-options).

Other details that have become clear through the evaluation

- The IDDO says that the offender will rarely be dealt with on the street (as per SCON). Instead they will be brought back to the station. The case officer will then weigh the drugs and confirm eligibility and then explain to the offender their options: e.g. PED or charge. Occasionally the IDDO will do this, but this is rare i.e. unlike the EIPP process, the IDDO has a more hands-off/liaison role.
- By entering referrals into SupportLink the ACT Health Directorate ADS will be promptly notified of a new PED client. If offenders are detected during ADS working hours (Monday to Friday 9-5) ADS assessors are notified immediately (workload permitting); if it is a weekend or Friday night, the ADS will be notified Monday morning. The exception to this is that the police may not place a referral on SupportLink for PED until some months after the apprehension. The reasons for this are not always known but investigations are sometimes lengthy.
- The ADS Clinician will then download the information and starts to contact the client to arrange an appointment for a face-to-face assessment. They have a tick box to say 'have made contact' or 'have not made contact'. If they have not made contact a reminder notice is sent to the ADS clinician 3 days later.
- ADS Clinicians then report back, using SupportLink, to the AFP that the assessment is complete.
- The AFP IDDO will monitor SupportLink and report back to the case-officer if there is non-compliance and then an alternate action is required (i.e. is the intermediary). N.B. Case officer's response to non-compliance is unclear/not fully monitored. It appears that most officers will issue a caution (even though this conflicts with the police directive).

- Police training is ongoing for example, 6 PED/EIPP training sessions were conducted in the July-September 2011 quarter – each lasting 45 minutes, and during the October-December 2011 quarter 5 sessions were conducted, 4 lasting 1 hour and 1 x 30 minutes (Alcohol & Drug Service (Health Directorate) 2011).

Early Intervention Pilot Program (EIPP)

AFP police directives (Australian Federal Police 2010) note that if a young person is eligible the case officer must firstly take into account their duty of care for the young person and if there are no urgent issues:

- Notify the parents or guardian
- Offer the child or young person, in the presence of a person with parental responsibility, the opportunity to participate in the program
- Explain the terms and conditions of the EIPP e.g. that the child/young person will be required to attend one alcohol diversion program session, which will incorporate assessment, education and treatment and that a prosecution may be initiated for an alcohol related offence if the child/young person does not attend and comply with the requirements of the program.
- As soon as possible, preferably before the end of the shift in which the incident occurs, inform the ACT Policing Drug and Alcohol Diversion Team of the child/young person involvement by way of the on-line SupportLink Referral Process.
- The Drug and Alcohol Diversion Team will then prepare and send correspondence to the child/young person's parents or guardians, which will encompass: the details involving the child/young person's alcohol offence or incident; and various educational material and treatment options associated with underage drinking and alcohol abuse. The goal is to contact the young person within four working days.

ACT EIPP members, working alongside police, participate in operations and major events in Canberra where young people are likely to attend and be consuming alcohol. During operations, ACT EIPP officers manage all administration and processing associated with each apprehension and diversion of young people. Duties include:

- managing reception centres – where police handover the young people and return to patrols;
- completing Supportlink referrals for arresting officers;
- recording each apprehension on the AFP database (PROMIS);
- interviewing the young person and parents to gain consent for diversion; and
- providing young people and parents with an information booklet on the effects of alcohol (Australian Federal Police 2012).

Between January to June 2011, 4 major operations/events attended (Australian Federal Police 2010; Australian Federal Police 2011), with 5 attended between July 2011 to January 2012 (including 1 x 2 day event and 1 x 3 day event) and 4 between January to April 2012 (Australian Federal Police 2012; Australian Federal Police 2012).

In addition, EIPP reports to the Commonwealth indicate another role of EIPP officers is also “to assist the ACT Department of Education and Training to draft and deliver drug and alcohol education to school students in the ACT” (Australian Federal Police 2010:2). It further states that the nature of the presentations are:

- To identify a range of drugs, explain their short-and long term effects and speculate about reasons people may choose to use or not use them.
- They understand that lifestyle choices that impact on later health can be formed in adolescence.
- They identify factors that influence the use of alcohol and tobacco and other drugs and explain some of the consequences of drug use for individuals and society (Australian Federal Police 2010:4).

Other details that have become clear through the evaluation

- The EIPP team have stated that normally potential offenders are brought to the police station, and when the EIPP team are sitting in custody they take over at that point. The EIPP team ring parents/guardian and request they attend the police station. They then sit down with the young person and parents and explain the options: namely to caution, which will stay on the record or to provide an AOD diversion, which will not be on the record. They obtain informed consent and explain the process if they proceed with the EIPP.
- As with PED by entering referrals into SupportLink the ACT Health Directorate ADS will be promptly notified of a new EIPP client (particularly during ADS hours of Monday to Friday 9-5).
- Details on compliance or non-compliance of referred offenders are reported back to the EIPP team and EIPP arresting officer (so they follow up any non-compliant offender) as well as details on whether the client was referred for ongoing counselling. Information on potential program impacts, such as the offender found the experience, are however limited due to a strict ACT Health policy on confidentiality.
- In cases where the alcohol diversion involves an Aboriginal and Torres Strait Islander person, the ACT Policing Aboriginal Liaison Officer will be made aware of the referral and may become involved with individual referral cases where appropriate.

Police training: 6 information sessions between Sep 2010 and Dec 2010 (pre hiring of ACT EIPP officers) and 19 between Jan-Jun 2011 (98 officers) (Australian Federal Police 2010; Australian Federal Police 2011). 17 sessions were delivered between Jul 2011 and Jan 2012 (124 officers) but 0 between Jan and Apr 2012 (Australian Federal Police 2012; Australian Federal Police 2012).

Court Alcohol and Drug Assessment Scheme (CADAS)

There are a number of different protocols for CADAS etc, but none covers all of the current models. Nevertheless, as exemplars of the types of models that operate, we outline key steps in each here.

Magistrates Court: Pre plea (procedure for adults only)

The Magistrates Court directive of 2000 notes that:

- Application for referral for a CADAS assessment may be made by an accused, his or her counsel, a prosecutor or by the court directly. A referral for assessment can however only be made by the Court itself.

- At the next appearance of the client the CADAS clinician will then provide the Court with a written assessment report, with copies for the DPP, the defendant and his/her legal representative.
- The Magistrate decides whether to release the person to 'comply with the CADAS treatment plan' and/or be 'subject to CADAS supervision'.
- A Magistrate will determine the issue of bail. If granted, a defendant may be required to attend the treatment recommended by the CADAS clinician.
- If mandated the CADAS clinician will monitor the progress of the defendant, including compliance or non-compliance. If CADAS is informed that there has been non-compliance, CADAS will inform the court. The Magistrate, may, if it results to a breach of bail, cause the notification to be sent to the AFP for breach action.
- A report on CADAS treatment progress will be provided to the Court within 3 weeks.
- At the second appearance the defendant will be required to enter a plea.
- CADAS staff monitors compliance with the treatment plan, and all outcomes are reported immediately to the Court. CADAS do not breach clients, but will report non-compliance as soon as possible by submitting a report through the Magistrate's associate.

Procedure for Supreme Court (adults only): Bail or Sentencing

The Supreme Court practice directive no. 1 of 2010 - using CADAS in the Supreme Court – notes that:

- An application for referral for a CADAS assessment can be made by the accused/offender, their counsel, or a prosecutor. An application for referral may be made with a bail application, prior to sentencing, or at sentencing.
- Additionally, the Court may make a referral on its own initiative, however only the Court can order a referral.

Bail Hearings

An assessment may be ordered in preparation for a bail hearing (if the application is lodged at least 4 days before the hearing), or at the bail hearing. Usually the Court will request a short form report for a bail hearing.

Bail conditions may include requiring the accused to undertake treatment, accept supervision by ACT Corrective Services and comply with CADAS monitoring. Any breach action is taken by ACT Corrective Services.

Sentencing Hearings

A full assessment may be ordered when an offender has AOD issues that are relevant to a sentence that is to be imposed. In this case, a full report should be provided to the parties.

Good behaviour orders may include requiring the offender to complete a treatment program, accept supervision by ACT Corrective Services and/or comply with CADAS monitoring.

Procedure for Young People

The MOU between CADAS and Youth Justice was developed in 2003 but never formally signed off, however key informants suggested practice largely mimicked the protocol. This highlights

how a young person can be referred to CADAS by an ACT Court (Children’s Court or Supreme Court) or Youth Justice Services (YJS), with different processes for each.

Procedure if by court

- CADAS assessors will assess the referral then contact the young person and set-up an appointment for an AOD assessment
- Staff will then follow the practice directive for the Magistrates Court – including providing copy of assessment report to the Court, DPP, young person’s lawyer and YJS.
- If released on bail to comply with the CADAS treatment plan, CADAS officer will monitor compliance and report all outcomes to the Court and YJS.

Procedure if by YJS

- YJS will fax a referral application to the CADAS assessors.
- CADAS assessors will assess the referral and provide advice on whether the assessment can proceed.
- If proceeding, the CADAS assessor will contact the young person and set up an appointment for an AOD assessment (goal is within 10 days).
- CADAS assessor will provide a written assessment report with recommendations and treatment options to YJS. If deemed eligible, the CADAS assessor can facilitate entry into AOD services e.g. Ted Noffs.
- This ends CADAS role – i.e. YJS will be responsible for all supervision and monitoring requirements.

2012 protocol for Community Youth Justice, Bimberi and alcohol and other drug services working with young people, which encompasses any young person identified as needing an AOD assessment (Community Youth Justice et al. 2012). The protocol states:

- When a young person is identified as needing the support of an alcohol and other drug service by Community Youth Justice, they will initiate a CADAS Assessment.
- Within one week of referral CADAS will undertake an assessment to determine AOD treatment needs and the most appropriate support option/s for the young person and treatment provider/agency.
- Support options include counselling, a structured program (for non custodial clients), a social inclusion option such as a sport or recreation program (again for non custodial clients), or a referral to a residential AOD program. For non custodial clients or clients transitioning from Bimberi, referral options may include an interstate residential program.
- CADAS will compile the assessment information into a report and e-mail this to the referring case manager with a rationale for treatment recommendation.
- The designated support agency will initiate contact with the young person via the Community Youth Justice Case Manager, or Bimberi staff if the young person is in custody.
- After one or two visits with the young person, the alcohol and other drug service will fax or email a progress report to the specified Community Youth Justice Case Manager and CADAS.
- If the agency in receipt of the CADAS referral evaluates their agency as not appropriate for the young person, or are unable to engage the young person in the support process,

they will advise CADAS. CADAS will undertake to source an alternative support option for the young person.

Other details that have become clear through the evaluation

- Following the removal of CADAS assessors from the courts, CADAS assessors rarely sit in the courts. They always attend for complex cases, but otherwise it becomes too time consuming and time management is important, as CADAS clinicians have about 28 people at any one time to manage.
- A diversion email inbox was established in 2008 (although the first use by Magistrates was December 2010). The role of the diversion email inbox was twofold: streamlining the process by which courts (Magistrate's and Children's) could alert the Health Directorate of new CADAS clients and by which ADS could submit CADAS assessment reports back to the courts. The Supreme Court continues to fax referrals to ADS. The ADS Diversions manager reviews the referrals and allocates to diversion staff. The CADAS clinicians undertake the assessment and write the report for the courts, about whether an offender is suitable for treatment and the recommended course of treatment. They also then follow up for accepted clients on whether clients are attending services. If they do not attend they ring client to see why they are not turning up and whether an alternate treatment type may work better.

Youth Drug and Alcohol Court (YDAC)

The YDAC Practice Directives state that:

- Child or young person makes an application to the Court to be referred to the YDAC
- Children's Court hears submissions by prosecution and defence if child or young person is prima facie eligible (determination of CJS eligibility)
- Court decides whether or not to refer child or young person for assessment
- If court decides to refer, child/young person is referred for an assessment of treatment needs with a CADAS assessor (determination of therapeutic eligibility). This occurs WITH or WITHOUT consent of young person.
- Matter adjourned by court for 2 weeks.
- Court meets to decide if accepted onto the YDAC program – informed by initial assessment by CADAS, assessment of CJS eligibility (prior criminal history and likely sentence) and if there is availability in the program
- If decides not to refer, court endorses bench sheet as "YDAC declined" or "ineligible for YDAC" and proceeds as normal matter
- If decides to refer, court endorses bench sheet as "eligible for YDAC" and matter is adjourned for at least 4 weeks for a Comprehensive Assessment by a Joint Assessment and Review Team (JART) and development of a program plan.
- Court determines if child or young person is formally accepted onto the YDAP program – based on if appropriate program plan can be developed AND if child or young person CONSENTS to participate in program. N.B. Court can still decide at this point to reject someone. If accepted onto the program, matter is adjourned for a minimum of 6 months (may be on bail or in custody).

APPENDIX D: OUTLINE OF A PROPOSED EVALUATION OF THE YOUTH DRUG AND ALCOHOL COURT

In this appendix we present an outline evaluation protocol for the Youth Drug and Alcohol Court (YDAC). Although the program commenced at the end of 2011, we understand that little attention has yet been given to developing a monitoring and evaluation framework for it.

Background

Part of the context for developing and implementing a monitoring and evaluation strategy is the 2011 report 'The ACT youth justice system 2011: a report to the Legislative Assembly by the ACT Human Rights Commission'. Its recommendation no. 7.29 reads "The Justice and Community Safety Directorate, in partnership with other Directorates, consider implementing and evaluating a two year pilot of a Youth Drug and Alcohol Court". The ACT Government's response reads, in part:

Agreed and commenced.

The ACT Government notes a pilot of a Youth and Drug Alcohol Court (YDAC) has been announced.... An across Government group involving the Health Directorate, the Community Services Directorate and the Justice and Community Safety Directorate will work to develop an evaluation framework. The funding implications of implementing the YDAC will need to be considered in the budget context taking into account competing funding priorities (Legislative Assembly for the Australian Capital Territory 2011:60).

So far as we know, work has yet to commence on developing an evaluation framework. This appendix is intended to contribute to that process.

Program description

YDAC was announced by Magistrate Karen Fryar in mid-2011, with the Practice Directive stating that the program would commence on 1 September 2011. It is a two-year trial, with an evaluation "to assess the effectiveness of the program" (Children's Court of the Australian Capital Territory 2011). There were no specific resources attached. A large number of stakeholders have been involved in establishing the YDAC model and agreed protocols, including Magistrates, DPP, Legal Aid ACT, Youth Justice, Health Directorate diversion team, and others.

YDAC is a program of the Children's Court concerned with reducing drug- and/or alcohol-related criminal activity by children and young people through judicial and therapeutic interventions that are designed to reduce or manage drug and/or alcohol use. It provides a pre-sentencing process that aims to divert young offenders from custody by addressing the issues related to drug and alcohol offending in a holistic way.

To be eligible for the program a child or young people must have pleaded guilty to or admitted the offence(s) or the Children's Court can exercise discretion to refer and accept a child or young person who has pleaded not guilty to some offence(s) but guilty to the majority of the matters.

People referred to the program receive an initial assessment from CADAS and the court then determines whether or not to admit the offender to the program. If admitted, an assessment is undertaken by the Joint Assessment and Review Team (JART) and the Program Plan is developed for the young person. The program then commences, with Report Back Sessions occurring weekly or fortnightly, at least at the early stages. The Practice Directive states that “A Program Plan will ordinarily be completed in six months but may be extended”. If the child or young person is in breach of their YDAC program obligations, the person is brought before the Children’s Court in the case of a serious breach, or the JART in the case of a minor breach, for review and decision about the appropriateness of the person continuing on the program. Upon successful completion of the program the child or young person returns to the Children’s Court for the finalisation of sentencing. The Practice Directive includes a provision that “Any sentence imposed following completion of the program shall not be more punitive than that which may have been imposed had the child or young person not participated in the program. Such a sentence may require the child to participate in the after-care phase of his/her Program Plan as a condition of a good behaviour order” (p. 10).

Evaluability assessment

Considering that the YDAC program commenced only a few months ago it is not feasible to conduct an outcome evaluation at present. As noted above, YDAC is intended to be a two year pilot program evaluated at the end of the two years. Presumably by that time there will have been a sufficient number of children and young people eligible for the program, referred to it, accepted into it and completing it for summative, outcome evaluation to be viable.

In the meantime, it will be necessary to do two things: 1) to establish an ongoing and comprehensive performance indicator data collection both for monitoring the program during its first two years and for use in the summative, outcome evaluation; and 2) to establish an ongoing evaluation throughout the first two years using a formative evaluation model that is appropriate to this early stage of development of the program.

The program theory

Based on the wording of the Practice Directive we have drafted a preliminary program theory for YDAC as follows:

The Youth Drug and Alcohol Court is a program concerned with reducing drug- and/or alcohol-related criminal activity by children and young people through judicial and therapeutic interventions that are designed to reduce or manage drug and/or alcohol use. It provides a sentencing process that aims to divert young offenders from custody by addressing the issues related to drug and alcohol offending in a holistic way.

YDAC’s managers may care to refine this statement of program theory and document it more fully including, for example, the outcomes hierarchy, success criteria, assumptions about factors within control of the program, assumptions about factors outside control of the program, the program’s activities and resources, etc. A useful approach is, through discussion with stakeholders, to create a series of if-then-because-as long as statements. Doing so makes explicit the program inputs, activities, outputs and outcomes, demonstrating the causal links between them and the influences of contextual factors. Funnell & Rogers (2011) provides details on how this can be done.

Purpose, users and uses of the monitoring & evaluation framework

The monitoring and evaluation project has two main purposes:

- To produce a flow of evaluative information that those responsible for the program, and other stakeholders, can use to understand what is happening in the program and make any changes to it that appear warranted.
- To assess, at the end of the two-year pilot program, its effectiveness (i.e. the degree to which it meets its stated goals).

The intended users of the monitoring and evaluation products will be the Children's Court Magistrate, the Chief Magistrate, program staff, others in the broader diversion system, DPP, Community Youth Justice, Care and Protection Services, Health Directorate, Education Directorate and others.

Evaluation questions

The evaluation questions will need to be developed through discussion. The questions should cover both implementation and outcomes and could address such things as:

- the soundness of the rationale for the program
- the soundness of the design of the program
- the fidelity of implementation of the program
- effectiveness (the extent to which YDAC's objectives were achieved)
- efficiency (how economically the resources were used to produce YDAC's results)
- value for money
- any unintended consequences (positive or negative)
- attribution (the extent to which the program actually produced or significantly contributed to producing the observed outcomes)
- lessons learned
- sustainability
- next steps
- etc.

Evaluation models and methods

As noted above, considering that the YDAC program has been running for only a short period of time, with just a small number of participants, it is not appropriate to implement an outcome evaluation at this stage. By way of comparison, the initial evaluation of the NSW Youth Drug and Alcohol Court was conducted two years after it commenced operating, by which time it had received 164 referrals, 75 engagements and 29 graduates (Eardley et al. 2004:111).

Nonetheless, work needs to commence now to design the outcome evaluation so as to ensure that the right indicators are collected throughout the life the program. The outcome evaluation will need to take into account the fact that the program is not intended to serve large numbers of young offenders, possibly 10-15 in each of its initial two years. This number of participants will not produce sufficient statistical power to undertake an evaluation that has as its core sophisticated statistical analysis. That means that the outcome evaluation design will probably be

a mixed methods approach that uses the performance indicators and qualitative, case-based methods.

To produce a flow of evaluative information that stakeholders can use to understand what is happening in the program and make any changes to it that appear warranted (the first purpose of the evaluation documented above) other approaches, which can be implemented now, are needed. In addition to collecting, collating and reviewing the types performance indicator data suggested below, we recommend that narrative, case based approaches be used. Two approaches are worthy of close consideration:

1. Structured reflective practice sessions held, say, monthly. In this approach, the key personnel responsible for the program engage in structured reflection aimed at problem-solving. This is built on the understanding that professionals generally know more than they readily put into words. To be successful in their work, they tend to improvise as they go, building on what they learn in practice. What is required is ‘reflection-in-action’ to surface this tacit knowledge about what is happening in the programs and the impacts on the various stakeholders: reflection on action so as to engage in a process of continuous learning (Schön 1983).
2. The success case method. This is “a quick and simple process that combines analysis of extreme groups with case study and storytelling”. Its originator describes it in the following terms (full details are in Brinkerhoff 2003).

The essential purpose of a Success Case study is to find out how well some organizational initiative...is working. A Success Case study also identifies and explains the contextual factors that differentiate successful from unsuccessful adopters of new initiatives. The Success Case study process has two fundamental parts. First, the evaluator identifies the few program participants who were the most (and least) successful. This is usually accomplished with a brief 3- to 5-item survey. That is, all participants are surveyed through self-report to determine to what extent they are using the new methods and tools a new initiative intended them to use and what, if anything, they are accomplishing.

Survey respondents are sorted into those few that are most and least successful. The evaluator then selects a random sample from among the most and least successful and, interviewing these people..., ‘digs deep’ into their experience to determine the exact nature and extent of their success. More specifically, the evaluator seeks to discover the following:

- Exactly what they used, when they used it, how, when, and so on
- What results they accomplished
- How valuable the results are...
- What environmental factors enabled their application and results.

Unsuccessful persons are interviewed to determine why they were unable to use or benefit from the program. Specifically, they are asked what got in the way, what factors kept them from being successful, and so forth.

The results of a Success Case study are communicated in ‘story’ form. That is, the evaluator finds the most compelling and descriptive examples of success the program

has achieved, then documents these examples in a few brief but richly detailed stories.
...

The Success Case Method differs from typical, more quantitative methods in that it does not seek to learn about the ‘average’ or modal participant in an initiative. It intentionally seeks the very best that a program is producing, to help determine whether the value a program is capable of producing is worthwhile and whether it may be possible to leverage this to a greater number of participants. A ‘success story’ is not a testimonial or a critical review. It is a factual and verifiable account—citing evidence that would ‘stand up in court—that demonstrates how and how valuably a person used some new method or tool or capability (Brinkerhoff 2005:401-2).

Details of methods of implementing the evaluation should be documented.

Indicators, data sources and data collection methods

Decisions need to be made on the indicators to be collected retrospectively to the commencement of the program and prospectively throughout the trial period. The details of the indicators will depend, to significant degree, upon the evaluation questions that are decided as being the top priority. On the basis that the practice directive states that the main purpose of the evaluation is to assess effectiveness (the extent to which YDAC’s objectives were attained), what follows is a starting point for reaching decisions on the indicators to be collected, collated and reviewed both on an ongoing basis and as part of the outcome evaluation.

Inputs

- Costs of the court including the magistrate, DPP, legal representatives (if publicly funded), Joint Assessment & Review Team, Youth Justice
- Costs of CADAS assessors

Activities

- Referrals to YDAC
- Referrals deemed eligible to participate
- Initial assessments undertaken by CADAS
- Assessments undertaken by the JART
- Admitted to the YDAC program & program plan developed
- Engaged in program
- Completed program
- Characteristics of offenders diverted
 - Demographics: gender, ATSI status, age (years)
 - Prior offences
 - Prior diversions
- Length of time receiving treatment (contact hours/days, for costings)
- Type of treatment received (e.g. assessment only, education, counselling, case management, opioid substitution pharmacotherapy, residential rehabilitation, other, combinations)
- Treatment provider
- Other agency involvement e.g. employment, training, mental health

Outputs

- Program penetration, e.g. numbers diverted of numbers eligible for diversion
- Principal drugs of concern for young people diverted
- Type of offence for which diverted (e.g. ANZ Standard Offence Classification (ANZSOC) code, theft/burglary, assault, public order, traffic, drug offence (possess, self-administration, manufacture, cultivate, supply), justice procedures, other)
- Dollar costs per assessment, accepted into YDAC and completed treatment versus non-completers
- Sentence on completion of program

Outcomes

- Changes in re-offending risk profile scores
- Rates and patterns of re-offending of people diverted and comparable offenders not diverted, and those diverted but who failed to complete
- Levels and patterns of drug use following diversion among treatment completers
- Levels and patterns of other risk-taking behaviour following diversion among treatment completers
- Physical and mental health generally following diversion among treatment completers
- Level of social reintegration following diversion among treatment completers
- Overall quality of life following diversion among treatment completers

Other

- Other

The data sources and data collection methods to be applied need to be documented for each indicator that is accepted as important for the monitoring and evaluation.

Resources

Resources to be used in the evaluation should be documented here. This will include staff and dollar costs as well as other resources such as time and physical resources.

Agreements

Any agreements entered into with regard to how the evaluation will be conducted and results used should be documented here.

Timetable

The evaluation timetable should be documented here.

Standards and ethics

Since the evaluation needs to be conducted in accordance with evaluation and research ethics, and accepted evaluation standards, the sources of the standards and ethical statements should be documented here.

APPENDIX E: SOME KEY MONITORING AND EVALUATION INDICATORS FOR SCON, PED, EIPP AND CADAS

Outlined here are the minimum indicators that the evaluation research team suggest should be collected for each program. Collecting these will enable the attainment of the primary objectives of each program to be assessed. Indicators for YDAC are included in the draft evaluation protocol for that program, Appendix D, rather than here.

Simple Cannabis Offence Notice (SCON)

Inputs

- Costs of ACT Policing's IDDO
- Costs of sworn officers' work in issuing SCONs, securing the cannabis, following-up offenders including court actions, etc.

Activities

- SCONs issued, paid, not paid, converted to caution, converted to PED, dealt with by the court
- Court penalties issued
- Number and mass of cannabis seized
- Demographics of people diverted: gender, age (juvenile/adult), ATSI status
- Length of time staff spend per SCON (contact hours/days, for costings)

Outputs

- Program penetration, e.g. numbers diverted of numbers eligible for diversion
- Type of cannabis offence for which SCON issued
- Dollar costs of the program per SCON issued

Outcomes

- Rates and patterns of re-offending of people diverted and comparable offenders not diverted: number, frequency, severity of offence (by ANZSOC)
- Amount of time and resources saved by utilisation of SCON, for police and courts
- Level of net-widening and net-deepening

Other

- Proportion of police who are aware of SCON
- Level of police support for SCON

Police Early Intervention and Diversion (PED)

Inputs

- Costs of ACT Policing's IDDO

- Costs of sworn officers' work in diverting the offender, weighing and securing drugs, documentation, etc.
- Costs of ADS diversion staff

Activities

- Referrals into PED
- Assessments undertaken
- Recommended for treatment
- Engaged in treatment
- Completed treatment
- Characteristics of offenders diverted
 - Demographics: gender, ATSI status, age (years), juvenile/adult
 - Drug type for which diverted
 - Prior offences
 - Prior diversions
- Length of time receiving treatment (contact hours/days, for costings)
- Type of treatment received (e.g. assessment only, not recommended for treatment, education, counselling, case management, opioid substitution pharmacotherapy, residential rehabilitation, other, combinations)
- Treatment provider
- Number and mass of drugs seized

Outputs

- Program penetration, e.g. numbers diverted of numbers eligible for diversion
- Principal drugs of concern for people diverted
- Type of offence for which diverted (e.g. ANZ Standard Offence Classification (ANZSOC) code)
- Dollar costs per assessment, referral and completed treatment

Outcomes

- Changes in re-offending risk profile scores
- Rates and patterns of re-offending of people diverted and comparable offenders not diverted: number, frequency, severity of offence (by ANZSOC)
- Extent to which PED clients increase their knowledge of AOD services and the harms related to drug use
- Levels and patterns of drug use following diversion among treatment completers

Early Intervention Pilot Project (EIPP)

Inputs

- Costs of ACT Policing's EIPP staff
- Costs of sworn officers' work in diverting the offender, contacting parents, documentation, etc.
- Costs of ADS diversion staff

Activities

- Referrals into EIPP
- Assessments undertaken
- Recommended for treatment
- Engaged in treatment
- Completed treatment
- Characteristics of offenders diverted
 - Demographics: gender, ATSI status, age (years)
 - Prior offences
 - Prior diversions
- Length of time receiving treatment (contact hours/days, for costings)
- Type of treatment received (e.g. assessment only, not recommended for treatment, education, counselling, case management, residential rehabilitation, other, combinations)
- Treatment provider

Outputs

- Program penetration, e.g. numbers diverted cf numbers eligible for diversion
- Type of alcohol offence for which diverted (e.g. purchase, possess, consume)
- Dollar costs per assessment, referral and completed treatment

Outcomes

- Changes in re-offending risk profile scores
- Rates and patterns of re-offending of people diverted and comparable offenders not diverted
- Levels and patterns of alcohol and other drug use following diversion among treatment completers
- Extent to which EIPP clients increase their knowledge of AOD services and the harms related to alcohol use

Court Alcohol and Drug Assessment Scheme (CADAS)

Please note that some of the specific indicators will differ depending on whether the offender is diverted for assessment only, for a pre-sentence intervention or a sentence (and more intensive) intervention.

Inputs

- Number of places available (to assess changes in system capacity)
- Dollar costs of staff involved: CADAS, magistrates and judges, youth justice, DPP, Corrective Services

Activities

- Referrals into CADAS

- Source of referrals (e.g. Magistrates' Court, Supreme Court, Children's Court, Youth Justice, other)
- Stage of referral (e.g. pre-sentence, sentence)
- Assessments undertaken
- Recommended for treatment
- Engaged in treatment
- Completed treatment
- Characteristics of offenders diverted
 - Demographics: gender, ATSI status, age (years), juvenile/adult
 - Prior offences
 - Prior diversions
- Length of time receiving treatment (contact hours/days, for costings)
- Type of treatment received (e.g. assessment only, not recommended for treatment, education, counselling, case management, opioid substitution pharmacotherapy, residential rehabilitation, other, combinations)
- Treatment provider

Outputs

- Program penetration, e.g. numbers diverted of numbers eligible for diversion
- Principal drugs of concern for people diverted
- Type of offence for which diverted (e.g. ANZ Standard Offence Classification (ANZSOC) code)
- Dollar costs per assessment, referral and completed treatment

Outcomes

- Changes in re-offending risk profile scores
- Rates and patterns of re-offending of people diverted and comparable offenders not diverted: number, frequency, severity of offence (by ANZSOC)
- Levels and patterns of drug use pre- and post-diversion among treatment completers and non-completers
- Sentence on completion of program
- Levels and patterns of other risk-taking behaviour such as needle sharing or unsafe sexual behaviour pre- and post-diversion among treatment completers and non-completers
- Physical and mental health generally following diversion among treatment completers
- Level of social reintegration following diversion among treatment completers
- Overall quality of life following diversion among treatment completers

APPENDIX F: EVIDENCE ON SCHOOL DRUG EDUCATION

The National School Drug Education Strategy puts forward key principles for drug education in school (Department of Education Training and Youth Affairs 1999). Key amongst them is that:

- Drug education is best taught in the context of the school health curriculum.
- Drug education in schools should be conducted by the teacher of the health curriculum.

The ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014 supports this notion, recognising that drug education needs to be carefully considered in terms of how and whom delivers the messages:

Evidence exists that certain types of school drug education programs can produce unintended adverse consequences in terms of drug use and related harms. This can flow from non-users being encouraged to try drugs or from interventions that bring together students with problematic drug use in ways that exacerbate their drug use and related patterns of harm. With regard to school drug education, the key issues include the content of the programs, the method of delivery and the specific target groups. ACT policy reflects the evidence base that it is preferable to focus school drug education programs on the whole school community rather than on particularly groups (especially current drug users) within it. The evidence also points to the value of having school drug education programs delivered by members of the school community as an integral part of the school's regular program of activities, rather than being delivered by outside, specialist drug educators. (Alcohol and Other Drug Policy Unit 2010:50)

School-based drug prevention, education and information provision: a summary of the research evidence

School-based programs to reduce alcohol, tobacco and drug use have been widespread since the 1970's. Originally concentrated on the provision of education and information alone, the variety of programs have progressed to be more focussed on personal development (known as 'affective education') and social skills training. The more well-known and promoted school-based programs that use a social learning framework and contain multiple components include Life Skills Training (Botvin and Kantor 2000), the D.A.R.E. programs, Project ALERT (Ellickson and colleagues) and Life Education (Australia). The common elements within such programs include alcohol and drug awareness education, social and peer resistance skills, normative feedback, and psycho-social skills.

Programs vary in the extent to which they are delivered by teachers, external presenters, peers or police officers. They also vary in terms of when they are delivered (to which grade or class level), and the program length.

Prior to reviewing the research evidence of effectiveness in relation to school-based AOD prevention interventions, it is important to remember that these school-based programs sit within a broader cluster of universal prevention programs. Universal prevention applies to the entire population and is not targeted at any one risk group. Other than school-based AOD prevention, the foremost universal prevention interventions, aimed to prevent or delay the onset of alcohol or other drug use, are: mass media campaigns/public service announcements; strengthening families and communities; and multi-component interventions (which include community strengthening and environmental measures such as restrictions on access). Thus, any

assessment of the value of school-based AOD interventions needs to be weighed up against the evidence of effectiveness of other universal prevention interventions.

Returning to the evidence for school-based AOD prevention programs, the best level of evidence is derived from systematic reviews across multiple research studies, that included randomisation, a comparison (control) group, and followed standardised meta-analytic techniques as specified by the Cochrane Collaboration. There have been three relevant Cochrane systematic reviews of school-based AOD prevention interventions: one in relation to alcohol (Foxcroft and Tsertsvadze 2011), one in relation to illicit drugs (Faggiano et al. 2008) and one in relation to tobacco (Thomas and Perera 2008).

Foxcroft and Tsertsvadze (2011) found 53 studies of school-based universal prevention for alcohol. Six out of 11 studies that used alcohol-specific interventions showed effectiveness relative to standard curriculum (5 studies found no effects). Fourteen out of 39 studies which examined generic interventions including things such as life skills training showed effectiveness regarding alcohol (with 24 studies finding no effects). Those studies that had positive effects largely found these on the outcome variables of drunkenness and binge drinking. The authors of the systematic review conclude, in relation to school-based alcohol prevention programs, that “current evidence suggests that certain generic psychosocial and developmental prevention programs can be effective” (Foxcroft and Tsertsvadze 2011:2).

The tobacco systematic review of school-based tobacco prevention programs (Thomas and Perera 2008) located 23 randomised studies, of which half found positive effects on smoking of the interventions. They draw cautious conclusions of the effectiveness of anti-smoking school programs.

The systematic review of school-based illicit drug prevention programs (Faggiano et al. 2008) located 32 studies to include in their review, the vast majority of which (n=28) hailed from the US. They found positive effects for knowledge-based programs in increasing knowledge (although note that the relationship between increased knowledge and subsequent drug use is not clear), and positive effects for skills-based programs. However, the majority of the studies measured outcomes immediately after (n=18 studies) or at one year (n=13 studies) post-intervention. They concluded “skills-based programs appear to be effective in deterring early-stage drug use” (Faggiano et al. 2008:1).

Of particular interest for the ACT diversion evaluation is examination of the evidence for school-based prevention programs that include delivery by police officers. The most well-known example of this is the USA D.A.R.E program, delivered by uniformed police officers in schools. The D.A.R.E. curriculum includes information components (largely harmful effects of AOD plus laws around AOD), resistance techniques, building pro-social skills, decision making skills, building support systems, and role modelling. There has been extensive evaluation of the D.A.R.E. programs, and across multiple studies it is concluded that this program is not effective in impacting on alcohol or drug use (for example Clayton et al. 1991; Rosenbaum and Hanson 1998; Gandhi et al. 2007). “Across more than 30 studies, the collective evidence from evaluations with reasonably good scientific validity suggests that the core D.A.R.E. program does not prevent drug use in the short term, nor does it prevent drug use when students are ready to enter high school or college. Students who receive D.A.R.E. are indistinguishable from students who do not participate in the program” (procon.org 2012). Furthermore, there are no significant differences in program effects delivered with and without teachers, peers or police officers (Gottfredson and Wilson 2003) (although the evidence for peer leaders is strongest).

Across all types of school-based drug prevention, the program with the highest level of support is the Life Skills Training Program (Botvin and Kantor 2000). A number of reviews conclude that programs that are generic psychosocial interventions are the most effective (Tobler et al. 2000; Foxcroft and Tsertsvadze 2011). Any investment in school-based prevention interventions would be best modelled on these programs.

Given the popularity and ubiquity of school-based AOD prevention programs, there have been substantial attempts to ensure that programs are based on research evidence. To this end, the USA has generated a number of lists of approved drug prevention programs. Schools may not deliver programs that are outside these lists. There has been significant controversy about the decision-making processes for inclusion on these approved drug prevention program lists (see, for example Gandhi et al. 2007; Gorman and Huber 2009; Midford 2010). While the research debate is certainly interesting, the important point for our purposes is that D.A.R.E. does not appear on any of the lists as an approved, evidence-based program. Education and information provision alone is also not included on the list.

Finally, as alluded to earlier, consideration should be given to the extent to which school-based prevention programs are the best form of universal prevention. The other universal prevention programs include mass media campaigns and community-wide interventions, such as Strengthening Families (Spoth and colleagues) and Communities that Care (Catalano & Hawkins). A systematic review of the effectiveness of mass media campaigns (in this instance termed anti-illicit drug public service announcements) by Werb et al. (2011) found seven randomised trials and four observational trials. The results indicated that public service announcements had a limited impact on the intention to use illicit drugs or on illicit drug use amongst the target population. Only one of the seven randomised trials showed a statistically significant positive effect. Indeed two other RCTs found evidence that public service announcements increased intention to use drugs. On the other hand, Strengthening Families and Communities that care, both multi-component community based programs have been found to have significant positive effects on alcohol and other drug use (Biglan et al. 2000; Perry et al. 2002; Cuijpers 2003).

In conclusion, generic psychosocial school-based drug prevention programs that include life skills training have moderate evidence of effectiveness. Research does not support the effectiveness of police officers providing information, education or psychosocial interventions in schools. The highest level of research support for universal prevention is found for community-wide programs such as strengthening families and communities that care.

APPENDIX G: COMPARISON OF SCON SCHEME WITH OTHER CANNABIS EXPIATION SCHEMES

A query raised by some key informants was how the SCON scheme varied with other operating (or previously) operating schemes across Australia. Table 33 provides an overview of the key factors. This demonstrates that relative to other schemes, the SCON scheme has a lower threshold quantity for the maximum quantity of cannabis that can be possessed – 25 grams, compared to 50 grams in the Northern Territory and 100 grams in South Australia. However, the civil penalty amount is also the lowest.

Table 33: Threshold quantities, penalties and payment options under all Australian cannabis infringement notice schemes

Scheme	Threshold quantity - possession	Threshold quantity - cultivation	Civil penalty amount	Payment options	Response to non-compliance
Simple Cannabis Offence Notice (SCON) scheme	≤ 25g dried cannabis	2 non-hydroponic cannabis plants	\$100	Payment of fine within 60 days. N.B. Police allow some payment via instalments.	May be withdrawn and offered a drug diversion (PED) or issued a summons to appear in court. Primary court response: conviction and fine of ≤ \$100.
Drugs of Dependence Act 1989 (DoDA)					
SA Cannabis Expiation Notice (CEN) scheme	≤ 100g cannabis ≤ 20g cannabis resin	1 non-hydroponic plant	\$150 for, <25g cannabis or <5g resin	Payment of expiation fee and receipt of educational material ≤ 30-60 days.	Failure to pay results in reminder notice and additional fee. Subsequent failure results in automatic conviction plus a fine equivalent to the unpaid expiation fee and additional costs.
Controlled Substances Amendment Act, 1984			\$300 for 25-100g cannabis, 5-20g resin or plant cultivation	N.B. Since 1997 offenders can apply to pay fee in instalments or via community service.	
NT cannabis expiation scheme	≤ 50 g cannabis	2 cannabis plants	1.7 penalty units	Fine must be paid within 28 days	Failure usually results in debt to state, and no conviction, but may result in prosecution.
Misuse of Drugs Act 2006	≤ 10 g cannabis resin ≤ 10 g hash, ≤ 1 g hash oil		where a penalty unit = \$130 i.e. \$221		
Western Australian Cannabis Infringement Notice (CIN) scheme Cannabis Control Act 2003 (CCA) *	≤ 30g cannabis	2 non-hydroponic plants	\$100-200 or an education session	Must pay fine or attend cannabis education session (CES) within 28 days.	Unpaid CINs are followed up through Fines Enforcement Registry (FER) - has option to offer payment via instalments. Further failure to pay results in automatic suspension of drivers licence.

Source: (Hughes and Ritter 2008). * Extinguished on 11 August 2011.

Relative to the other jurisdictions the ACT SCON also has fewer options available for how civil penalties may be paid – for example it has no use of community service and no systematic option to pay by instalments. Nevertheless, data on compliance and non-compliance appears to suggest the ACT SCON scheme may fair better than some of the other schemes.

First, while publicly available data on the level of compliance with the schemes is ad hoc, the ACT SCON appears to have a higher level of compliance (54.4%), than the SA scheme (38%) (Hunter 2001) and the WA scheme (43%) (Drug and Alcohol Office 2007). Second, the ACT SCON appears to also impose less adverse consequences on diverted users. For example, the Expiation of Offences Act SA (1986) expanded options for payment of expiation notices. Enacted in February 1987 this also increased the options for SA CEN expiation defaulters, providing options to apply to the court to pay the fine in instalments or via community service (Hunter 2001). Data immediately after this was implemented (2000) showed that only 10.5% CEN recipients applied to the court for relief e.g. to pay their CEN via community service. Instead, 46% SA Cannabis Expiation Notices continued to be forwarded to court for expiation, resulting in automatic convictions and a fine equivalent to the amount of the unpaid expiation notice and additional expenses of issuing the fine (Hunter 2001).

The WA CIN scheme similarly indicated that over the three years of operation from 2004-2007 57% issued CINs required follow up action by the Fines Enforcement Registry (Drug and Alcohol Office 2007). Indeed, as shown below, 27% of all proffered CINs resulted in motor driver's license suspensions:

- 30% paid fine (28 days + 28 Days)
- 13% did Cannabis Education session
- 24% referred on to Fines Enforcement Registry and resolved in full
- 6% referred on to Fines Enforcement Registry and resolved via FER time payment
- 27% referred on to Fines Enforcement Registry and resulted in motor drivers license suspended
- 3% referred on to Fines Enforcement Registry and resulted in other FER processes

APPENDIX H: LESSONS FROM OTHER COURT DIVERSION PROGRAMS

Most court diversion programs have adopted a pre-plea only model. Notable examples include the NSW based Magistrate's Early Referral into Treatment (MERIT) program and the Queensland Magistrate's Early Referral into Treatment (QMERIT). However a number of programs have expanded their criteria and provide multiple options:

Court Referral & Evaluation for Drug Intervention & Treatment

The Victorian Court Referral & Evaluation for Drug Intervention & Treatment (CREDIT) originally targeted exclusively at those on bail, access is also available to two groups: first, defendants who are subject to a current court order through Corrections and lack alternate access to AOD treatment and second, defendants who are in breach of a current AOD court order (Magistrates' Court of Victoria 2008).

Court Assessment and Referral Drug Scheme

The South Australian Court Assessment and Referral Drug Scheme (CARDS) provides two models: pre-sentence (bail) option and post-sentence (bond) option (Harkin et al. 2007). The model has similarities to the CADAS Supreme Court model in that under the former option the matter is adjourned/defendant placed on bail for 3 months to attend drug counselling. Under the post-sentence option the matter is finalised in court then the defendant is placed on a supervised bond/suspended sentence of imprisonment with a condition that they attend drug counselling, and be supervised by Department of Corrective Services. Interestingly, under both options, defendants have the same treatment requirement: attendance at four sessions of counselling.

The evaluators noted that most Magistrates and lawyers preferred the bail option. For Magistrates this was because it both gave "the defendant an opportunity to participate and demonstrate that they made changes which could be taken into account during sentencing" (Harkin et al. 2007:47). For lawyers this was because it made clients somewhat more likely to complete whilst on bail. Yet other Magistrates were moving away from the bail option, due to concerns about the breach of 'voluntary' clients. They did not note views of clinicians about the different options.

Court Mandated Drug Diversion Program

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

Critically, the evaluators collected data on the relative utilisation of the different options, length and time and reoffending risk. This showed that between 2007-2008 53% of offenders were placed on Category One 'Bail Diversion' orders, 21% on Category Three 'Drug Treatment Order' and 11% on Category Two 'Probation Order or Suspended Sentence with CMD component' (Success Works 2008). The remainder were as they stated made up of a "cocktail" of

the other orders e.g. 4% constituted a bail option plus a suspended sentence (Success Works 2008:59).

An average length for category one - bail option was substantially less: 118 days versus 134 days for category three – drug treatment order (Success Works 2008:59). Moreover the recidivism risk was considerably less: 38.6% for category one - bail option reoffended, 41.2% for category two – probation order or suspended sentence and 48.4% for category three - drug treatment order (Success Works 2008).