CRIME AND JUSTICE
Bulletin

NSW Bureau of Crime
Statistics and Research

Contemporary Issues in Crime and Justice **Number 108**

March 2007

The psychosocial needs of NSW court defendants

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The current study assessed levels of social and psychological disadvantage among a sample of NSW court defendants. Structured face-to-face interviews were carried out with 189 people appearing in one of two NSW Local Courts to determine (a) what proportion could potentially benefit from accessing social services (such as education/employment programs, substance abuse treatment or mental health treatment), (b) whether those in need of services were currently accessing them, (c) whether they would willingly access those services or additional services if they were made available and (d) what potential barriers hinder access to these services. The study found very high rates of unemployment, financial stress, literacy and learning difficulties, housing instability, problematic gambling behaviour, substance abuse and mental and physical health problems. The high rates of each of these problems, coupled with the fact that most of these areas of criminogenic risk or disadvantage are not mutually exclusive, suggests that comprehensive rehabilitation programs may be appropriate court-based crime prevention interventions. Essential components of good rehabilitation programs are discussed, as are other potential points of intervention.

INTRODUCTION

In the past decade there has been a gradual shift toward more therapeutic and restorative approaches to court-based crime prevention in New South Wales (NSW). The *Young Offenders Act 1997* has increased the use of alternative sanctions such as cautioning and youth justice conferencing for young offenders (Daly & Hayes 2001). Restorative justice programs are currently being piloted for adult offenders by way of young adult conferencing and circle sentencing for Aboriginal offenders. Problem-solving courts such as the Adult and Youth Drug Courts have also been implemented as alternatives to standard court jurisdictions, as have other remedial interventions that operate in parallel with usual court procedures (e.g. the Magistrates Early Referral into Treatment [MERIT] program).

Current court-based crime prevention programs tend to focus heavily on illicit drug-related crime. This is not without good reason – the causal relationship between illicit drug use and crime is well known (Makkai & Payne 2003; Stevenson & Forsythe 1998). However there are many other criminogenic – or crime causing – risk factors that might be the focus of treatment or intervention efforts. For example, poor school performance, markers of socioeconomic disadvantage (e.g. poverty and unemployment) and alcohol misuse are all known risk factors for involvement in crime (Weatherburn 2001). We also know that incarcerated populations are disproportionately more likely than the general population to suffer from chronic physical health problems, disordered gambling behaviours (Butler & Milner 2003), mental health problems (Butler & Allnutt 2003) and homelessness or unstable housing (Baldry 2005). These risk factors for offending and other areas of disadvantage might be important foci for any future crime prevention efforts.

Program development would be greatly assisted if we knew more about the degree to which relevant samples of court-based offenders present with these problems. It would also be useful for program managers to know whether court defendants are currently utilising social services to address these issues, whether they would be willing to engage with social services and what types of barriers inhibit access to these services. The aim of the current study was to empirically address these questions among a purposive sample of NSW court defendants. A survey instrument was designed which examined seven broad but interconnected themes: (1) education and training, (2) employment, (3) poverty and financial management, (4) housing, (5) gambling, (6) substance abuse and (7) physical and mental health. In addition to these themes, participants were given an open-ended opportunity to make suggestions about the sorts of social services that would be beneficial for them.

The specific aims of the project were to establish (a) what proportion of the sample could potentially benefit from accessing existing social services in the community, (b) whether those in need of services were currently accessing them, (c) whether they would willingly access those services or additional services if they were made available and (d) what potential barriers inhibit access to these services. It is important to note at the outset that the survey was not intended to explore each of the seven areas of social service demand in any depth. Furthermore, because this was not a random sample of court defendants

the results cannot be generalised to all Local Court defendants. The aim of the study was to flag areas where crime prevention efforts might be focussed and areas where further research might be informative.

METHOD

PARTICIPANTS

Participants were 189 adults appearing for criminal offences in either Blacktown Local Court (n=99) or Newcastle Local Court (n=90). As many defendants as possible were approached to participate in the study, although defendants who were in custody or appearing for civil matters were excluded because (a) the focus of the study was on identifying potential points of intervention for offenders on community-based justice orders and (b) people in custody are potentially much harder to access for interview. Toward the end of the data collection, a small number of drink-driving matters were also screened out to increase the representation of non-traffic defendants. All participants were aged 18 years or older. Participation was voluntary but participants were given either a double movie pass or a $25 department store voucher as compensation for their time.

The participants' demographic and offending-related characteristics are shown in Table 1. The characteristics of participants were similar across the two locations but for a few notable exceptions. Newcastle participants were younger (χ^2_2=8.2, p=0.017) and more likely to be single/never married (χ^2_1=5.1, p=0.024) than Blacktown participants. In keeping with the demographic profiles of the two locations, Newcastle participants were more likely to be born in Australia (χ^2_1=4.1, p=0.042), more likely to speak English at home (χ^2_1=7.6, p=0.006) and less likely to identify as Aboriginal or Torres Strait Islander (χ^2_1=3.5, p=0.060). Newcastle participants were also less likely to be appearing for drug offences (χ^2_1=6.2, p=0.013) and more likely to be appearing for traffic offences (χ^2_1=3.6, p=0.057).

PROCEDURE

Interviews took place between March and June 2006. Almost all interviews were conducted during the morning when the majority of court matters were heard.

Table 1: Participant characteristics

Characteristic	*Blacktown N (%)*	*Newcastle N (%)*
Male	79 (80)	72 (80)
Age group		
18-24	35 (35)	32 (36)
25-30	16 (16)	29 (32)
31+	48 (48)	29 (32)
Aboriginal/TSI	18 (18)	8 (9)
Born in Australia	83 (84)	84 (93)
Usually speak English at home	91 (92)	90 (100)
Marital status		
Single/never married	46 (46)	56 (63)
Divorced/separated	12 (12)	5 (6)
Widowed	0 (0)	1 (1)
Married/de facto	30 (30)	14 (16)
Partner – living together	2 (2)	4 (4)
Partner – living apart	9 (9)	9 (10)
Number of children		
0	49 (49)	54 (61)
1	20 (20)	18 (20)
2	10 (10)	5 (6)
3	10 (10)	6 (7)
4	7 (7)	4 (4)
5+	3 (3)	2 (2)
Appearing for: (Participants could be appearing for more than one offence)		
Acts Intended to Cause Injury	20 (20)	22 (24)
Sexual Assault and Related offences	1 (1)	0 (0)
Dangerous/Negligent Acts Endangering Persons	2 (2)	4 (4)
Unlawful Entry/Break and Enter	5 (5)	7 (8)
Theft and Related offences	15 (15)	14 (16)
Deception and Related offences	2 (2)	1 (1)
Illicit Drug offences	17 (17)	5 (6)
Weapons and Explosives offences	4 (4)	2 (2)
Property Damage	12 (12)	10 (11)
Public Order offences	7 (7)	3 (3)
Road Traffic/MV Regulatory offences	18 (18)	27 (30)
Against Justice/Government Operations	24 (24)	16 (18)
Miscellaneous offences	3 (3)	1 (1)
Previous court appearances		
0	14 (14)	15 (17)
1-5	34 (34)	34 (38)
6-10	14 (14)	17 (19)
11-15	7 (7)	5 (6)
16-20	11 (11)	7 (8)
21+	19 (19)	12 (13)
Previous prison sentences		
0	69 (69)	61 (68)
1	12 (12)	8 (9)
2	5 (5)	8 (9)
3	4 (4)	3 (3)
4	7 (7)	2 (2)
5+	2 (2)	8 (9)
Any time in custody last year?	33 (33)	28 (31)

Participants were recruited to the study through a number of different avenues and the recruitment procedures employed at the two courts differed slightly due to differences in their standard operating procedures. As standard practice, Blacktown court defendants first obtained a number from the court list and then checked that number off with a court officer. At this point the court officer handed each defendant a flyer outlining the nature of the study, the inclusion criteria, the compensation they would receive and the names of the interviewers. The interviewers wore nametags and stood near the court officers so that potential participants could immediately identify them. Defendants were also recruited by referrals from the Court Registrar, Aboriginal Legal Services and from the Legal Aid Commission, by personal approach and by leaving flyers on the seats outside the main courtrooms dealing with Local Court matters.

There was no central reference point at Newcastle court, and while some participants were referred through solicitors from the Legal Aid Commission and Aboriginal Legal Services, most were recruited through personal approach by the interviewers. Flyers were also posted on notice boards, left on seats and positioned in other key locations where potential participants could see them (e.g. next to the pile of Legal Aid application forms). Due to the number of different recruitment approaches adopted, it was not possible to estimate the response rate for this study.

Two trained interviewers conducted all of the interviews. Participants could be interviewed either before or after their court appearance, but the majority agreed to take part while they were waiting for their court matter to be heard. Most interviews were conducted in the waiting areas outside the courtrooms in quiet areas where privacy could be guaranteed. All participants were informed that the information they provided would be kept confidential and anonymous, and that their responses would not impact on their court matter in any way. Verbal rather than written consent was obtained from each participant and, once they had consented to take part, the interviewer read each question aloud to the respondent and coded their answers on a paper copy of the questionnaire. The mean interview time was 17 minutes (range: 7-51 minutes).

RESULTS

Apart from a slightly higher proportion of amphetamine users at Newcastle Local Court, there were few notable differences in the results obtained from the two locations. Responses were therefore pooled across locations for the sake of brevity and clarity.

1. Education and training

- Nine per cent of the sample had not continued school beyond year seven;
- Thirty per cent had not continued beyond year 10 of school and had not completed any other education or vocational training programs since leaving school;
- Nineteen per cent of respondents reported that they had “difficulties learning new things”;
- Twenty-one per cent reported that they had “difficulties reading or writing”.

Among participants who had not continued any education or training at all beyond year 10 of school (n=57), few (7%) were currently enrolled in any type of education or training. A large proportion (66%), however, indicated that they were interested in continuing their education. Of the 57 participants who had not continued any education or training at all beyond year 10, 29 identified barriers to continuing their education. In order of citation frequency, these barriers included: disability, literacy or learning difficulties; lack of time (due to work or children); lack of access to transport; poor motivation, laziness, fear of failure or indecision about what courses to undertake; instability due to substance abuse/treatment, lifestyle, family relationships or living conditions; criminal justice concerns (e.g. impending court cases, impending gaol or conditions of a justice order); and money.

2. Employment

- Twenty-five per cent of the sample nominated full-time paid employment as their main source of income at the time of interview, three per cent were dependent on others, 10 per cent were in part-time or casual employment and 63 per cent were receiving social welfare benefits;
- Among those receiving welfare benefits, 60 per cent were receiving unemployment payments, 27 per cent disability or sickness benefits and 13 per cent were receiving sole parent or carer’s benefits;
- Sixty-five per cent of the sample reported being in full-time paid employment for less than 13 of the previous 52 weeks.

Among participants who were not in full-time paid employment (n=141), approximately 40 per cent reported that they were currently seeking work through a government employment service. The proportions were lower for participants working part-time (35%), on a disability support pension (29%) or on sole parent or carer’s benefits (6%) but higher for those receiving unemployment benefits (61%). Many participants indicated that they would be interested in seeking a job or additional work through a government employment program: 41 per cent of part-time employees; 64 per cent of those on unemployment benefits; 55 per cent of those on disability support pensions; and 44 per cent of people on sole-parent or carer’s benefits. Thirty-eight respondents who were not in full-time paid employment identified one or more barriers to accessing existing or alternative employment programs, including, in order of cited frequency: not knowing what other programs were available; substance use or drug treatment; disability; previous trouble with government programs (e.g. finding the staff or service to be unhelpful); impending court appearances or other trouble with the criminal justice system; lack of access to transport; and various other barriers, including language problems, lack of time and feeling that they did not have the appropriate experience or qualifications to meet the requirements of employers.

3. Poverty/financial management

- Forty per cent of the sample reported that their household income was less than $20,000 per annum (15% either could not estimate their household income or refused to answer the question)[2];
- Twenty-four per cent indicated that their income was not enough to cover their basic needs and eight per cent indicated that their income was only sometimes enough to provide for their basic needs.

Among participants who indicated that the money they received was sometimes or never enough to meet their household needs (n=57), seven per cent reported currently getting advice about how to better manage their money. Slightly more than one-third (36 per cent) indicated that they would be interested in receiving advice about how to manage their money better. Only eight of these participants identified barriers to getting financial advice, the most notable of which was knowledge of what resources were available to provide this advice.

4. Housing

- Three per cent of the sample reported being homeless or living in a boarding house, hostel or supported accommodation for most of the previous 12 months;
- Eighteen per cent of the sample reported moving their home address once in the previous year, 10 per cent reported moving twice and 16 per cent reported moving three or more times.

Among those participants who reported moving one or more times in the previous year (n=80) and who therefore might have been experiencing some degree of housing instability, more than half were accessing housing services. Twenty-four per cent reported living in public housing for most of the previous year and a further 35 per cent reported receiving rental assistance payments at the time of interview. A large proportion (43%) of respondents who had moved during the previous year indicated that they would like further assistance with housing. Most were seeking access to public housing (40%), further rental assistance payments (33%) or assistance getting into their own rental accommodation (10%). Eighteen participants identified barriers to either getting housing services or accessing additional housing services. Foremost among these barriers were: already being on the maximum allowable rent assistance; having debts or previous trouble with housing services; and the waiting lists associated with public housing.

5. Gambling

- Sixty-three per cent of the sample reported gambling in the previous year (primarily on electronic gaming machines);
- Twenty-three per cent of gamblers (15% of the sample) responded "yes" when asked: "do you feel like you've had a problem with your gambling in the last 12 months?" (from McMillen, Marshall & Murphy 2004);
- Gamblers were asked "how would you rate your gambling right now on a scale of 1 to 10, where 1 means you feel your gambling is not at all a problem and 10 means you feel your gambling is a serious problem?" (from McMillen et al. 2004). While 47 per cent rated their gambling as one out of 10, 28 per cent rated their gambling as four or higher.

Seven per cent of all gamblers (28% of those who felt they had a problem with gambling) reported that they were currently getting help to stop or reduce their gambling. Among the 28 people who identified that they had a problem with gambling in the previous 12 months, eight (29%) reported that they would be interested in seeking help (or additional help) to try and stop or reduce their gambling. Only four people identified barriers to gambling treatment and the only identified barriers were pride, difficulties talking about gambling problems or a lack of personal motivation to seek help for their gambling problem.

6. Substance abuse/dependence

- Eighty-five per cent of the sample reported drinking alcohol at least once in the previous year, 60 per cent reported using cannabis, 34 per cent reported using methamphetamine or amphetamine ('speed', 'ice' or 'base'), nine per cent reported using heroin and six per cent reported using cocaine;
- Twenty-five per cent of the sample reported injecting meth/amphetamines, heroin and/or cocaine in the previous 12 months;
- Sixty-four per cent of drinkers (54% per cent of the entire sample) showed signs of disordered or harmful alcohol use (as indicated by a score of 5 or higher out of 20 on a short version of the AUDIT questionnaire, Piccinelli et al. 1997)[3];
- The Severity of Dependence Scale ([SDS], Gossop et al. 1995)[4] was employed to assess dependence on each of cannabis, meth/amphetamine, heroin and cocaine. A score of three or higher was adopted as a marker for cannabis, cocaine and heroin dependence (Kaye & Darke 2002; Swift, Copeland & Hall 1998)[5], and a score of five or higher was adopted as a marker for meth/amphetamine dependence (Topp & Mattick 1997). Fifty-four per cent of cannabis users (32% of the sample) scored three or higher on the cannabis-SDS, 30 per cent of meth/amphetamine users (10% of the sample) scored five or higher on the meth/amphetamine-SDS, 69 per cent of heroin users (6% of the sample) scored three or higher on the heroin-SDS and eight per cent of cocaine users (n=1 or 0.5% of the sample) scored three or higher on the cocaine-SDS;
- Seventy per cent of the sample met the criteria for one or more of our measures of disordered/dependent substance use.

Nearly one-quarter (22%) of participants were currently receiving some form of treatment to reduce their substance use. Among those who met our criteria for disordered or harmful alcohol use, 21 per cent were currently in treatment. Forty-one per cent of participants who met the diagnostic criteria for cannabis dependence were in treatment at the time of interview, 53 per cent of participants who met the diagnostic criteria for meth/amphetamine dependence were in treatment at the time of interview and 36 per cent of participants who met the diagnostic criteria for heroin dependence were in treatment at the time of interview. Only one person met the diagnostic criteria for cocaine dependence and they indicated that they were receiving treatment. Of the 148 people not receiving treatment for drug or alcohol use, 63 per cent met our criteria for disordered or dependent use of one or more substances and 20 per cent (n=29) indicated that they would be interested in seeking treatment for a substance abuse problem. Most of these 29 people identified alcohol (n=20), cannabis (n=12) or meth/amphetamine (n=5) as the main substances for which they would like to seek treatment. Fourteen of these 29 people identified barriers to drug treatment, including, from most to least

frequently cited: motivation, laziness or fear; lack of time (e.g. some treatment options are only available during the day); interruptions related to their offending and court attendances; being deemed ineligible for treatment; and not knowing what resources were available.

7. Health

- Twelve per cent of the sample rated their health as 'excellent', 25 per cent rated their health as 'very good', 37 per cent rated their health as 'good', 23 per cent rated their health as 'fair' and three per cent rated their health as 'poor' (from the National Drug Strategy household survey, Australian Institute of Health and Welfare 2005b);
- Fifty-one per cent of the sample reported receiving one or more blows to the head resulting in a dazed or confused state without losing consciousness (from Schofield et al. 2006). Among participants reporting one or more such blows, the mean number reported was eight (median=3, range: 1-100). A further eight per cent of the sample reported one or more blows but could not estimate how many they had received;
- Forty-five per cent reported one or more blows to the head resulting in loss of consciousness (mean number=3, median=1, range: 1-50). A further two per cent could not recall how many such blows they had received;
- Measures of several specific psychiatric and physical health problems were adapted from the National Drug Strategy household survey (Australian Institute of Health and Welfare 2005b) and the proportions who reported suffering from these conditions are shown in Table 2.[6]
- Fifty-six per cent of the sample reported suffering one or more physical health problems. Most notable among these were very high rates of asthma, hepatitis infection and (among women) low iron.
- Fifty-five per cent of the sample reported suffering from one or more psychiatric disorders. There were particularly high rates of depression and anxiety-related disorders among this sample.
- Among participants who self-reported suffering from one or more psychiatric disorders, 75 per cent also met one or more criteria for disordered or dependent substance use.

Participants were asked whether they were receiving treatment for any of these specific health problems and whether they required treatment, or further treatment for that condition. There appeared to be a significant level of unmet demand for treating low iron levels, hepatitis infection and 'other' physical health problems. The main areas of unmet treatment, though, were in relation to mental health disorders.[7] This was particularly apparent for depression, anxiety disorders, bipolar disorder and other psychiatric disorders (which mainly included reports of attention deficit hyperactivity disorder or post-traumatic stress disorder). Thirty-eight participants reported barriers to treatment, including, from most to least cited: personal motivation, fear or poor organisational skills; previous trouble with services, inadequate diagnoses or incompatible medications; lack of time or money; problems with the criminal justice system; and not knowing where to go to access services.

Open-ended suggestions

Fifty-nine per cent of the sample (n=112) made one or more suggestions when asked "is there any assistance that you need which might help you on a day-to-day basis?" The most frequently cited suggestions were: treatment or support for substance abuse and/or mental health problems (n=39); employment (n=22); financial assistance (n=20); transport (n=17); legal assistance (n=7); home help (n=6); help with family relationships (n=6); help with a disability (n=3); education (n=3); parenting advice (n=3); housing (n=2); and food (n=2).

DISCUSSION

Participants showed a very high degree of need for each of the social services discussed during the interview. Almost one-third of the sample had not finished any education or training at all beyond year 10 of school, one in five reported that they had learning difficulties and one in five suggested they had literacy problems. The majority of the sample was not in full-time paid employment and approximately two-thirds had been out of the full-time workforce for most of the previous year (i.e. were long-term unemployed). Two in every five respondents reported having an annual household income of less that $20,000. One-third of the sample reported that their basic household needs were at least sometimes not being met.

Very high proportions reported that they had gambling and substance abuse problems. Fifteen per cent felt they had a problem with gambling in the previous year, more than half met our criteria for problematic alcohol use, one-third met the criteria for cannabis dependence and one in ten met our criteria for amphetamine dependence. Heroin and cocaine dependence were not particularly prevalent among this sample. This is not surprising as far as cocaine is concerned, because this has not historically been a prominent drug of abuse among lower socioeconomic drug user groups in Sydney (Hando, Flaherty & Rutter 1997). The findings in relation to heroin are more surprising but may be at least partly reflective of a sustained reduction in availability of heroin in Australia over the previous five years (Day et al. 2003; Weatherburn et al. 2003). While the heroin market has stabilised since the initial effects of this reduction were felt, there were no indications that supply had returned to pre-shortage levels at the time our participants were interviewed (Stafford et al. 2006).

While most respondents reported that their health was excellent, very good, or good, the proportions self-reporting these health ratings were slightly lower than the corresponding proportions from the most recent National Drug Strategy household survey (Australian Institute of Health and Welfare 2005a). More than half of the sample reported suffering from one or more physical health problems. There were particularly high reported rates of asthma, low iron (among women especially), hepatitis infection and 'other' physical health problems, including limb, back, and neck or head injuries. Evidence for the high rates of traumatic head injury among this sample is provided by the observation that up to 60 per cent reportedly had one or more blows to the head without losing consciousness. Nearly half had been knocked unconscious one or more times throughout their lifetimes. Reported rates of brain injury have also been shown to be very high among Australian prisoners (Schofield et al. 2006). This is a matter of concern given that brain injury may be causally related to violent crime (Turkstr, Jones & Toler 2003).

The very high reported rates of mental illness and unmet demand for mental health treatment are particularly troubling. More than half of the sample reported suffering from one or more mental

Table 2: Proportion of (a) current sample who reported 'suffering from' physical and psychiatric problems, and (b) NSW subsample of National Drug Strategy household survey reporting being 'diagnosed or treated for' those conditions in the preceding 12 months*

	(a) Current sample		(b) NSW 2004 (weighted)	
Condition	Males (%)	Females (%)	Males (%)	Females (%)
Type 1 diabetes	1.3	2.6	1.6	1.1
Type 2 diabetes	3.3	0	3.7	3.6
Heart disease	5.3	2.6	5.2	3.7
Cancer	0	2.6	2.6	2.6
Asthma	16.7	21.1	6.1	9.3
High blood pressure	9.3	5.3	15.2	18.1
Low iron	4	42.1	1.8	8.4
Hepatitis B or C	13.3	10.5	0.9	0.4
Other physical health problems**	26.7	23.7	N/A	N/A
Depression	45.3	47.4	5.4	8.6
Anxiety disorder	19.3	29	2.6	4.1
Bipolar disorder	9.3	7.9	0.6	0.3
Schizophrenia	9.3	2.6	0.3	0.2
Eating disorder	3.3	7.9	0.6	0.9
Other psychiatric disorders***	13.3	10.5	N/A	N/A

* *These data are drawn from secondary analysis of the National Drug Strategy household survey. Data are weighted for age, sex and sampling design effects. NB: the NDS survey asked participants to identify whether they had been 'diagnosed or treated' for these illnesses within the previous year whereas our sample were asked whether they currently 'suffered from' these conditions so the two measures are not directly comparable. The NDS data are presented for reference purposes only.*

** *Other physical health problems typically included limb, back, neck or head injuries.*

*** *Common among the other psychiatric disorders were post-traumatic stress disorder and attention deficit hyperactivity disorder.*

illnesses – mood disorders in particular. Our results also suggest that people who report psychiatric disorders almost universally present with a co-morbid substance use disorder. It should be remembered, however, that we did not employ a validated measurement scale and there may have been a tendency among some participants to over-diagnose particular health problems. This is less likely for physical health problems because awareness of health problems such as high diastolic blood pressure requires objective measurement. Mental health, on the other hand, can be subjectively assessed and might therefore be more susceptible to erroneous diagnoses. In saying that, our mental health estimates were consistent with other studies that have found the prevalence of mental health disorders among criminal justice populations to be very high (Butler & Allnutt 2003; Teplin et al. 2006).

Prima facie, homelessness was the only area of disadvantage explored in the survey that did not appear to be very prevalent. However this finding needs to be treated with caution for two reasons. Firstly, we asked participants where they had lived for most of the previous 12 months. Even if only three per cent were mainly homeless over that time period, a larger proportion may have experienced episodes of homelessness during the preceding year. Secondly, 44 per cent of the sample had moved address on one or more occasions over the previous 12 months, which would tend to indicate a degree of housing transience, even if that instability did not constitute homelessness.

Before we begin to discuss the implications of this research, it may be useful to note certain caveats surrounding our findings. These data cannot tell us the overall prevalence of these various problems among court defendants because the sample generated for this study was self-selecting. While the gender breakdown and rates of Indigenous appearance are similar between our sample and the population of Local Court defendants (unpublished statistics, NSW Bureau of Crime Statistics and Research), there are two reasons for suspecting that our final sample may have been unrepresentative. Firstly, few participants (4%) reported that they usually spoke a language other than English at home. In the 2001 Census, 31 per cent of Blacktown residents and 7.5 per cent of the Newcastle population indicated that they usually spoke a language other than English at home (Australian Bureau of Statistics 2005). This suggests either that there was a significant under-representation of non-English-speaking people in the sample or that non-English speaking people are less likely to appear in Blacktown and Newcastle Local Courts. Secondly, providing movie tickets and department store vouchers as compensation for taking part in the study may have led to an over-sampling of disadvantaged court defendants. This is also an empirical question for future research, although the implications for the current study should be put in context. It is important to bear in mind that there would be diminishing returns associated with offering crime prevention programs to all court defendants. If the current sampling strategy did result an over-representation of disadvantaged court defendants, it may have been quite effective in targeting those defendants who are inherently more likely to be the focus of crime prevention programs.

The usual caveats must also be placed around interpreting self-report information. As mentioned above, this is especially pertinent for our mental health estimates but caution is also urged in relation to estimates such as household income and whether this was sufficient to meet participants' basic household needs. For example, there was a tendency for some people to mistake goods such as tobacco as 'basic needs'. If there appeared to be any confusion, the question was asked again with emphasis placed on the fact that we were referring only to basic needs such as food, clothing and housing. However, it is still likely that this is an over-estimation of the proportion of people who were regularly unable to cover these basic household needs. Other self-report estimates should also be treated with caution. For example, there may be some confounding between

self-reported learning difficulties and low levels of formal education.

These limitations aside, the results of this research will, we hope, be informative for the development of crime prevention programs. Given that most of these areas of risk or disadvantage are not mutually exclusive, a comprehensive rehabilitation program may be one option for intervention. Rigorously conducted program evaluations carried out in the United States of America (USA) have provided strong evidence that appropriately conducted rehabilitation programs can reduce recidivism by up to 20 per cent (MacKenzie 2002). In her comprehensive review, MacKenzie suggests that good rehabilitation programs should (a) include multiple treatment components, (b) focus on the development of skills that will improve both social interactions and employment possibilities, (c) encourage extensive contact between the treatment providers and the offender and (d) use behavioural methods that positively reinforce appropriate behaviours.

Alternatively, crime prevention programs might focus intensively on one or more of these areas of disadvantage. There was a particularly high level of unmet demand for education and employment, and high levels of self-reported learning and literacy difficulties among participants in this sample. The evidence reviewed by MacKenzie (2002) suggests that vocational education programs and community-based employment programs may be effective means by which to reduce recidivism. There is also at least some evidence that basic education programs for adult offenders may be effective in reducing rates of re-offending. Basic literacy programs may be useful for a proportion of NSW court defendants in light of the fact that literacy and learning difficulties were among the most commonly cited barriers to engaging in education or training courses.

Given the high levels of substance abuse disorders among this sample, it may be critical to continue the current focus on intensive drug treatment programs. A randomised controlled trial of the NSW Adult Drug Court found that, for some offence types, it effectively increased the time to first offence and reduced the frequency of offending among program participants relative to controls (Lind, Weatherburn & Chen 2002). Although it was only marginally more cost-effective than regular sanctions for drug-dependent offenders, changes to the program procedures since its inception may have improved this cost-effectiveness. This is an issue for further research. In view of the limited 'catchment' area of the NSW Drug Court to parts of western and southwestern Sydney, expansion of this program to other areas with high demand for illicit drug treatment may be one option. MacKenzie (2002) suggests that less intensive diversion into drug treatment may be effective if it is combined with urine testing to ensure program compliance. A very recent review of the evidence suggests that there is also some evidence for the effectiveness of diversion into drug treatment programs that include components of aftercare, or lower intensity ongoing supervision (Harvey et al. 2006). Even if diversion into drug treatment is not the main intervention focus, providing options for drug treatment may be important given that a considerable proportion of the sample identified their substance abuse as a barrier to employment and education services.

Finally, it would appear that focusing on the mental health needs of NSW court defendants would be an important part of any offender-based criminal justice intervention. There were very high rates of self-reported mental illness among this cohort. This was particularly true for mood disorders (e.g. depression) but also for anxiety-related disorders and other psychiatric health problems. While there is currently little evidence that treating psychological symptoms alone has any effect on rates of recidivism, the paucity of studies that have addressed this issue suggests that it would be unwise at this stage to assume that mental health treatment has no role to play in reducing recidivism.

These suggestions are but a subset of all available options emerging from a growing body of Australian and international literature on evidence-based crime prevention. Even if the specific programs trialled in NSW have not been tried and tested elsewhere, it is worth reiterating in closing that building an evaluation framework into any new programs is critical if we are to further advance our knowledge of "what works" in preventing crime amongst known offenders. The gold standard in scientific evaluation is the randomised controlled trial and this should be a primary consideration. Of course, it is not always either ethically or practically feasible to randomly allocate offenders into treatment and control groups. In such situations there are also a number of quasi-experimental alternatives that can provide evidence – albeit never as strongly as a randomised trial – bearing on the effectiveness or otherwise of government programs.

ACKNOWLEDGMENTS

Thanks to Bruce Flaherty, Brendan Thomas and Dr Don Weatherburn for their contributions to the study concept and questionnaire design. The authors would like to thank the following people for providing advice on the survey instrument: Lily Trimboli and Joanne Baker (NSW Bureau of Crime Statistics and Research), Dr Tony Butler (NSW Justice Health), Professor Jan McMillen (Centre for Gambling Research, Australian National University), Fiona Shand and Dr Anthony Shakeshaft (National Drug and Alcohol Research Centre), and Associate Professor Kate Conigrave (School of Public Health, University of Sydney). We would also like to thank the solicitors from both the NSW Aboriginal Legal Service and the NSW Legal Aid Commission - particularly Anne Corbett and Matthew Coglan - who referred participants to the study and the court Registrars and other court officers who also helped facilitate the recruitment process. We are particularly indebted to the participants who took their time to speak with us.

NOTES

1. Formerly with Crime Prevention Division, NSW Attorney General's Department.
2. It was often difficult for participants to estimate their household income. While all efforts were taken to improve accuracy, it is possible that there was some residual error in these estimates.
3. The 10-item alcohol use disorders identification test (AUDIT) developed by the World Health Organisation (Babor et al. 1989) was considered to be the most appropriate screener for alcohol-related problems. However, because interview time was very limited in the current study, an abbreviated version of the AUDIT was adopted (Piccinelli et al. 1997). Only five of the 10 items were explored: items one (drinking frequency), two (number of drinks consumed on a typical drinking day), four (ability to stop drinking once they had started), five (failing to do what was normally expected because of drinking) and 10 (whether others had been concerned about their drinking). Piccinelli et al. (1997) report that scoring five or higher (up to a maximum score of 20) on this 'short-AUDIT'

provides adequate sensitivity, specificity and positive predictive value to be useful when screening for problematic alcohol use.

4. The SDS is a five-item scale frequently used by researchers to assess how severely dependent someone might be on a particular drug. The score assesses elements of dependence including loss of control, worries about using drugs, withdrawal symptoms and difficulties ceasing use. It has been shown to have good psychometric properties (Gossop et al. 1995).
5. This diagnostic cut-off has been validated among adult drug users for cannabis and cocaine dependence but no data have been published on an appropriate diagnostic cut-off for heroin dependence.
6. While the corresponding figures from the most recent national survey are also presented in this table, note that the measures were not directly comparable. Whereas the National Drug Strategy household survey included 'treated or diagnosed' conditions, the current survey asked respondents whether they 'suffered from' these conditions. This difference in wording was necessary in order to estimate unmet demand for health care.
7. These statistics are not presented for the sake of brevity but are available from the primary author upon request.

REFERENCES

Australian Bureau of Statistics 2005, *ABS Regional Profile*, ABS cat. no. 1379.0.55.001, Australian Bureau of Statistics, Canberra.

Australian Institute of Health and Welfare 2005a, *2004 National Drug Strategy Household Survey: Detailed Findings*, Drug Statistics Series no. 16, Australian Institute of Health and Welfare, Canberra.

Australian Institute of Health and Welfare 2005b, *2004 National Drug Strategy Household Survey: First Results*, Drug Statistics Series no. 13, Australian Institute of Health and Welfare, Canberra.

Babor, T., de la Fuenta, J.R., Saunders, J.B. & Grant, M. 1989, *The Alcohol Use Disorders Identification Test. Guidelines for use in Primary Health Care*, World Health Organisation, Geneva.

Baldry, E. 2005, 'The effect of post-release housing on prisoner re-integration into the community', in *Corrections Criminology*, Eds S. O'Toole & S. Eyland, Hawkins Press, Sydney.

Butler, T. & Allnutt, S. 2003, *Mental Illness Among New South Wales' Prisoners*, NSW Justice Health, Sydney.

Butler, T. & Milner, L. 2003, *The 2001 New South Wales Inmate Health Survey*, NSW Justice Health, Sydney.

Daly, K. & Hayes, H. 2001, *Restorative Justice and Conferencing in Australia*, Trends and Issues in Crime and Criminal Justice no. 186, Australian Institute of Criminology, Canberra.

Day, C., Topp, L., Rouen, D., Darke, S., Hall, W. & Dolan, K. 2003, 'Decreased heroin availability in Sydney in early 2001', *Addiction*, vol. 98, no. 1, pp. 93-95.

Gossop, M., Darke, S., Griffiths, P., Hando, J., Powis, B., Hall, W. & Strang, J. 1995, 'The Severity of Dependence Scale (SDS): Psychometric properties of the SDS in English and Australian samples of heroin, cocaine and amphetamine users', *Addiction*, vol. 90, no. 5, pp. 607-614.

Hando, J., Flaherty, B. & Rutter, S. 1997, 'An Australian profile on the use of cocaine', *Addiction*, vol. 92, no. 2, pp. 173-182.

Harvey, E., Shakeshaft, A., Hetherington, K., Sannibale, C. & Mattick, R.P. 2006, *Methodological Review: Outcome Studies of Diversion and Aftercare Programs for Adult Drug-Involved Offenders*, NDARC Technical Report no. 259, National Drug and Alcohol Research Centre, Sydney.

Kaye, S. & Darke, S. 2002, 'Determining a diagnostic cut-off on the Severity of Dependence Scale (SDS) for cocaine dependence', *Addiction*, vol. 97, no. 6, pp. 727-731.

Lind, B., Weatherburn, D. & Chen, S. 2002, *NSW Drug Court Evaluation: Cost-effectiveness*, NSW Bureau of Crime Statistics and Research, Sydney.

MacKenzie, D.L. 2002, 'Reducing the criminal activities of known offenders and delinquents', in *Evidence-Based Crime Prevention*, Eds L.W. Sherman, D.P. Farrington, B.C. Welsh & D.L. MacKenzie, Routledge, London.

Makkai, T. & Payne, J. 2003, *Key Findings from the Drug Use Careers of Offenders (DUCO) Study*, Trends and Issues in Crime and Criminal Justice no. 267, Australian Institute of Criminology, Canberra.

McMillen, J., Marshall, D. & Murphy, L. 2004, *The Use of ATMs in ACT Gaming Venues: An Empirical Study*, ANU Centre for Gambling Research, Canberra.

Piccinelli, M., Tessari, E., Bortolomasi, M., Piasere, O., Semenzin, M., Garzotto, N. & Tansella, M. 1997, 'Efficacy of the alcohol use disorders identification test as a screening tool for hazardous alcohol intake and related disorders in primary care: A validity study', *British Medical Journal*, vol. 314 (February), pp. 420.

Schofield, P.W., Butler, T., Hollis, S.J., Smith, N.E., Lee, S.J. & Kelso, W.M. 2006, 'Traumatic brain injury among Australian prisoners: Rates, recurrence and sequelae', *Brain Injury*, vol. 20, no. 5, pp. 499-506.

Stafford, J., Degenhardt, L., Black, E., Bruno, R., Buckingham, K., Fetherston, J., Jenkinson, R., Kinner, S., Newman, J. & Weekley, J. 2006, *Findings from the Illicit Drug Reporting System (IDRS)*, NDARC Monograph no. 59, National Drug and Alcohol Research Centre, Sydney.

Stevenson, R.J. & Forsythe, L.M.V. 1998, *The Stolen Goods Market in New South Wales: An Interview Study with Imprisoned Burglars*, NSW Bureau of Crime Statistics and Research, Sydney.

Swift, W., Copeland, J. & Hall, W. 1998, 'Choosing a diagnostic cut-off for cannabis dependence', *Addiction*, vol. 93, no. 11, pp. 1681-1692.

Teplin, L.A., Abram, K.M., McClelland, G.M., Mericle, A.A., Dulcan, M.K. & Washburn, J.J. 2006, *Psychiatric Disorders of Youth in Detention*, Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice, Washington, D.C.

Topp, L. & Mattick, R.P. 1997, 'Choosing a cut-off on the Severity of Dependence Scale (SDS) for amphetamine users', *Addiction*, vol. 92, no. 7, pp. 839-845.

Turkstr, L., Jones, D. & Toler, H.L. 2003, 'Brain injury and violent crime', *Brain Injury*, vol. 17, pp. 39-47.

Weatherburn, D. 2001, *What Causes Crime?*, Crime and Justice Bulletin no. 54, NSW Bureau of Crime Statistics and Research, Sydney.

Weatherburn, D., Jones, C., Freeman, K. & Makkai, T. 2003, 'Supply control and harm reduction: lessons from the Australian heroin 'drought'', *Addiction*, vol. 98, no. 1, pp. 83-91.

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ISSN 1030 - 1046 • ISBN 0 7313 2692 X