

# Improving Aboriginal Participation in the MERIT program



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## **Terminology**

This report refers to 'Aboriginal people' in preference to 'Aboriginal and Torres Strait Islander people', in recognition that Aboriginal people are the original inhabitants of NSW. Where National data refers to Indigenous people or Aboriginal and Torres Strait Islander people, these terms have been used.

## **Abbreviations**

AOD - Alcohol and other Drugs

ACCHS - Aboriginal Community Controlled Health Service

AH&MRC - Aboriginal Health & Medical Research Council of NSW

ABS - Australian Bureau of Statistics

AIHW - Australian Institute of Health and Welfare

IDDI - Illicit Drug Diversion Initiative

NSP - Needle and Syringe Program

MERIT - Magistrates Early Referral Into Treatment Program

NCHECR - National Centre in HIV Epidemiology and Clinical Research

## **Executive Summary**

The Magistrates Early Referral into Treatment Program (MERIT) has operated in NSW since 2000. MERIT is a tailored case management program developed to divert adult defendants with demonstrable drug problems appearing before the Local Court to a three-month intensive, drug treatment program.

Aboriginal people are overrepresented at every stage of the criminal justice system, with NSW having one of the highest rates of Aboriginal incarceration nationally.

In response to findings that Aboriginal defendants were being referred to MERIT at the same rate as they appeared in NSW Local Courts, but were being accepted onto the program and completing at lower rates than their non-Aboriginal counterparts (Cain 2006), NSW Health funded the 'Improving Aboriginal participation in MERIT' program to make recommendations to inform future policy and program directions to improve Aboriginal participation in the MERIT program.

The project found that the MERIT program can be a suitable intervention for many Aboriginal offenders with demonstrable drug problems. Initially, the project identified a subset of MERIT teams who had higher levels of Aboriginal participation and program completion, in some cases completion rates greater than for non-Aboriginal clients. A number of these teams were a major focus in determining the elements of best practice for Aboriginal participation in MERIT.

Once best practice elements were identified, specific training, service planning and support were provided to selected MERIT teams with the aim of reducing barriers for Aboriginal defendants to access the program, and changing the way the program is structured and delivered such that more Aboriginal offenders may participate in, and benefit from, the program. The project also developed resources and tools to assist MERIT teams work toward culturally safe service provision, develop or strengthen relationships with key Aboriginal community workers and organisations and raise program awareness among eligible people.

Where MERIT teams implemented the suggested changes, there was a larger increase in the proportion of Aboriginal clients completing the program, compared to teams that made no changes to service delivery (33% increase compared to a 7% increase in teams that made no changes). The methods included participating in consultations, training and the development of resources. These findings suggest that identifying barriers to participation, improving knowledge and skills of MERIT staff and implementing current best practice strategies to work towards providing a culturally appropriate and relevant service, will enhance Aboriginal clients' completion of the program.

While the program is not suitable for all offenders, and further measures could be made to increase Aboriginal participation, the findings reinforced that Aboriginal people are more likely to remain on the MERIT program if they have adequate support from a service that has an understanding of the barriers a client faces, if their therapeutic needs can be met and some of the practical hurdles such as transport and family commitments can be overcome.

## **Recommendations**

### **NSW Health & Department of Justice and Attorney General**

1. Where Aboriginal participation rates in MERIT are low and there are high rates of Aboriginal attendance at local courts, implement strategies to improve Aboriginal participation and retention, including those outlined in this report.
2. Revise the MERIT Policies and Procedures Manual to ensure it is inclusive of Aboriginal people, and policies are consistent with Aboriginal health policies. Ensure all new policies are created in consultation with Aboriginal organisations.
3. Strengthen efforts to recruit Aboriginal staff in MERIT. Approximately 20% of the local court demographic is Aboriginal people. For staffing levels to be equivalent to this proportion, approximately 15 Aboriginal people would need to be employed at 2009 staffing levels.
4. Explore the feasibility of trialling the MERIT program through an Aboriginal community controlled organisation/s as a method of ensuring a holistic, culturally appropriate and acceptable option for Aboriginal clients.
5. Broaden the eligibility criteria to allow flexibility in assessment for Aboriginal people to include alcohol related offenses. Consider past or current minor violence-related offences as inclusion criteria for MERIT, while remaining mindful of staff and community safety.
6. Continue to ensure that the MERIT program is expanded into areas with a high proportion of Aboriginal people, particularly in outer metropolitan Sydney and rural and regional areas.
7. Fund a position whose role would be to maximise access to culturally appropriate MERIT services and improve linkages with Aboriginal services and community based programs.

### **MERIT Teams**

8. Continue to develop and strengthen referral pathways with local Aboriginal Community Controlled Health, Aboriginal Legal Services and other Aboriginal services to increase appropriate health, legal and support options for clients where appropriate.
9. Continue to emphasise the importance of a holistic approach to delivering services for Aboriginal clients. MERIT teams should ensure they have the knowledge and skills to meet the needs of Aboriginal people with drug & alcohol issues including working with families and community based options
10. Increase options for intensive case management for complex clients including those with mental illness, disabilities and/or poor life skills
11. Increase communication between MERIT teams, including ways for more experienced teams and teams with high rates of Aboriginal participation to share knowledge and skills

**General**

12. Invest in developing Aboriginal expertise in alcohol and other drug services provision by encouraging traineeships and scholarships for Aboriginal people wanting to undertake formal studies in the alcohol and other drug field, providing workforce opportunities, development of career paths and providing culturally safe working environments.
13. Fund detoxification and rehabilitation services for Aboriginal people, including an Aboriginal controlled facility accessible to the metropolitan area and service/s specifically for Aboriginal women and children
14. Review assessment and screening tools to ensure they are the most brief and effective psychosocial measures currently available and are appropriate for Aboriginal clients

# **1. Project Aims and Methods**

## **Project aims**

The project was funded by the Mental Health and Drug and Alcohol Office (MHDAO), NSW Health, to develop a best practice model for engaging and retaining Aboriginal clients and to make recommendations to inform future policy and program directions to improve Aboriginal participation at all levels in the MERIT program.

To achieve these aims, the AH&MRC employed a project officer to work in consultation with Aboriginal communities, MERIT teams, and a project steering committee.

## **Project steering committee**

The MERIT Project steering committee was formed with representatives from the Attorney General's Crime Prevention Division, NSW Health Mental Health and Drug and Alcohol Office, Aboriginal Justice Advisory Council, Aboriginal Health and Medical Research Council, Network of Drug and Alcohol Agencies (NADA), Aboriginal Drug and Alcohol Network (ADAN), Aboriginal Community Justice Group coordinators, MERIT managers and Aboriginal case managers working within MERIT.

The steering committee advised on all aspects of the project.

An attempt was made to ensure that at least half of the project steering committee membership was Aboriginal to represent the needs of Aboriginal people and ensure the project was relevant. This was not sustained as there were few or no Aboriginal people employed within many of these agencies.

## **Project methods**

The project officer:

- Examined the literature to determine current best practice for possible strategies for program improvements, reducing barriers and accommodating the specific needs of Aboriginal clients
- Identified MERIT programs with higher rates of Aboriginal participation and program completion. Of particular interest were teams who demonstrated completion rates greater than for non-Aboriginal clients. These teams were a major focus in determining the strategies to improve Aboriginal participation in MERIT.
- Identified factors that contribute to successful program completion for Aboriginal clients through consultations with the MERIT Teams and local Aboriginal communities within the MERIT catchment areas
- Developed a range of strategies to improve MERIT service provision for Aboriginal people, based on the literature review and consultations
- Trialled the model within several MERIT teams to determine if it contributed to improved program completion by Aboriginal participants. This included the development of resources such as a poster and an Aboriginal Practice Checklist.
- Examined the MERIT participation and completion data pre and post intervention, to assess the effectiveness of the intervention.



### **Project context**

Aboriginal people in NSW make up approximately 29% of the Aboriginal population in Australia and 2% of the population of NSW (AIHW, 2005). Aboriginal people are over-represented at every stage of the criminal justice system. In 2001, more than forty percent of the Aboriginal male population aged 20-24 in NSW appeared before a NSW court charged with a criminal offence. One in ten Aboriginal males in NSW aged 20-24 received a prison sentence (Weatherburn et al 2003). At 1 November 2008, 21% of the male prison population and 28% of the female prison population were Aboriginal (22% of the total prison population) (NCHECR, 2008).

Despite the recommendations of the Royal Commission into Aboriginal Deaths in Custody (1991), the over-representation of Aboriginal people in custody persists. Research indicates that Indigenous young people are particularly vulnerable to contact with the criminal justice system (Chen *et al*, 2005).

NSW data shows that Aboriginal defendants tend to have a higher likelihood of violent charges and previous convictions, which may restrict their access to bail. In contrast, a non-Aboriginal person with the same charge is more likely to receive bail as they tend to have fewer previous charges (Weatherburn 2006). They may, therefore also be more likely to be assessed as suitable for early court intervention programs such as MERIT.

## **2. Background to MERIT**

### **The MERIT Program**

The Magistrates Early Referral Into Treatment (MERIT) Program was developed to divert adult defendants with demonstrable drug problems from Local Court to a three-month intensive, tailored drug treatment program. The defendant is not required to enter a plea of guilty in order to participate in the program and the Court can make the defendant's involvement in MERIT a condition of bail. MERIT is guided by a Local Court Practice Note and operates under the *Bail Act (1978)* (NSW Attorney General's 2002). Defendants return to court for sentencing and the Magistrate is able to consider the defendant's progress in treatment as part of final sentencing.

MERIT is a joint initiative between the criminal justice and health sectors funded under the Illicit Drug Diversion Initiative agreement between the NSW and Australian Governments.

MERIT operates at 61 Local Courts across metropolitan and regional NSW covering approximately 80% of the local court population (NSW Attorney General's Department, 2008). Of the twenty four MERIT Teams across NSW, most are staffed by Area Health Services and two by non-Government organisations.

### **Aims of MERIT**

MERIT aims to:

- decrease illicit drug use and drug-related crime by participants, during the program and following completion
- improve health and social functioning among participants, during the program and following completion
- produce sentences which better reflect the rehabilitation prospects of MERIT participants

(NSW Attorney Generals 2003)

### **Acceptance onto the MERIT Program**

Entry into the Program is strictly voluntary, in contrast to some other diversion programs, and participation is not restricted to first time offenders. It is an "early" court scheme that is intended to target defendants charged with relatively minor offences appearing at the Local Court, and aims to break the drug-crime cycle through addressing the underlying factors associated with criminal behaviour (NSW Government 1999; Spooner, Hall and Mattick 2001).

Defendants charged with serious violent or sexual offences, or those with wholly indictable offences are not eligible to participate (NSW Attorney Department 2002).

The primary referral sources to the program are solicitors and magistrates. In 2008, the most common offence type for accepted clients was 'theft and related offences' followed by 'illicit drug offences' and 'road and traffic offences'.

Once accepted, a comprehensive assessment of a program participant is carried out by a MERIT team to assess issues associated with offending including health, housing, employment and financial issues. A comprehensive case plan for the defendant is prepared.

The primary reason for non-acceptance into the MERIT Program is the defendant's unwillingness to participate.

## **Effectiveness of MERIT**

MERIT has been shown to be effective in its aims of reduced drug use and associated harms, improved health and social functioning, reduced re-offending and sentencing that reflects the improved rehabilitation prospects of successful participants (NSW Health 2007, Lulham 2009). Of the participants completing the program, 98% said the services they received as part of the MERIT program had helped them deal more effectively with their problems and over 90% said they were satisfied or very satisfied with their experience (NSW Health 2007).

Since the MERIT program was first trialled in 2000 over 10,000 people have participated in the program, of which approximately 16% (n=1,516) identified as Aboriginal. Aboriginal status was not recorded for 13% of participants (NSW Health 2008).

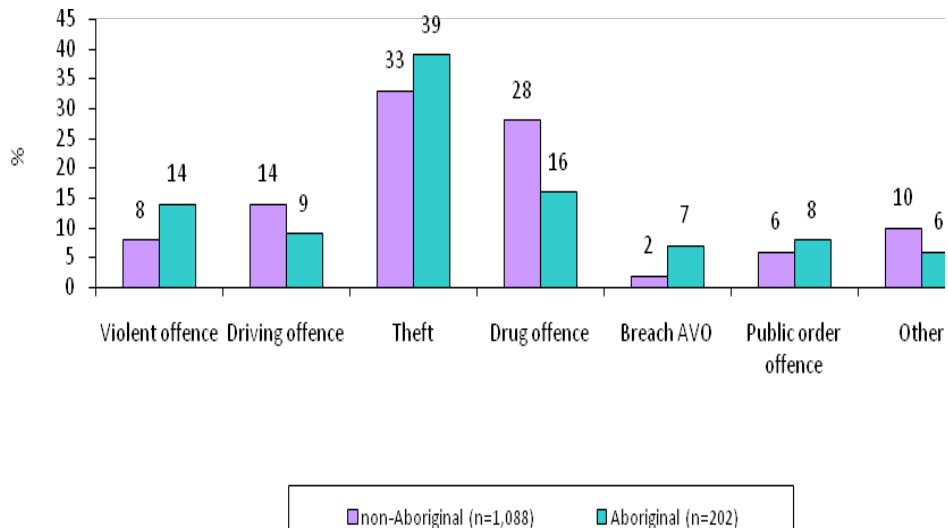
## **Aboriginal participation in MERIT**

In 2004, the Crime Prevention Division of the NSW Attorney General's Department undertook an evaluation of Aboriginal participation in the MERIT program. Significant findings were that, while Aboriginal people were referred in proportion to Aboriginal attendance in Local Courts, the likelihood that Aboriginal clients would be accepted into MERIT was lower than that of non-Aboriginal defendants – 63% of Aboriginal clients compared to 73% of non-Aboriginal clients. Aboriginal defendants were also less likely to complete the program (50%) compared to non-Aboriginal clients (60%) (Cain 2006). The evaluation was repeated in 2008 and similar results were found (Martire & Larney 2008). Significant variation in Aboriginal participation was also found between MERIT teams.

The 2008 study of Aboriginal participation in the MERIT program analysed available criminal justice data for a subset of 1,290 participants, of whom 202 (16%) were Aboriginal. The evaluation found that Aboriginal participants were more likely to have been referred to MERIT following a violent offence or the breach of an apprehended violence order (AVO), whereas non-Aboriginal participants were more likely to have been referred to MERIT following a drug-related offence. Aboriginal and non-Aboriginal participants were equally likely to be convicted of any new offence, but Aboriginal participants were more likely than non-Aboriginal participants to be convicted of a new violent offence (Martire & Larney 2008).

At sentencing, there were no differences in sentence type by Aboriginal status (Martire & Larney 2008). Those who participated in the program but did not complete the program were 36% times more likely to be convicted of a drug offence than program completers (Martire & Larney 2008). The 2004 evaluation also showed about 41% of program completers had a recorded reappearance at court for any offence within 12 months versus 54% of non-completers (or were 32% more likely to appear at court) (Bolitho et al 2005).

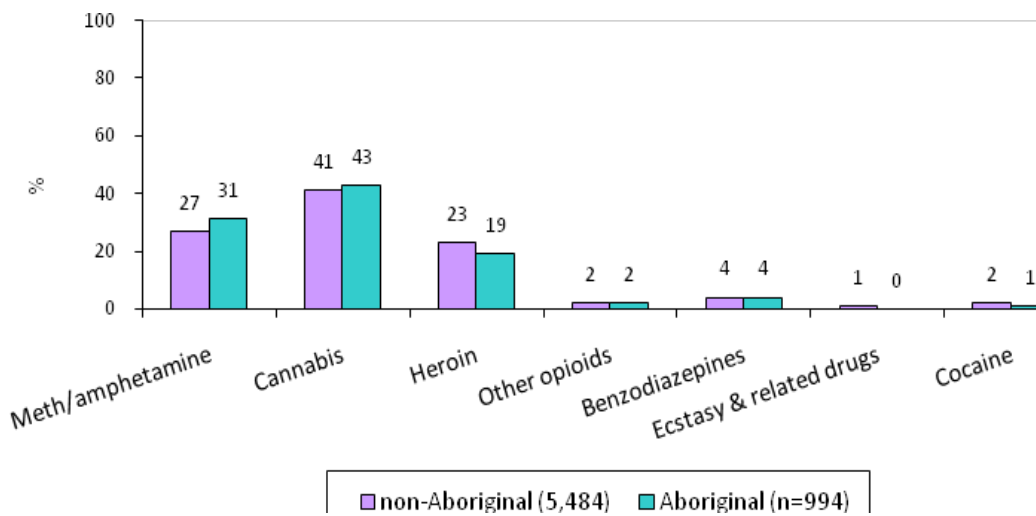
**Figure 1: Referred offence, by Aboriginal status (n=1,290)**



(Martire & Larney 2009)

The principal drugs of concern at program entry for Aboriginal clients were cannabis (43%), heroin (19%) and amphetamines (31%). Aboriginal participants were more likely to report methamphetamine, and less likely to report heroin, as their principal drug compared to non-Aboriginal participants. Aboriginal and non-Aboriginal participants were equally likely to have injected drugs (Martire and Larney 2009).

**Figure 2: Principal drug, by Aboriginal status (6,478)**



(Martire & Larney 2009)

## **Identifying factors affecting Aboriginal participation in MERIT**

### **Literature**

General principles of best practice for early court intervention programs identified in the literature include;

- I. Voluntary participation, rather than mandatory intervention, as voluntary programs are empowering and more aligned to the principals of self determination (Youth Justice Board, 2002).
- II. Support and treatment, as this method is more effective in addressing rates of recidivism than monitoring and supervision (Amos, Miller and Drake, 2006). Several evaluations of bail support programs in the UK have indicated that supporting offenders on bail has a significant impact on reducing recidivism (Pritchard and Cox, 1996; WMPS, 1997). Similarly, reduced recidivism has been found for clients completing the MERIT program compared to those that do not complete the program (Martire and Larney 2009, Lulham, 2009)
- III. A holistic approach, which incorporates providing information and support on a broad range of interventions to reduce rates of recidivism (MacKenzie, 2002). Similarly, research into stages of change for a person suggests that implementing support programs at the point of bail is the optimal time for effective intervention (Kubiak *et al*, 2006).
- IV. Coordinated and interdepartmental service provision, to provide access *to pathways* across different service systems. Programs should offer a coordinated, inter-agency service to provide a pathway to navigate through complex systems (Allen, 2001).
  - I. Adaptable and responsive to local conditions. To be effective, support programs need to adapt to the specific context in which the program is run including vast distances of catchment areas and take into account the needs of the local community (Victorian Law Reform Commission, 2007, Denning-Cotter 2008)

In addition, key characteristics of effective crime prevention programs involving Aboriginal people identified in the literature include:

- Adopting a holistic view of Indigenous health and wellbeing
- Having meaningful, not tokenistic, involvement of Aboriginal people
- Involvement of significant others such as family and the community
- Emphasis on Indigenous heritage, culture and law
- Culturally appropriate program content and staff trained to work cross-culturally by participating in cultural awareness and recruiting Aboriginal staff
- Assisting in establishing and strengthening relationships with Indigenous people who can become mentors and role models (Cunneen 2001, Dance et al 2004)

An assessment of drug and alcohol service delivery needs for local Aboriginal people conducted by the (then) Hunter Area Health Services in 2003 found similar key characteristics. Findings from key informants, service providers and local Aboriginal community members identified;

1. Important factors to improve the quality of a service:
  - access to the service, such as locating services in communities or delivering as outreach
  - working with other services and good communication with staff
  - Culturally competent workers
2. Possible barriers to accessing services
  - Intrinsic motivators to accessing services. E.g., Issues of trust, broken confidentiality and issues relating to the Stolen Generations.
  - 'because they [clients] are afraid or unwilling to admit they have a problem'

The report also found that the majority of community members said they would turn to the drug and alcohol worker at the Aboriginal Medical Service for help for someone with a drug or alcohol problem, indicating the importance of culturally competency and Aboriginal people within services that treat Aboriginal people (HCHA Ma kumba....Porun 2003).

Connection to community is an essential element of successful programs involving Aboriginal people. Empowerment and community participation are major strategies, worldwide, for alleviating poverty and social exclusion, thereby reducing health disparities (Tsey K, Harvey D, Gibson T and Pearson L 2009). Connecting with others may reduce isolation, increase self esteem and assist in establishing goals and promoting pro-social values. Feeling connected and supported within one's culture can support opportunities to be involved in and learn relevant skills and practice these skills in real life ways.

The involvement of Aboriginal people within treatment programs and supporting Aboriginal participants in treatment are essential elements of culturally secure programs. Processes to seek feedback, ensure program relevance, and raise awareness of agency objectives within local communities are essential elements of a quality program.

### **3. Findings from consultations**

MERIT teams with a significant Aboriginal population within their area and local Aboriginal communities were invited to participate in consultations. MERIT is largely an Area Health Service program, and invitations were sent to Area Health Service Executive Officers and Drug and Alcohol program coordinators. Aboriginal community members were also invited through local Aboriginal Community Controlled Health Services (ACCHS), Aboriginal Drug and Alcohol workers, Aboriginal Clients Service Specialists (Local Court) and Aboriginal Liaison Officers (NSW Police). Representatives from Aboriginal community controlled residential rehabilitation services and Aboriginal specific Drug and Alcohol services in MERIT catchment areas were interviewed. The Aboriginal Legal Service (ALS) was invited after discussion with the principal solicitor, although consultations with ALS were limited due to demanding court schedules.

Consultations with various stakeholders were held in Western Sydney, South Western Sydney, Inner Western Sydney, Central Coast, Wollongong, The Hunter, Mid North Coast, North Coast, Queanbeyan, Tamworth, Dubbo, Wellington, Broken Hill and Wagga Wagga.

Initial consultations were conducted separately for MERIT teams and Aboriginal communities. Later consultations included MERIT representatives together with the Aboriginal community representatives after seeking permission. Consultations were found to be an excellent opportunity for MERIT teams and local Aboriginal community members to meet and gain a greater understanding of local issues, services and improve communication and working relationships. The consultations were also an occasion to raise awareness of the MERIT program and local services and activities.

The consultation questionnaire is in Appendix B.

#### **Findings from Aboriginal Community consultations**

Although findings from consultations varied across the state, several consistent themes emerged:

##### **1. Cultural Safety**

Respecting Aboriginal culture and protocols was raised as an essential part of working with Aboriginal clients and services. Being culturally aware and working in cultural competent ways create a more acceptable or safe environment for Aboriginal clients and families.

Several aspects of providing a culturally safe program were identified in the consultations. Employing Aboriginal staff was seen as obvious and the most effective method of making the service inviting and making the client feel welcome with comments such as “ *An Aboriginal face could help*”. Aboriginal people were also identified as being best placed to understand the issues from an Aboriginal client’s perspective:

*“Aboriginal people understand what is like because we’ve been through it with our families - we live it”*

*“One-day cultural awareness training is not enough....need to also work with Aboriginal people”*

It was emphasised that if Aboriginal people are employed in mainstream organisations, to be able to work in culturally appropriate ways, they need to be heard and supported. One suggestion was to ensure Aboriginal workers are included in participating within Aboriginal health worker networks.

Other strategies identified to promote cultural safety in MERIT services included working more closely with Aboriginal services and Aboriginal community members. Suggestions included:

- Finding out what services are in the area (e.g., men's groups, women's groups etc) and linking Aboriginal clients into existing networks
- Liaising with and referring to Aboriginal Drug & Alcohol workers and Social and Emotional Wellbeing Workers
- Identifying cultural mentors in the community, and inviting their support of the program.
- Developing an agreement with local ACCHSs and Aboriginal Legal Services to refer Aboriginal clients for an *Adult Health Check* if appropriate
- Ensuring MERIT policies are consistent with Aboriginal health policies and created in consultation with Aboriginal people or peak organisations.

Some ACCHSs identified an absence of Aboriginal alcohol and other drug and/or social and emotional wellbeing workers as an issue for delivering services to the community. Larger ACCHSs, however, noted that they already provided the therapeutic services described as part of the MERIT program as part of normal service delivery, commenting: *"we do all that anyway"*.

The importance of reciprocal trusting relationships with Aboriginal staff and Aboriginal organisations was emphasised, and consultations were made aware of many effective practices and effective partnerships. For example, one MERIT team co-facilitated an Aboriginal Men's support group at their service in partnership with the local ACCHS. Both MERIT clients and community members were invited to weekly gatherings. Both organisations expressed satisfaction with the partnership and stated they shared two-way learning and were more aware of the roles and functions of each other's agencies which facilitated improved referral pathways for clients.

## 2. Awareness of MERIT

Programs that were known in the community tended to have stronger relationships with Aboriginal community agencies, although the need to raise awareness of the program to eligible people and Aboriginal communities was also highlighted during consultations. Aboriginal community members generally had no knowledge of the MERIT program with the exception of those working directly with Aboriginal offenders (eg Court staff, Probation and Parole and Aboriginal Liaison officers of NSW Police). Comments included:

*"Now that MERIT seems ideal but I've not heard of it"*

*"A lot of programs that non-Aboriginal people have just - sit in the community but they do not promote it to us".*

People who had participated in MERIT or knew people who had, however, spoke highly of the MERIT experience and explained benefits to other community members at consultations:



*“it keeps him here in the community”*

*“The one thing I see it’s good for (MERIT) is it’s an option...so if they are serious about getting off the drugs well there’s another option there instead of going to goal, and if they want to push themselves, it’s voluntary”.*

### 3. Inclusion of family and community

Aboriginal community members emphasised the need to include partners, families and community in the client’s treatment where the client has provided permission. Working in isolation from family and community was seen as counterproductive. Family members were deeply affected by the clients substance use or may have a substance use issue themselves;

*“A lot of situations I come across, partners have drug and alcohol problems too. One may have committed a crime and not the other. One may be referred to the MERIT program and they will only do it together. If they can’t do it together they won’t do it”.*

Where residential rehabilitation is located locally and is available,, the importance of staying close to family and community for some Aboriginal people was emphasised.

*“To take an Aboriginal person away from their family is like cutting off their arm”*

### 4. Program integrity

The consultations revealed the importance of ensuring that the aims of the program and what the program involves are clearly understood by the Aboriginal program participants and community. An accurate understanding of what the program can and can’t do is important so as not to raise unrealistic expectations. For example, perceived shortcomings of MERIT such as: *my nephew went on MERIT but there were no spaces in rehab* or *MERIT didn’t come take him to the program after he was sent by court* may in fact be the result of factors external to the program, including client motivation.

### 5. Transport.

Accessibility of the MERIT program was identified as a major issue in many areas. For many Aboriginal people, access to public transport can be ad hoc at best. Taking the program to where people can access it was suggested as transport could be an issue for many.

*“One of the ways in which Aboriginal community controlled services have always differed from mainstream health services is in recognising the transport issues and providing a transport service”*

In places where transport is not available through the ACCHS or other services, clients are expected to make their own arrangements to ensure they access the MERIT program.

## **Findings from MERIT teams consultations**

Consultations with MERIT teams also identified a range of barriers as well as factors that supported Aboriginal participation on MERIT. Some of the barriers identified included:

1. Transport was raised by most teams as a major barrier for many clients.
2. Not having a home or stable home environment was identified as a barrier for some clients. Homeless clients were generally not suitable for the program as making lifestyle changes is extremely difficult in an unstable or unsafe environment.
3. Lack of flexibility in service delivery. Some teams noted that they were unable to change appointment times if required due to high case loads and staffing issues. For example, if a client misses an appointment it can be difficult to reschedule and support the client to remain on the program
4. Staff shortages and job security. Where staff were not employed on permanent contracts, MERIT's short funding cycle contributed to staff turnover, loss of corporate knowledge and experience and difficulty developing and maintaining partnerships and community relations.
5. Eligibility criteria. Exclusion of offenders with alcohol as the primary drug of concern or not receiving bail were cited as the major reasons why Aboriginal people who may benefit from drug treatment were found ineligible for the program. Minor violence offences, mental health issues, homelessness or unsuitable accommodation were also common reasons offered for why offenders were found unsuitable for the program.
6. Bail criteria. Changes to the Bail Amendment (Repeat Offenders) Act 2002 in December 2007 (Bail Amendment Bill) resulted in more Aboriginal people being refused bail, and reducing the number of Aboriginal people eligible for the MERIT program. This is in direct conflict with a recommendation of the *Aboriginal deaths in custody report* which recommends custody be used as a last resort. Aboriginal people are less likely to receive bail for the same charge as a non-Aboriginal offender and may be remanded in custody on relatively minor offences, because of prior offences.
7. Appropriate policies and procedures. The MERIT policy and procedure manual currently does not include specific policies or approaches to accommodate the needs of Aboriginal people. Variations from the original model have resulted in notably different programs across NSW with differences in rates of program completion by Aboriginal clients. Some of the reasons behind the differences were attributed to local organisational cultures and management, including interpretation of program eligibility and outreach to clients.
8. Capacity of service to work with Aboriginal clients. This capacity was dependant on;
  - Local demographics including location of service, clients and transport infrastructure.
  - Ability of staff to become more culturally aware (knowledge of Aboriginal history and culture and skills for working with Aboriginal clients).

- Case loads and resourcing of MERIT teams; Teams proposed high case loads resulted in a less comprehensive service and reduced flexibility. Clients with complex needs requiring intensive case management and/or coordinated shared care were less likely to remain on the program, Aboriginal clients being most affected.
- 9. Aboriginal staff. All MERIT staff identified an absence of Aboriginal staff as a barrier to Aboriginal participation in their team. During the project period, two Aboriginal staff were identified as working within MERIT programs across NSW. A skills shortage of Aboriginal alcohol and other drug staff was also identified as a limiting factor.
- 10. A lack of culturally appropriate detoxification and rehabilitation services for Aboriginal people were identified in some areas. No specific facility for Aboriginal women and children exists in NSW.

According to MERIT staff, essential factors for Aboriginal participation included:

1. Program support by magistrates.
2. Program integrity and partnerships; important for client trust and outcomes and good relationships with allied agencies such as Aboriginal Legal Service, Legal Aid and community agencies.
3. The involvement of Aboriginal people; Aboriginal staff, consultancy or supervision by Aboriginal health workers within the Area Health Service or partnerships with community based organisations
4. Supportive and proactive management
5. Service structure and delivery appropriate for Aboriginal people including;
  - flexible service delivery
  - Intensive and/or shared case management for complex clients
  - Inclusion of family and/or significant others
  - Minimising transport issues by providing outreach to clients close to where they live or supporting clients by providing a bus or train fare.
  - Empowering and culturally relevant practices

### **Suggestions to improve Aboriginal participation in MERIT**

The consultations identified a range of strategies to improve Aboriginal participation in MERIT. These are shown in order of importance, determined by the number of consultations in which the issue was raised as significant.

- Include alcohol-related crime as an eligibility criterion. Expansion of this criteria will assist people who may benefit from the program but are currently excluded from participation
- Incorporation of regular communication with local stakeholder groups including Aboriginal workers and organisations into program delivery. Working with Aboriginal health workers was regarded as an excellent opportunity to develop skills required for working with Aboriginal clients. Positive Aboriginal role models for clients were

considered important in understanding issues and supporting clients to connect to community, integrate a healthy identity and raise self esteem.

- At the discretion of the presiding Magistrate and team skills, be more flexible about program eligibility and suitability criteria to include violence offences (past and/or current charge) and defendants in custody, while remaining mindful of the safety of staff on MERIT.
- As much as practical, match client, case manager and intervention. Ensure staff are skilled in working with Aboriginal clients and clients are given staff and program options to match need. For example, a woman who is a victim of domestic violence may feel more comfortable with a female case manager. Similarly, it may be more appropriate for an Aboriginal man to discuss intimate issues with a male counsellor. A case manager with expertise in Aboriginal mental health may be more suited to support a client with mental health issues. An overriding principal is to ensure the client is empowered in the development of their case management plan.
- A holistic treatment approach that accommodates the needs of Aboriginal people. Where there is staff capacity and commitment by the client, broaden the scope of treatment beyond alcohol and other drug issues. In areas of inadequate infrastructure, few employment prospects for Aboriginal people and minimal recreational opportunities, MERIT case managers felt the program had limited benefits to offer clients. In other areas literacy and numeracy programs run by Aboriginal people and the Community Development Employment Program (CDEP) were described as protective options. It was suggested to *'think outside the box'* when developing and delivering programs for Aboriginal clients and community.
- As with many other health and social services, advocate for stable transitional housing for people with co-morbid mental health and drug and alcohol issues. For example, provide a safe house where clients could continue their recovery and work with other programs beyond the scope of the MERIT program. This was specifically for people who did not require detoxification or residential rehabilitation services.

## **4. Factors affecting Aboriginal participation in MERIT**

The consultations and literature revealed that there are three intersecting domains that impact on Aboriginal people's participation and retention in MERIT programs. These are:

1. MERIT program specific factors – relating to the way the programs are structured and delivered locally
2. External factors – relating to the influences outside the scope of MERIT teams and
3. Client specific factors – relating to client suitability and effectiveness of programs to meet the needs of individuals.

Details of these factors are summarised below:

### **Program specific factors**

- Supportive policies – ensuring appropriate policies are in place to facilitate Aboriginal people's participation in MERIT, and that these policies are reflective of NSW Aboriginal health policies
- Identification and reduction of barriers for Aboriginal clients.
- Adequate staff and resources – to ensure that MERIT teams have the capacity to provide a comprehensive, flexible, community based service to meet the needs of Aboriginal clients
- Staff characteristics (attitude, knowledge and skills) – and training is provided to work cross culturally
- A service desire to improve Aboriginal participation, including proactive management
- Effective relationships with Aboriginal Legal Service and Aboriginal community organisations
- Promotion of MERIT to Aboriginal organisations and communities
- Ensuring therapeutic models used are effective and appropriate for Aboriginal people and are inclusive of family and community.
- Cultural acceptability of service by Aboriginal clients
- Aboriginal community involvement in service delivery, and referral to Aboriginal programs such as Aboriginal women's or men's groups

### **Factors external to the MERIT program**

- Program support by Magistrates – granting of bail and sentencing vary by Aboriginality and location. Bail support and sentencing options vary markedly, particularly in rural areas.
- Location and demographics of Aboriginal population and access to transport.
- Availability of Aboriginal specific alcohol and other drug services, including Aboriginal residential rehabilitation facilities
- Support of Aboriginal Client Service Specialist (court support and referral) and Aboriginal Community Justice Groups

### **Client-specific factors**

- Primary drug of concern
- Motivation to participate in treatment
- Social and emotional wellbeing (Mental health)
- Family and social support
- Homelessness and suitable accommodation

## **5. Testing transferability**

Once the Program specific factors affecting Aboriginal people's participation in MERIT were identified (section 4), it was agreed to select 'intervention sites' to test these factors for transferability and acceptability.

The intervention sites initially included four MERIT teams; Central Sydney Area Health Service, Wentworth Area Health Service, Mid North Coast Area Health Service and Hunter Area Health Service agreed to participate, however this was extended to seven teams when Area Health Service boundaries expanded. Intervention sites were chosen for diversity and included a combination of Sydney metropolitan, outer metropolitan and rural teams. Prior to the intervention project, five teams had average to below average Aboriginal completion rates and two had slightly above the NSW average. All invited teams agreed to participate and one team requested inclusion in the trial and was accepted.

Being involved in the intervention included the development and participation in tailored training, service planning and support, including:

- Identifying access barriers for Aboriginal clients, such as transport, feeling safe and welcome, effectiveness of program
- Developing a plan to address barriers in the short and longer term
- Strengthening knowledge of Aboriginal culture and developing skills around working with Aboriginal clients and organisations. Training was delivered in one to three sessions over six weeks with an Aboriginal co- facilitator for at least one session
- Promoting MERIT to eligible people, people associated with the local court and Aboriginal communities
- Developing or strengthening relationships with Aboriginal agencies including referral pathways
- Identifying a senior staff member to take responsibility for Aboriginal participation and partnerships (all team members were involved but one person was responsible for coordination and driving the project)
- Developing an advisory group consisting of MERIT staff and Aboriginal health and court workers to meet regularly to identify issues, solutions, and share knowledge
- Arranging appropriate supervision for staff by an Aboriginal health worker

Factors that impacted on a team's capacity to participate in the intervention included the desire to improve Aboriginal participation, the level of staffing and resources – specifically a case load and management that can support the identified intervention, and organisational and demographic features of each team.

The degree to which each team participated in training, planning and implementing changes varied and was not quantitatively measured. One team had no direct support from the project but successfully implemented program changes when Area Health Services merged. Another intervention team declined training but successfully implemented program improvements using project resources (cultural checklist, posters and guide to working with Aboriginal clients on MERIT).

### Did Aboriginal participation improve at intervention sites?

An analysis of data from the NSW Health MERIT Information Management System (MIMS), a database designed specifically to facilitate the monitoring and evaluation of the MERIT program, was conducted post intervention. Program referral, acceptance and completion\* by Aboriginal clients were examined. Teams who participated in the intervention were compared to those whom had no specific intervention. All MERIT teams were aware of the project.

\*The number of people exiting the program was used as a marker for completion, as those accepted may not have completed the program during the evaluation period (at 30 June 2008).

### Results of intervention

All seven intervention teams made program changes to improve Aboriginal participation and demonstrated an increase in Aboriginal participation and program completion during the trial period, between 1 July 2007 and 30 June 2008.

Between 2003 and 2008 there was a steady increase in the total *number* of Aboriginal people being referred, accepted and completing MERIT (Table 3). Importantly, while the *proportion* of Aboriginal clients being referred and accepted onto the program remained steady there was an increase in the *proportion* of these clients completing the program during the intervention period (2007-08).

**Table 1: Participation of Aboriginal clients on MERIT**

Year	No of Aboriginal people referred	No. of Aboriginal people Accepted (%)	No. of Aboriginal people Completed (%)
2003-04	350	214 (61)	114 (53)
2004-05	364	223 (61)	114 (51)
2005-06	353	241 (68)	128 (53)
2006-07	415	254 (61)	140 (55)
2007-08	427	264 (62)	169 (64)

Between 2003 and 2008 approximately two thirds of Aboriginal people referred to MERIT were accepted onto the program (Table 1). These figures were consistent throughout the intervention period. While there was no change in the *proportion* of this group of clients being accepted, there was an increase in the *number* of Aboriginal people being referred to the program.

Twenty-nine more Aboriginal people completed the MERIT program in 2007-08 compared to 2006-07 (55% completion in 2006-07 compared to 64% in 2007-08). This represents a 21% increase in program completion by Aboriginal clients across all MERIT teams. This increase was largely with the intervention groups; 73% of Aboriginal clients completed the program in 2007-08 (Table 2).

**Table 2: Program completion of Aboriginal clients by intervention group**

Intervention team	Program completion/total enrolled 2007	Program completion/total enrolled 2008
1	1/4 (25%)	3/5 (60%)
2	16/27 (59%)	14/23 (61%)
3	16/31 (52%)	15/22(68%)
4	11/18 (61%)	13/18 (72%)
5	8/12 (67%)	8/11 (73%)
6	7/15 (47%)	13/15 (87%)
7	5/10 (50%)	11/12 (92%)
Total (Average)	117 (52%)	106 (73%)

The non-intervention sites also had an increase in completion rates among Aboriginal clients during 2007-2008 (of 7%). However, Table 3 demonstrates that the increase in completion rates largely occurred among the teams that participated in the intervention.

**Table 3: Program completion rates by Aboriginal clients: intervention vs non- intervention groups**

Year	Completion rates/Aboriginal participants	
	Intervention	Non-intervention
2003-04	45/82 (55%)	69/132 (52%)
2004-05	50/96 (52%)	64/127 (50%)
2005-06	60/114 (53%)	70/133 (53%)
2006-07	64/117 (55%)	76/137 (55%)
2007-08	77/106 (73%)	92/157 (59%)



## **6. Strategies for improving the participation of Aboriginal people in the MERIT program**

Based on the consultations with Aboriginal communities and MERIT teams, examination of peer-reviewed and grey literature, and the trialling of an intervention within MERIT teams, a model of 'best practice' was developed. Although there are a number of influencing factors external to the delivery of the MERIT program that will impact on the successful participation of Aboriginal people in the program, there are a number of activities that MERIT teams can implement within their current structure.

These are summarised below.

### **Strategies to improve Aboriginal participation within the MERIT program:**

#### **1. Reorient services to be inclusive of Aboriginal clients**

- Provide staff training and skills development in working cross culturally
- Ensure a culturally secure service by involvement of Aboriginal workers, services and community in program planning and delivery
- Identify staff characteristics (attitude, knowledge and skills) towards providing a culturally secure environment
- Encourage a service commitment to improve Aboriginal participation and outcomes
- Ensure policies and procedures are inclusive of Aboriginal people's needs, and that strategies are implemented
- Select a staff member to take responsibility for all aspects of Aboriginal participation and partnerships

#### **2. Identify and reduce barriers for clients**

- Identify acceptability of service for Aboriginal clients
- Ensure service has adequate staff and resources to ensure Aboriginal people's participation and retention on the program
- Prioritise and implement service changes to reduce barriers
- Advocate for flexibility with eligibility and assessment,
- Identify and minimise client specific barriers, which could include;
  - Primary drug concern
  - Social and emotional wellbeing (mental health)
  - Motivation to participate in treatment
  - Homelessness and suitable accommodation
  - Access to transport
  - Access to phone and credit
  - Family and social support

3. Develop or strengthen relationships with Aboriginal health workers and community agencies

- Arrange consultancy or supervision by an appropriate Aboriginal Health Worker. Be mindful of existing high workload of many Aboriginal Health Workers and be clear about workload expectations.
- Develop referral pathways to Aboriginal specific Alcohol & other Drug services or Aboriginal workers in Area Health Services and non-government organisations, where available
- Develop quality referral pathways to Aboriginal Community Controlled Health services and other Aboriginal community based agencies
- Invite consultation and feedback on services from local Aboriginal community and services

4. Ensure program is effective and meets needs of Aboriginal people

- Ensure programs and intervention techniques are effective in attracting and retaining clients on the program. Evaluate psychosocial outcomes of Aboriginal clients and ensure processes to seek feedback from clients, family and partner agencies
- Ensure assessment, program delivery and structure are appropriate for Aboriginal clients (see program framework model Figure 4)
- Ensure appropriate therapies and emphasis on Aboriginal culture and values
- Ensure program content and delivery is developmentally appropriate
- Involve family and community where appropriate. Assist in establishing and strengthening relationships with significant others, mentors and role models
- Evaluate program content and delivery and make changes as necessary

5. Promote service to eligible people and Aboriginal communities

- Raise awareness of the program within the local Aboriginal community through interagency meetings, participation in community events, developing Aboriginal specific resources, approaching Aboriginal organisations and communities.
- Work with court users to encourage program support and feedback, particularly magistrates, solicitors and Aboriginal Client Service Specialists and Aboriginal Community Justice Groups

**Assessment and intervention framework**

Based on project findings and current evidence, an assessment and intervention framework for Aboriginal clients on the MERIT program was developed for clinicians to demonstrate the elements of best practice discussed throughout this report. Figure 4 outlines a practice framework broadly categorised into; assessment, client specific and program specific factors.

Further work is required in the areas of culturally appropriate assessment to effectively identify and assess the needs of Aboriginal clients and culturally appropriate therapeutic groups to address these needs and build skills in relevant ways. In particular, workers should be aware when assessing Aboriginal clients of communication styles, cultural heritage and norms, as well as jargon or language.

**Figure 3.**

## **Conclusion**

There were a number of MERIT teams that had been previously identified as having higher levels of Aboriginal participation and program completion, in some cases completion rates greater than for non-Aboriginal clients. This indicates that the MERIT program can be appropriate for Aboriginal people, and the project identified a range of strategies that were shown to improve MERIT program completion by Aboriginal participants. It is recommended that where there are lower Aboriginal participation and completion rates, and higher rates of Aboriginal court attendance, MERIT teams consider strategies such as identifying barriers and improving knowledge and skills of MERIT staff to work with Aboriginal clients, families and communities.

While there is significant variation in the way the MERIT program is delivered across NSW due in part to organisational, operational and demographic differences, it was demonstrated that Aboriginal people are more likely to remain on the MERIT program if they have adequate support from a service that can meet their therapeutic needs and overcome some of the practical hurdles such as transport and family commitments.

The degree to which service reorientation occurred in the 'intervention' sites varied from team to team. Supportive factors included a desire to improve Aboriginal participation, capacity of staff to implement identified strategies and a MERIT program manager who is available to focus on program improvement, partnerships and program promotion.

The importance of Aboriginal people's genuine participation in the program design, delivery, monitoring and evaluation was recognised as integral to improving health and sentencing outcomes for Aboriginal clients. Working in partnership with Aboriginal health workers and organisations was found to benefit both parties. MERIT staff reported improved skills, confidence and capacity to work in more culturally appropriate ways, improved communication and increased referral pathways. Aboriginal health and court staff reported improved program awareness, trust and transparency resulting in increased access and support for Aboriginal offenders to both the MERIT program and community based options.

In response to identified needs, the project developed resources and tools to assist MERIT teams work toward culturally safe service provision, develop or strengthen relationships with key Aboriginal community workers and organisations and raise program awareness among eligible people. MERIT teams involved reported positively on training and resources.

A small increase in Aboriginal participation in non-intervention teams was encouraging. A focus on Aboriginal participation through funding the project may have contributed to this improvement through consultations, resource development, general training, information exchange and raising program awareness across the state.

Broadening the eligibility criteria to include alcohol and minor violent offences would increase access to the program for Aboriginal offenders who may benefit from treatment. Providing intensive case management for clients with multiple and complex needs including social and emotional wellbeing would improve Aboriginal participation and outcomes.

Further work is required to develop case management skills for working within the context of family and community. With kinship and relationships core to Aboriginal culture, strengthening the client's relationships with social and emotional support is essential for sustainable outcomes. It is crucial to acknowledge that Aboriginal people are best placed to understand the entrenched social and economic marginalisation associated with alcohol and

other drug misuse among Aboriginal people which may be linked to dispossession, oppression and loss of family and culture. Treatment must address multiple needs, requiring holistic and well-resourced strategies to address the underlying social determinants of Aboriginal ill-health. To be successful, interventions should be developed in consultation with and include the local Aboriginal community.

The model presented in this report and evidence of its successful implementation supports further transference to MERIT teams and potentially other diversion programs across NSW. Based on evaluations of the MERIT program, it is reasonable to assume program modifications will reduce drug use and drug-related crime and improve health outcomes and social functioning of Aboriginal people who complete the program. Further benefits may extend to the partners, families and communities in which the individual lives. Additionally, improved sentencing outcomes which better reflect the rehabilitation prospects for MERIT participants may significantly reduce associated costs through reduced involvement in the criminal justice system and improve community safety.

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## **Appendix A**

### **Steering Committee Members**

Jude Page, Aboriginal Health & Medical Research Council

Colin Phillips, Aboriginal Health & Medical Research Council

Bruce Flaherty Manager NSW Attorney General's Department

Karen Patterson, NSW Attorney General's Department (2008)

Jonathan Clark, NSW Attorney General's Department (2007-2008)

Terry Chenery, Aboriginal Justice Advisory Council

Sam Joseph, Aboriginal Justice Advisory Council (2007-2008)

Linda Crawford, Aboriginal Justice Advisory Council (2008)

Tanya Merinda, Network of Alcohol and other Drugs Agencies (2007)

Heidi Becker, Network of Alcohol and other Drugs Agencies (2008)

John Haydock NSW Health

Jamie Key, SESIAHS NSW Health

Elizabeth Haines SSWAHS NSW Health (2008)

Angela Keating WSAHS NSW Health

Stephen Ward, SSWAHS NSW Health (2007)

## **Appendix B**

### **Consultations**

#### **Improving Aboriginal Participation in the Magistrates Early Referral Into Treatment (MERIT) Program**

This interview framework is intended *as a guide* only.

Not everyone will be able to answer all questions, and some will be explored in greater depth than others, depending on the local situation.

The consultant would like to have *a flexible, informal conversation* around the key issues/questions rather than going through them by rote.

#### **Confidentiality:**

*In the report of the project, **individuals will not be identified**.* However, the *information* provided *will* be used in the report. Generally it will be analysed with all the other data collected, for instance to identify *common themes and findings* across an Area Health Service, or across NSW.

Occasionally, in the report, a direct quote may be used from the interviews, but the person speaking will **not** be identified.

The consultant may use case studies of initiatives that are proving particularly successful or are of value to others. In this case, the description used will be checked with the responsible person.

The framework we propose is to ask questions about -

- What is happening now?
- What are the gaps and issues?
- What needs to happen in the future?

- in relation to eligible Aboriginal people accessing and completing the MERIT program.

Key areas to be explored include:

- resources and support provided to MERIT teams to improve Aboriginal access to MERIT;
- ways of working (such as partnerships with Aboriginal communities and agencies);
- the capacity of MERIT teams to make improvements; and
- assessment of the effectiveness of interventions.

**Contact details**

If at any time you need information about the project please contact the project officer;

Jude Page    Tel. 02 9212 4777 Mob: 0439987954

Email [jpage@ahmrc.org.au](mailto:jpage@ahmrc.org.au).

**ABORIGINAL COMMUNITY CONTROLLED HEALTH SERVICES**

**A) CEO, Board members, elders**

1. What is your experience or knowledge of Aboriginal people with demonstrable drug problems and treatment for their drugs problem?
2. How big a problem do you feel drug use and associated crime is in Aboriginal communities in this locality?
3. What do you think about what is being done for these people through the MERIT program? Is it working?
4. What is the AMS/ACCHS able to do to help?
5. Are there things the AMS would like to be able to do but can't at the moment? Why? What needs to happen for the AMS to do more?
6. What would be your advice to the MERIT program to encourage eligible Aboriginal people to come to the services and complete the program?

What about getting information to people who may benefit from MERIT but may not know about it – what is the best way to do this?

**B) Aboriginal Health staff, community members and Aboriginal community controlled services**

1. **How do you see your role?** For example is it mainly counseling, case management, outreach, or coordination of other services? **Are you able to support MERIT clients within your role? If so, in what way?**
1. **Briefly, what are your views about the extent to which Aboriginal people in your area are *accessing and completing* the MERIT program now?** Do you think people are being offered the program? Are they interested? Are they completing the program? Why?

2. What are your views **about what *factors* might be important in increasing access to MERIT and Aboriginal people graduating from the MERIT program?** For example, outreach, community partnerships, knowledge & perception of the program.
2. What do you see as the main *barriers* to access, or *gaps* in **improving access and retention on the MERIT program?**
3. What are your views **about what *factors* might be important in increasing access to MERIT by the target group?** For example, community partnerships, perception of the program, outreach.
4. **What can you do in your role to help?**
5. Would you like to talk about **any initiatives, services or programs that are *working well (or have in the past)* in terms of increasing access for Aboriginal people with drug problems?** (If so – would it be a useful case study for the project report, of interest to others? NB: Arrange to obtain more detailed information; check if any written documentation is available).
6. **Are there things you would *like to be able to do but can't* at the moment?** Why? What needs to happen for more to be done?
7. **Alcohol and other drug Workers only: What *resources and support are available to you in your role*** (eg mentoring/supervision, peer support, support from other workers, funds/infrastructure, links to related areas such as mental health, health promotion, skills transfer, training, education materials appropriate to the client group, networking opportunities). Are there *gaps* – if so, what are they?
8. What about getting ***information to people who are eligible for the MERIT program*** – what is the best way to do this? Is there anything needing to change in the Area to improve the way this happens – if so, what specifically?
9. Are there *other important issues* you would like to raise?



**Aboriginal Drug & Alcohol Network (ADAN) Leadership Group Consultation**

***Access to MERIT***

3. Briefly, what are **your views about the extent to which Aboriginal people in your area are *accessing and completing* the MERIT program now?** Do you think people are being offered the program? Are they interested? Are they completing the program? Why?
4. What are your views **about what *factors* might be important in increasing access to MERIT and Aboriginal people graduating from the MERIT program?** For example, outreach, community partnerships, knowledge & perception of the program.
5. Would you like to talk about **any initiatives, partnerships or programs that are *working well* in terms of increasing access to MERIT and retaining clients on the program?** (or have worked well in the past). If so – would it be a useful case study for the project report or of interest to others?
6. What do you think **needs to happen *in the future* to address these barriers to access and staying on the program,** and in what specific areas? Would you like to make suggestions?
7. What about getting ***information* to people who are eligible for the MERIT program** – what is the best way to do this? Is there anything needing to change to improve the way this happens – if so, what specifically?
8. **What can you do in your role to help?**

***Client confidentiality and data***

9. Do you think there is enough ***client confidentiality in your local MERIT, if not what needs to be done differently?***

***Other issues***

10. Are there any ***other issues*** you would like to raise?

**AHS STAFF WITH MANAGEMENT OR CO-ORDINATION RESPONSIBILITIES, MERIT STAFF AND ALCOHOL AND OTHER DRUG WORKERS**

***Overall Area approach and service provision***

1. **What overall approach or strategy does the AHS have in relation to Aboriginal people with Drug problems?** What key *partnerships* are important (at the broader/Area level)? What relevant policy/planning documents. (managers only)

***Access***

2. What are your views about **the extent to which illicit drugs are affecting Aboriginal people in this Area? Which drugs?** What is the basis for those views (eg data, anecdotal information)?
3. What are your views **about the extent to which people in the target group are accessing the MERIT program now?** How are clients being referred? Are some MERIT teams being accessed more than others – if so, which ones? Any ideas about what *factors* might be important in increasing access and completion of MERIT?
4. Would you like to talk about **any initiatives, partnerships or programs that are working well in terms of increasing access to MERIT and retaining clients on the program?** (or have worked well in the past). If so – would it be a useful case study for the project report, of interest to others? (NB: Arrange to obtain more detailed information; check if any written documentation is available).
5. What do you see as **the main gaps or barriers to access and retaining Aboriginal clients on the MERIT program?**
6. What do you think **needs to happen in the future to address these barriers to access and retention**, and in what specific areas?
7. Do you think local **MERIT programs have the capacity to address these barriers to access?** Why?

***Aboriginal Health Workers***

8. How do you see **the contribution of Aboriginal Health Workers in supporting MERIT teams? Are Aboriginal Workers available to support MERIT?** (eg mentoring, skills transfer, peer support, training, education appropriate to the client group, networking opportunities).

***Client confidentiality***

9. How is ethical implementation of Area-wide policy/practice about maintaining client confidentiality ensured? Are there particular issues in relation to Aboriginal people?

***Effectiveness***

10. Is there any Area-wide approach to monitoring or evaluating the *effectiveness* of A&OD services, interventions or programs for Aboriginal people? If so, can we discuss?

***Other issues***

11. Are there any other issues you would like to raise?

## **Appendix C**

### **Training Agenda**

#### **Improving the way we work with Aboriginal clients on MERIT**

Association of Children's Welfare Agencies

Haymarket

Level 4

699 George St (corner Ultimo Rd)

Sydney NSW 2000 [View Map](#)

#### **Friday 14 March 2008 9.00 – 4.30**

This is a one day workshop looking at how MERIT teams can improve the way they contact and interact with Aboriginal clients and organisations. Aboriginal communities and organisations have developed a strong feeling to the way in which agencies deal with them. Unless agencies make this initial contact in a culturally sensitive and appropriate way the individual, community or organisation can be closed to their approaches. Often this can even be to the detriment of the person or community itself. This workshop is designed to offer practical strategies to increase access for Aboriginal clients to participate in the MERIT program and complete the program. It will also assist in ways to make contact with Aboriginal clients and organisations and how to develop trust in your agency. In turn this will lead to agencies having better access to cultural skills of members of the communities and more support for clients. Through open and frank discussions participants can gain understanding of how to become culturally and effectively involved in Aboriginal clients and organisations.

#### **Who should attend?**

MERIT case managers/managers

#### **Agenda**

9.30 Introductions and housekeeping

9.45 MERIT Questionnaire and discussion

10.00 What is culture? What is important in your culture?

10.15 Aboriginal culture – what do you know about it?

- myths, differences, strengths

11.00 Break

11.20 Developing trust and rapport

11.40 Body language

12.00 Aboriginal view of Health (Holistic Health)

12.30 Barriers to participating in MERIT

1.00 Lunch

1.40 Developing, maintaining and valuing partnerships with Aboriginal organisations 2.30  
Aboriginal community Justice Groups and circle court

3.00 Strong spirit strong mind DVD

3.40 Discussion; what might you do differently?

4.00 Questions, wrap and evaluation

Facilitators: Jude Page and Tony Ryan

Attendees: 12

Evaluation: 100% very good to excellent