

MERIT Evaluation Report

Impact of MERIT, an alcohol and other drug
diversion program, on health services utilisation

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1. Executive summary

1.1 Purpose

The aim of this project was to assess if the frequency of health service utilisation is different between people referred to MERIT¹ from 2012–2017 compared to their matched controls.

This project builds on findings of an evaluation by Weatherburn et al. (2025) [1] suggesting MERIT participants access health services earlier with significantly fewer deaths compared to their matched controls.

This report, using the same cohort as Weatherburn et al. (2025) [1], presents and compares the frequency of recorded health service use of NSW Ambulance, Emergency Departments (ED), and NSW hospitals over two years of follow-up between people referred to MERIT and their matched controls. It also examines differences between the two groups in the number of alcohol and other drug (AOD) related ED presentations and hospital admissions, high acuity ED presentations, and total length of hospital stay.

1.2 Methods

Using linked administrative health and justice datasets², descriptive and comparative analyses were conducted. Negative binomial regression was performed to assess differences in health service utilisation and total length of stay among people referred to MERIT and their matched controls.

¹ MERIT originally stood for Magistrates Early Referral Into Treatment. Following legislation introduced in September 2025, NSW Local Court Magistrates will be officially referred to as “Judges.” To maintain name continuity for this long-standing program, the MERIT Steering Committee decided to retain the abbreviation MERIT without spelling it out.

² MERIT Information Management System (MIMS), NSW Emergency Department Data Collection (EDDC), NSW Ambulance Computerised Automated Dispatch (CAD), NSW Ambulance Emergency Medical Record (EMR) and Patient Healthcare Record (PHCR), NSW Admitted Patient Data Collection (APDC), NSW Minimum Data Set for Drug and Alcohol Treatment Services (MDS DATS), NSW Controlled Drugs Data Collection (CoDDaC), NSW Registry of Births, Deaths, and Marriages (RBDM)

1.3 Findings

Results suggests that people referred to MERIT have higher rates of ambulance callouts, unplanned ED presentations, and hospitalisations compared to their matched controls. AOD-related ED presentations and hospitalisations were also higher among those referred to MERIT. However, the frequency of high acuity ED presentations was same between people referred to MERIT and their matched controls, and length of hospital stay was significantly lower among people referred to the MERIT program.

1.4 Conclusions

Increased health service utilisation with decreased length of hospital stay among people referred to MERIT supports the assumption that AOD treatment within MERIT may be addressing barriers to health service utilisation. While the findings from this analysis provides insights into health service use, more refined outcome measures are needed to capture the impact of MERIT on health outcomes.

2. Background

2.1. What is MERIT?

MERIT is a 12-week voluntary, pre-plea diversion program for adults aged 18 years or older appearing in New South Wales (NSW) Local Courts who have issues related to alcohol and other drug (AOD) use [2]. Operating since 2000, MERIT aims to intervene in the interplay between AOD use and criminal conduct by addressing health and social welfare issues while court matters are adjourned [2]. Services to support people within MERIT include counselling, case management, referral to other specialist AOD services such as residential rehabilitation, withdrawal management, and opioid agonist treatment, and to social welfare support services where needed [3-6]. MERIT is delivered as an interagency partnership between NSW Health, the Department of Communities and Justice (DCJ), NSW Police, Legal Aid, and the Aboriginal Legal Service. Currently, MERIT is available in 81 Local Courts. Through expansion, the program is expected to be available in 89 Local Courts to reach approximately 93% of eligible defendants in NSW by the end of 2026 [7].

2.2 Evaluation of MERIT

Despite variations in methodological approaches and exposure definition, program-wide MERIT evaluations conducted to date unequivocally indicate that MERIT is associated with reduction in recidivism [1, 3, 8, 9] and lower rates of imprisonment [1, 9].

With many of the MERIT evaluations focusing on justice outcomes, the evidence remains limited for effect of MERIT on health outcomes.

A 2007 health outcome evaluation of MERIT [10] indicated that MERIT completion is associated with considerable reduction in psychological distress levels and improvement in quality of life as measured by SF-36 scores [11]. The study also indicated reduction in frequency and intensity of drug use for most drugs. These outcomes were measured at the time of program exit and only for those who completed the program and agreed for an exit interview. Although this study indicated differential MERIT completion rates by Aboriginality, primary drug of concern, and housing status,

these results are subject to selection bias. Furthermore, the study did not assess evidence of sustained health benefits beyond the program period.

A large-scale evaluation of the MERIT program by Weatherburn et al. (2025) [1] assessed justice and health outcomes for people referred to MERIT and their matched controls for a two-year follow-up period. The findings of reduced reoffending and imprisonment were broadly similar to justice outcomes reported in earlier evaluations. Health outcomes assessed were AOD-related hospital admissions, AOD-related Emergency Department (ED) admissions, ED admissions (general), hospital admissions (general), ambulance callouts, AOD-related deaths, and deaths from any cause. The findings suggest substantial reduction in all-cause mortality among MERIT participants compared to matched controls. For all outcomes related to health service utilisation, people referred to MERIT had higher rates compared to their matched controls.

2.3 Rationale for this project

Weatherburn et al. (2025) [1], offers two plausible explanations for the paradoxical finding of increased health service interaction, yet fewer deaths: 1) possibility of selection bias, and 2) experience of AOD treatment within the MERIT program, which may have increased the likelihood of higher health service use. While the second explanation is supported by other studies, it warrants further research and possibly requires refinement of outcome measures.

3. Research purpose

This project builds on the findings of a MERIT evaluation by Weatherburn et al. (2025) [1] indicating increased health service use and fewer deaths among MERIT participants compared to their matched controls. Weatherburn et al. (2025) [1] assessed health service utilisation as the time to first evidence of service use, using Cox regression analysis. We use the same cohort as Weatherburn et al (2025) to expand this analysis, and aim to compare the frequency of recorded health service use of NSW Ambulance, Emergency Departments (ED), and NSW hospitals over two years of follow-up between MERIT participants and their matched controls. This study also examines differences in the two groups for the number of AOD-related ED presentations and hospital admissions, high acuity ED presentations, and total length of hospital stay.

3.2 Research objectives

To assess differences between people referred to MERIT and their matched controls in:

1. Number of unplanned ambulance callouts, ED presentations, and hospital admissions in follow up period of 12 and 24 months.
2. Number of high acuity unplanned ED presentations in the follow up period of 24 months.
3. Total length of stay in the hospital in the follow up period of 24 months.

4. Methodology

4.1 Study design and study cohort

This is a retrospective cohort study. It builds on the previous MERIT evaluation by Weatherburn et al. (2025) [1] and utilises the same 11,232 matched pairs of observations obtained using Propensity Score Matching (PSM); one which was referred to MERIT and the other, though eligible for MERIT, not referred to MERIT. Matching was performed on demographic characteristics, justice variables, AOD-related ED and hospital admissions and non-AOD related ED and hospital admissions. Further information on methodology can be found in the original publication [1].

As in the parent study by Weatherburn et al. (2025) [1], follow-up period commenced at the date of referral for the MERIT group and from the date of case finalisation for the comparison group. This is considered as the index date. For individuals (N = 188) who died within two years of index date, the follow-up time was censored at date of death.

4.2 Exposure of interest

The exposure group consisted of defendants appearing in the NSW Local Courts between 2012 and 2017 who met the eligibility criteria and were referred to MERIT called the MERIT group. The controls were defendants appearing in the NSW Local Courts between 2012 and 2017 who met the eligibility criteria but were not referred to the MERIT program called the control group.

4.3 Outcomes

The following outcomes were assessed:

1. **Ambulance callouts:** Number of ambulance callouts in 12 and 24 months of follow-up period in the linked NSW Ambulance dataset.

2. **Unplanned ED presentations:** Number of unplanned ED presentations in 12 and 24 months of follow-up period in the linked Emergency Department Data Collection (EDDC).
3. **AOD-related ED presentations:** Number of AOD-related unplanned ED presentations in 24 months of follow-up period using EDDC.
4. **Hospital admissions:** Number of hospital admissions in 12 and 24 months of follow-up period in the Admitted Patients Data Collection (APDC).
5. **AOD-related hospital admissions:** Number of AOD-related hospital admissions in 24 months of follow-up period.
6. **High acuity ED presentations:** Number of ED presentations with triage category classification of 'Resuscitation' or 'Emergency' or 'Urgent' in 24 months of follow-up in the EDDC.
7. **Total Length of Stay (LoS) in hospital:** Days in hospital within the follow-up time of 24 months using APDC.

Data sources and details of outcome coding criteria are described in the parent study [1].

4.4 Analysis

Data analysis was performed using RStudio version 4.4.1 [12].

From the 11,232 matched pairs, observations in the MERIT group indicating not eligible for MERIT were excluded. To address multiple court appearances in MERIT and control groups, maximum bipartite matching was utilised with the following objectives:

1. Retain the earliest court appearance in the MERIT group;
2. MERIT group matched to control group without replacement;
3. Retain maximum number of matched pairs.

This resulted in 9,561 matched pairs, where a person was referred to MERIT and 9,561 court appearances of comparable people not referred to MERIT (19,122 total).

Distribution of outcome variables for the overall study cohort as well as by exposure group was assessed.

For ambulance callouts, unplanned ED presentations, and hospital admission, a negative binomial regression model was fitted for 12 and 24 months. For high acuity ED presentations and hospital LoS, negative binomial regression was performed on matched pairs with evidence of at least one ED presentation and hospital admission respectively in 24 months of follow-up period.

Several sensitivity analyses were performed adjusting for:

- 1) Variable follow-up time: To account for differences in follow-up duration due to people dying during the follow-up period (N=188);
- 2) Zero inflation: To account for proportion of people who had no evidence of ED presentation, hospitalisation, or ambulance callout during the follow up;
- 3) Clustering effect due to matching: To account for correlation between matched pairs.

4.5 Ethics approval

The research and use of linked data for this study was approved by the NSW Population and Health Services Research Ethics Committee (REF No. 2021/ETH00616).

5. Results

All outcomes were count variables and highly skewed. A large proportion of people had no evidence of ambulance callouts, unplanned ED presentation, or hospital admission during the follow-up time. Distribution of these variables are presented as range and median with interquartile ranges.

5.1 Ambulance callouts

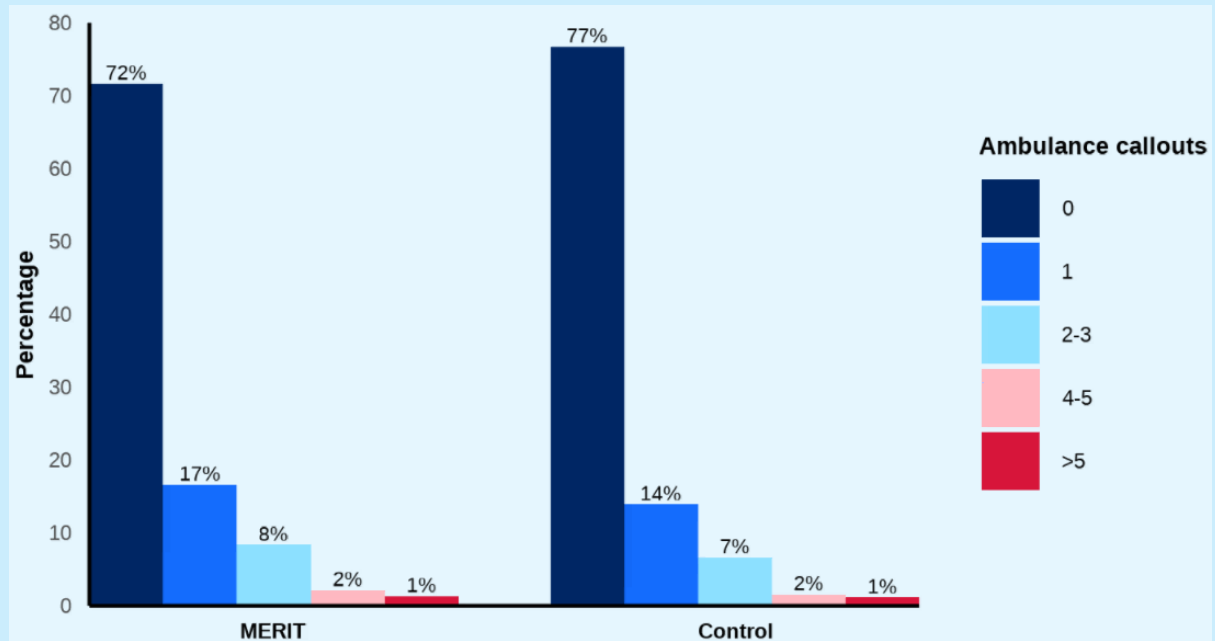
Overall, about three quarters (74%) of the cohort did not have evidence of ambulance callouts in 12 months from index date; this reduced to 63% in 24 months from index date. Among people who had evidence of at least one ambulance callout, most had between 1-3 callouts. Only 3% and less than 7% of the cohort had evidence of 4 or more ambulance callouts in 12 and 24 months respectively (Table 1)

Table 1: Distribution of Ambulance callouts in 12 and 24 months from index date (N = 19,122)

	Ambulance callouts	
	12 months	24 months
Range	0–52	0–66
Median (IQR)	0 (0–1)	0 (0–1)
Counts (%)		
0	74	63
1	15	19
2-3	7.5	12
4-5	1.8	3.5
>5	1.2	3.3

Distribution of ambulance callouts by MERIT referral status had a similar pattern as the overall ambulance callout distribution. About 72% of people in MERIT and 77% in the control group had no evidence of any ambulance callouts in 12 months from index date. This reduced to 60% and 66% in 24 months from index date. Figure 1 shows the distribution of ambulance callouts by exposure status.

A) 12 months



B) 24 months

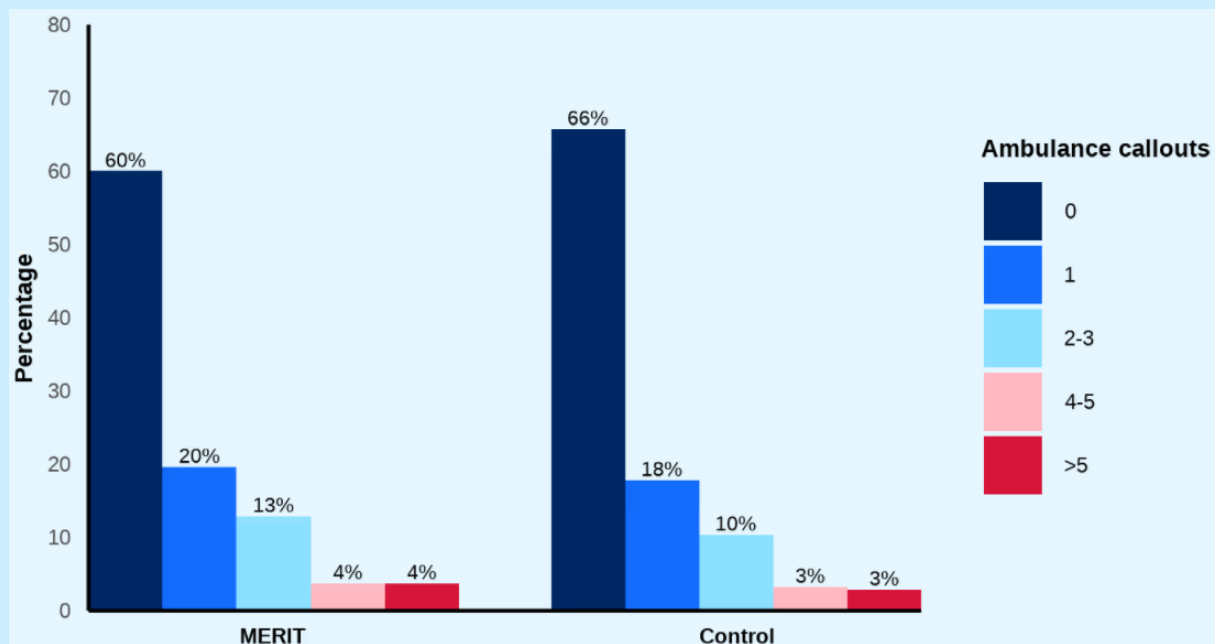


Figure 1: Distribution of Ambulance callouts in A) 12 months and B) 24 months from index date by exposure status

Negative binomial regression to assess if the number of ambulance callouts differed with respect to MERIT referral status suggests that the MERIT group had 18% higher rate of ambulance callouts compared to matched controls in 12 and 24 months (Table 5).

5.2 Unplanned ED presentations

More than half the cohort (53%) had no evidence of unplanned ED presentation in 12 months from index date. This reduced to 37% in 24 months. Among people who had evidence of at least one unplanned ED presentation, the majority had 1–3 presentations. However, unlike ambulance callouts, 9.3% of the cohort had 4 or more presentations to ED in the 12 month follow up period which increased to more than 20% in 24 months.

There were 7,782 observations with 3,891 pairs who had at least one ED presentation in the 24 months following index date. Among them, 85% did not have any ED presentation related to AOD and 32% had no high acuity ED presentation in 24 months from the index date.

Table 2 presents the descriptive statistics of unplanned ED presentations for the overall cohort.

Table 2: Distribution of cohort outcomes related to unplanned ED presentations

	ED presentation		AOD-related ED presentation*	High acuity ED presentation*
	12 months	24 months	24 months	24 months
	N = 19,122	N = 19,122	N = 7,782	N = 7,782
Range	0–52	0–66	0–20	0–73
Median (IQR)	0 (0–1)	0 (0–1)	0(0–0)	1(0–2)
Counts (%)				
0	53	37	85	32
1	21	21	11	32
2–3	17	22	3.1	23
4–5	5.2	9.3	0.7	6.4
>5	4.1	11	0.5	5.7

*For matched pairs with evidence of at least one unplanned ED presentation in 24 months

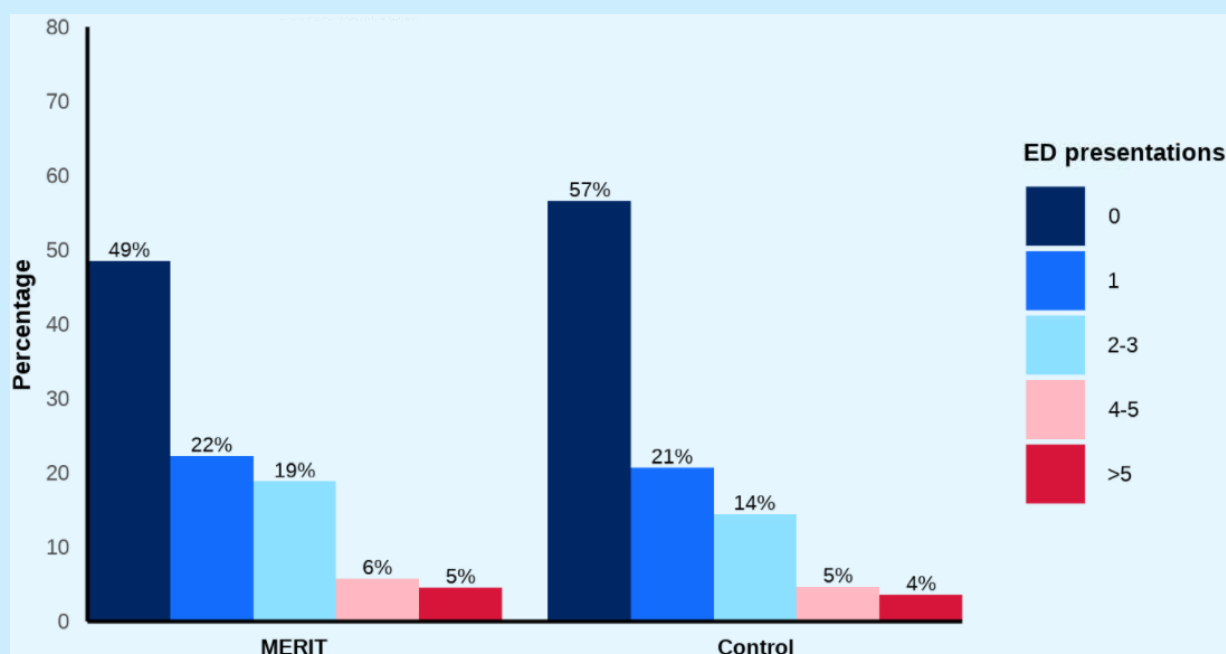
Similar to the overall pattern, 49% of people referred to MERIT and 57% in the control group had no evidence of unplanned ED presentation in 12 months. This reduced to 33% and 41% in 24 months. Figure 2 shows the distribution of ED presentations by exposure status.

Only 16% of individuals in MERIT with evidence of at least one ED presentation in 24 months of follow-up had an AOD-related presentation. The corresponding percentage for the control group was 13% (Figure 3A).

For high acuity ED presentations among matched pairs of people with at least one unplanned ED presentation in 24 months, both MERIT and control groups had 32% of people with no high acuity ED presentation. Frequency distribution between MERIT and control groups were similar for all other categories of high acuity ED presentation (Figure 3B).

Similar to ambulance callouts, unplanned ED presentation rates in 12 and 24 months were significantly higher in the MERIT group compared the control group (IRR_{ed-12} : 1.20 [95% CI: 1.14–1.26]) and (IRR_{ed-24} : 1.17 [95% CI: 1.12–1.22]). AOD-related ED presentations were also significantly higher among the MERIT group compared to the control group (IRR_{aod-ed} : 1.25 [95% CI: 1.09–1.44]). However, high acuity ED presentations were not significantly different between the MERIT and control groups (Table 5).

A) 12 months



B) 24 months

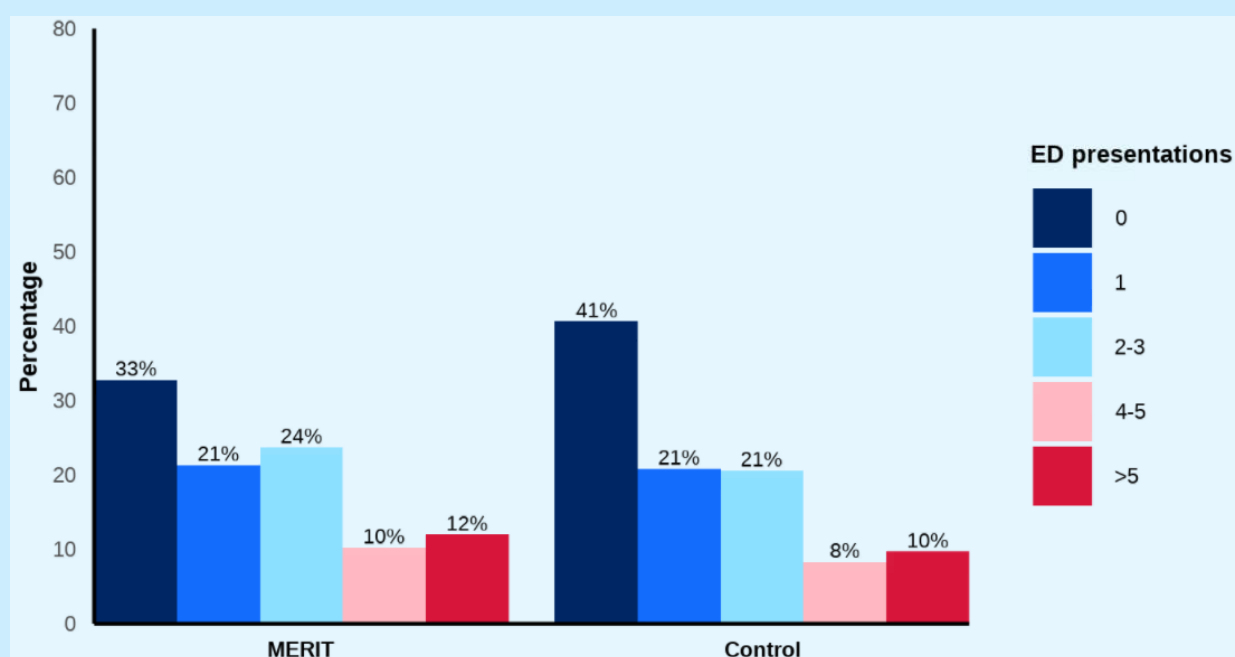
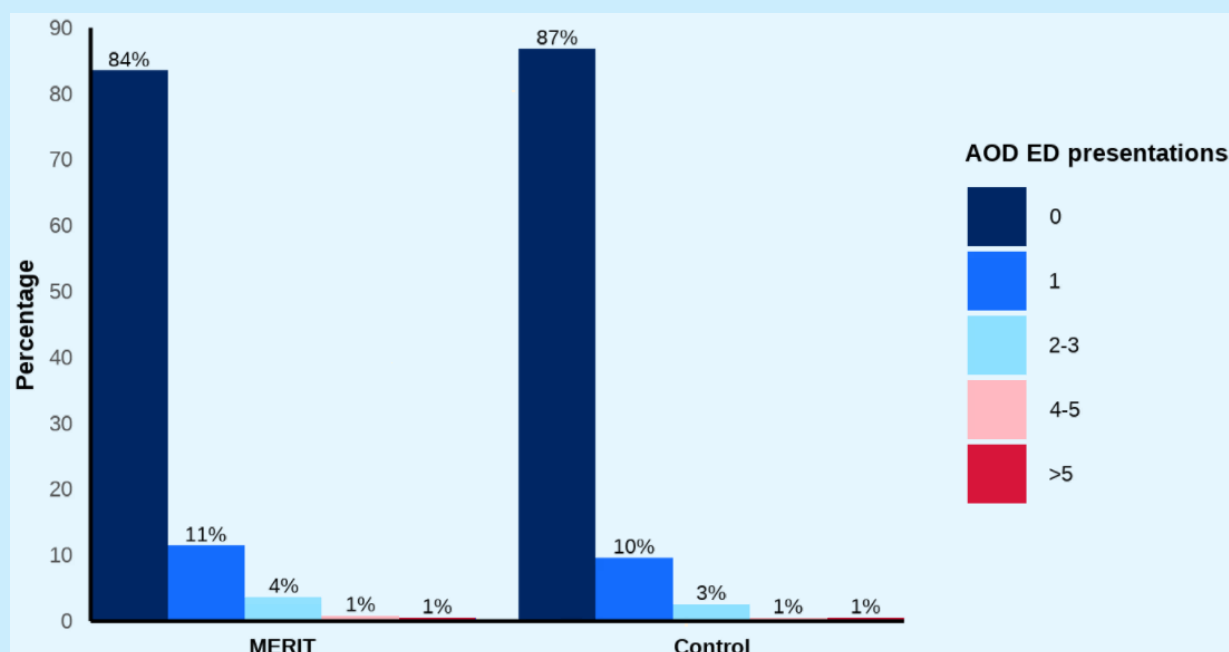


Figure 2: Distribution of unplanned emergency department presentations in A) 12 months and B) 24 months from index date by exposure status

A) Alcohol and/or other drug (AOD) related Emergency department (ED) presentations



B) High acuity ED presentations

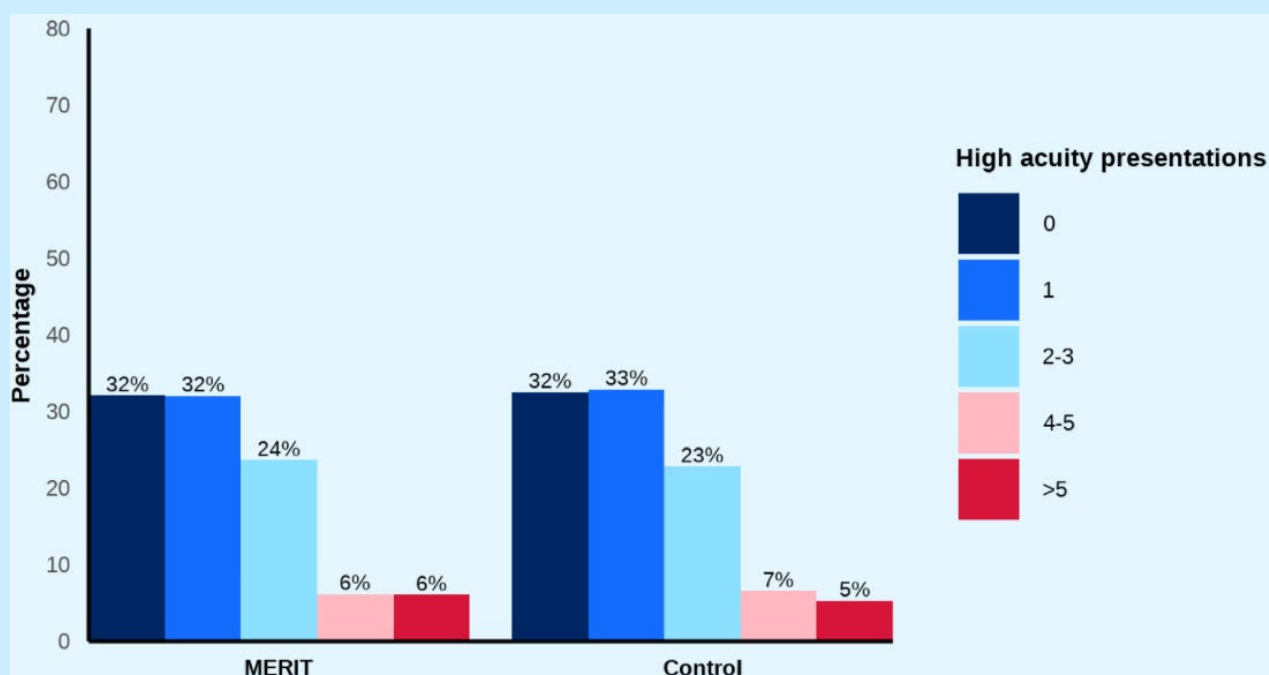


Figure 3: Distribution of A) Alcohol &/or other drug related, and B) High acuity ED presentations in 24 months from index date by exposure status among matched pairs who had at least one ED presentation

5.3 Hospital admissions

Three quarters of the cohort had no hospitalisation in the 12 months of follow-up, reducing to 63% in 24 months. Among people who had at least one hospital admission, the majority had 1–3 admissions. About 2% and less than 6% of the cohort had evidence of 4 or more hospital admissions in 12 and 24 months respectively.

There were 2,682 observations with 1,341 pairs who had at least one hospital admission in 24 months following index date. Among them, 44% had no AOD-related hospitalisations; 32% had at least one AOD-related hospitalisation; another 16% had 2–3 AOD-related admissions; and 8.1% had 4 or more AOD-related hospital admissions (Table 3).

Table 3: Distribution of hospital admissions and AOD-related hospitalisations from index date

	Hospital admissions		AOD-related hospital admissions*
	12 months	24 months	24 months
	N = 19,122	N = 19,122	N = 2682
Range	0–52	0–66	0–31
Median (IQR)	0 (0–1)	0 (0–1)	0(0–1)
Counts (%)			
0	75	63	44
1	15	19	32
2-3	7.4	12	16
4-5	1.3	3.2	4.7
>5	0.8	2.3	3.4

*For matched pairs with evidence of at least one hospitalisation in 24 months

Among matched pairs with at least one hospital admission in the 24 months from the index date, 41% had a hospital stay of 2–7 days. One fifth (21%) had a hospital stay of 8–28 days and about 13% had a hospital stay of more than 28 days (Table 4).

Table 4: Distribution Length of hospital Stay (LoS) in 24 months from the index date

	Length of hospital stay*
	N = 2682
Range	1-458
Median (IQR)	4(2–11)
Counts (%)	
Overnight admission (LoS = 1)	25
Week- long stay (LoS = 2–7 days)	41
Month-long stay (LoS = 8-28 days)	21
Hospital stay of more than a month (LoS >28 days)	13

*For matched pairs with evidence of at least one hospitalisation in 24 months

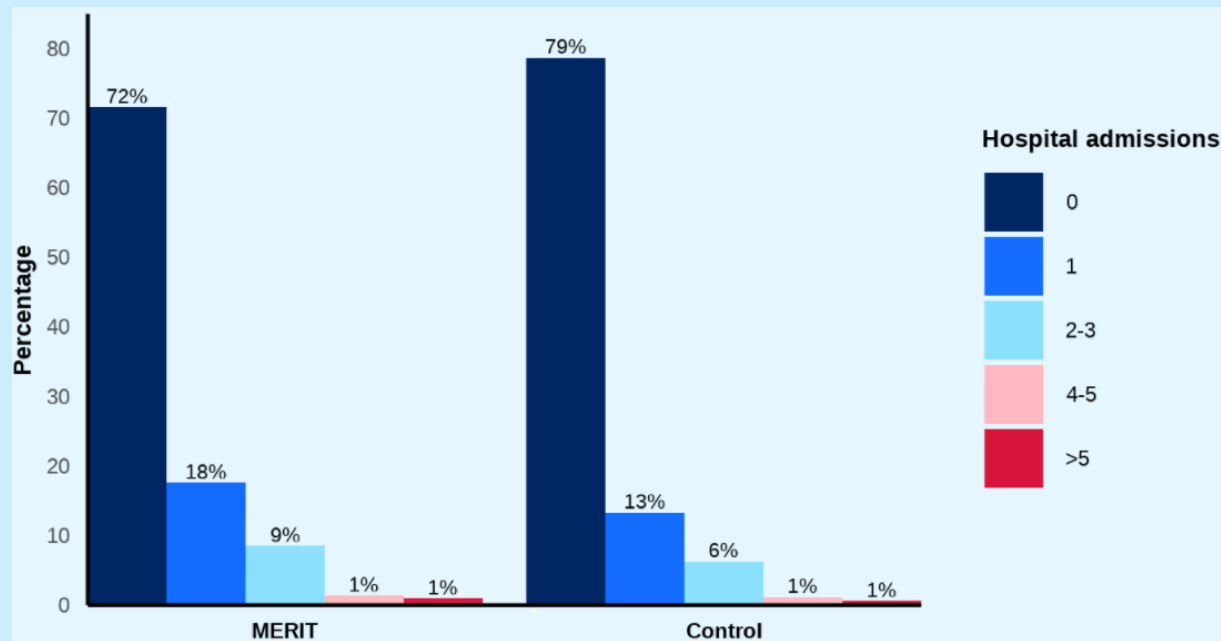
Similar to the overall pattern, 72% of people referred to MERIT and 79% in the control group had no evidence of hospital admission in 12 months from the index date. This reduced to 59% for MERIT and 67% for control in 24 months. Figure 4 shows the distribution of any hospitalisations by treatment status.

About 36% of people referred to MERIT with evidence of at least one hospitalisation in 24 months of follow-up had an AOD-related presentation, compared with 29% in the control group (Figure 5A). For LoS among matched pairs with at least one hospitalisation in 24 months of follow-up, 23% in MERIT

and 26% in control groups had an overnight admission. Frequency distribution between MERIT and control groups is presented in Figure 5B.

Similar to other outcomes, rates of hospitalisations and AOD-related hospitalisations were significantly higher among people referred to MERIT compared to controls. However, negative binomial regression indicates strong evidence that length of stay is 16% [95% CI: 7%–24%] shorter among the MERIT group compared to their matched controls (IRR_{los}: 0.84 [95% CI: 0.76–0.93]) (Table 5).

A) 12 months



B) 24 months

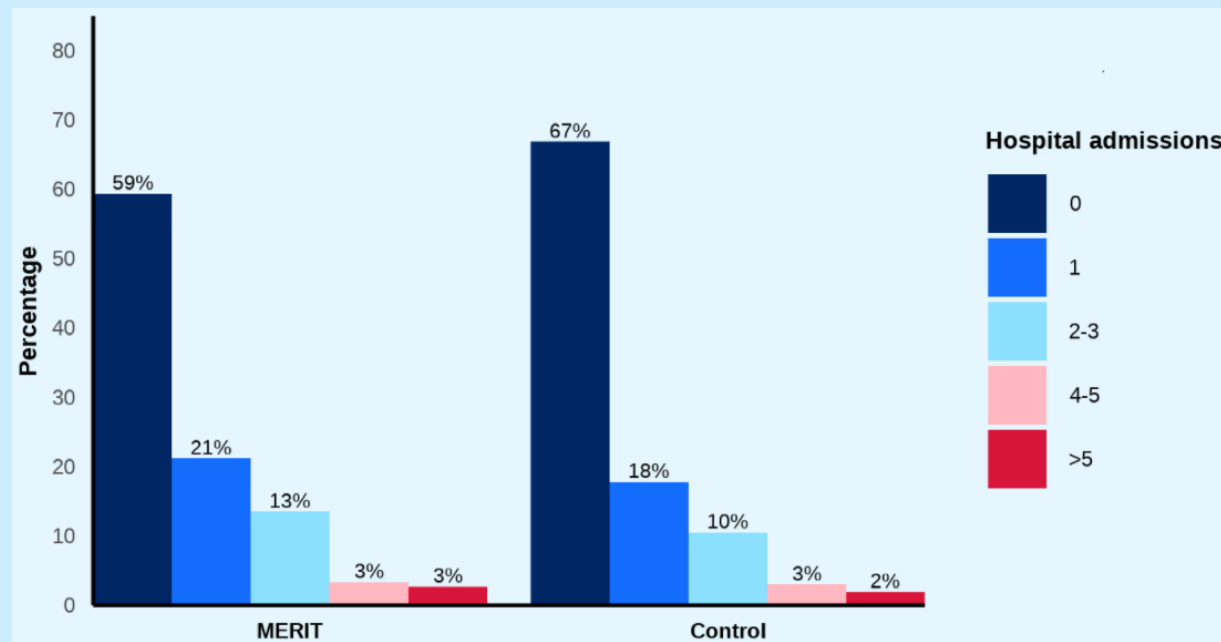
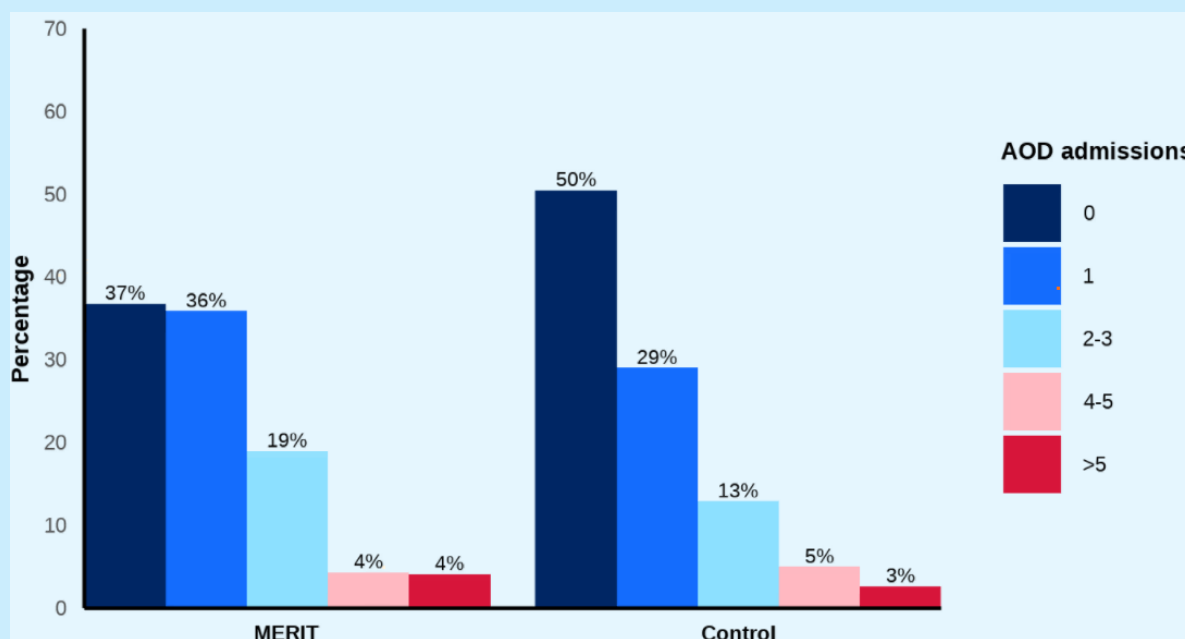


Figure 4: Distribution of hospital admissions in A) 12 months and B) 24 months from index date by exposure status

A) Alcohol and/or other drug (AOD) related hospital admissions



B) Length of hospital stay

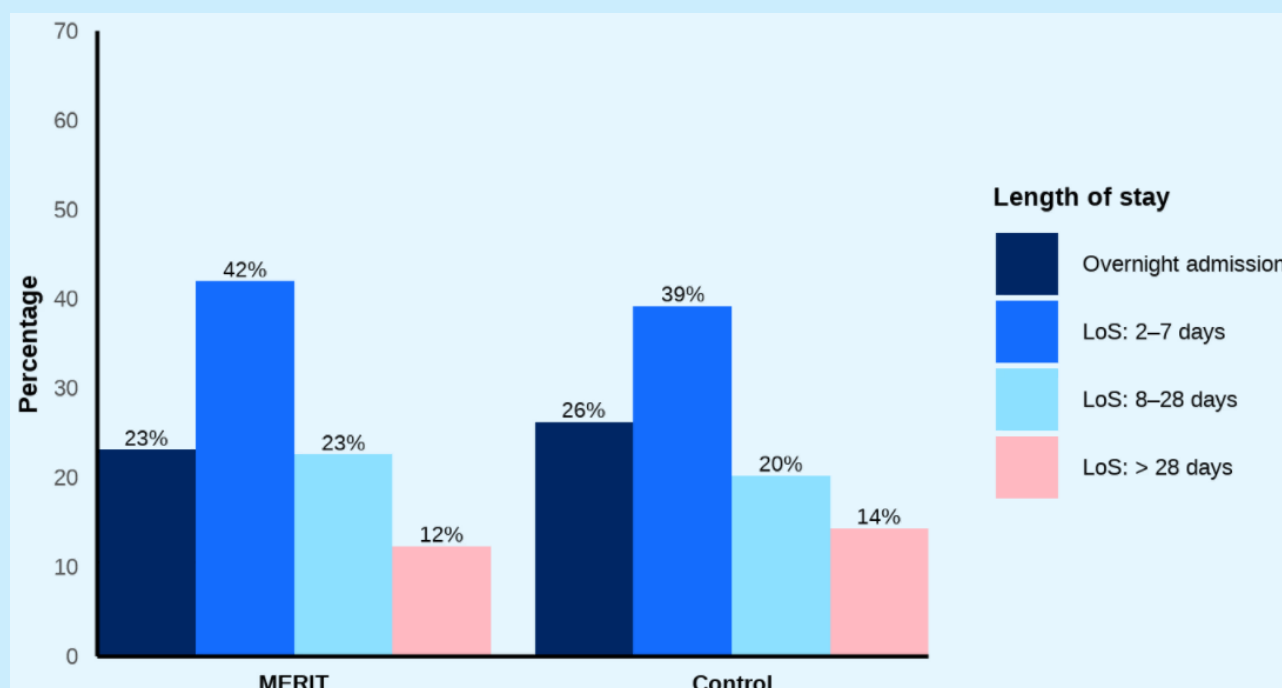


Figure 5: Distribution of A) Alcohol &/or other drug related hospital admissions, and B) Length of hospital stay in 24 months from index date by MERIT referral status among matched pairs who had at least one hospital admission

Table 5: Incident rate ratios from negative binomial regression analysis for people referred to MERIT compared to matched controls

Outcome	Point estimate	95% CI	p-value	N (no. of people)
Ambulance callouts				
Number of ambulance callouts in 12 months	1.18	(1.10–1.26)	< 0.001	19,122
Number of ambulance callouts in 24 months	1.18	(1.12–1.25)	< 0.001	19,122
ED presentations				
Number of ED presentations in 12 months	1.20	(1.14–1.26)	< 0.001	19,122
Number of ED presentations in 24 months	1.17	(1.12–1.22)	< 0.001	19,122
Number of AOD ED presentations (24 months) *	1.25	(1.09–1.44)	0.001	7,782
Number of high acuity ED presentations (24 months) *	1.01	(0.96–1.07)	0.667	7,782
Hospital Admissions				
Number of hospital admissions in 12 months	1.38	(1.30–1.48)	< 0.001	19,122
Number of hospital admissions in 24 months	1.33	(1.26–1.41)	< 0.001	19,122
Number of AOD-related hospital admissions (24 months) ^	1.35	(1.21–1.50)	< 0.001	2,682
Length of hospital stay (24 months) ^	0.84	(0.76–0.93)	0.001	2,682

*For matched pairs with evidence of at least one unplanned ED presentation in 24 months.

^For matched pairs with evidence of at least one hospital admission in 24 months

Note: A total of N=188 (0.95%) of cohort died within the follow-up period. Differential follow-up period has not been adjusted in the results.

6. Discussion

6.1 Key findings

The findings suggest that people referred to MERIT experienced higher rates of ambulance callouts, unplanned ED presentations, and hospitalisations compared to matched controls. These results are consistent with a previous evaluation of MERIT (1). AOD-related ED presentations and hospitalisations are also higher among the MERIT group.

There was no difference between the MERIT and control groups in the frequency of high-acuity ED presentations. In addition, length of hospital stay was significantly shorter for people referred to MERIT. These findings indicate that while people referred to MERIT have substantial utilisation of acute health services, this use is not associated with high acuity presentations and shorter stay for hospital admissions.

When considered alongside previous findings of reduced all-cause mortality among MERIT participants (1), these results may suggest better long-term health outcomes for people referred to MERIT.

6.2 Interpretation of health service utilisation

Higher level of health service utilisation was observed among people referred to MERIT despite matching on prior health service use. Similar patterns have been reported previously, with the authors proposing that once people have received AOD treatment they are more likely to seek it again (1).

People with AOD-related issues commonly experience barriers to accessing healthcare, including stigma and previous negative experiences with health services [13], which may delay or even prevent people from seeking support. However, there is emerging evidence that engagement with AOD treatment may reduce stigma and through treatment people may receive encouragement, knowledge and skills that facilitate future use of health services [14, 15].

People with AOD-related issues are known to use acute health services at substantially higher rates than the general population [16, 17]. In this context, increased engagement with health services following referral to MERIT should not be interpreted as reduced program effectiveness. Rather, it may reflect reduced barriers to healthcare access for a population at high risk of adverse health

outcomes. However, this study is unable to determine whether increased health service utilisation reflects unmet needs, improved help-seeking behaviour, or ongoing barriers to accessing appropriate community-based care.

6.3 Understanding the role of case management and program completion

Case management is a core component of the MERIT program and is intended to support care coordination and linkage to health and social care services [5]. The higher level of acute health service utilisation observed in this study following referral to MERIT reinforces the importance of this role.

This analysis included all people referred to MERIT, regardless of whether they commenced or completed the program. Program data indicate that approximately 70% of people referred to MERIT commence the program, and around 70% of those complete the program [2]. Treatment completion within MERIT may be linked to better connections to health and social care as transfer of care is concluded at program completion. As AOD treatment completion is also associated with improved health and social outcomes [18] it would be of interest to understand the difference between people who complete and did not complete the program on the patterns of health service utilisation and long-term health outcomes.

6.4 Limitations

There are several limitations that should be considered while interpreting the results of this report:

1. Possible selection bias when creating the cohort and matched pairs from choice of matching algorithm and variables included in the analysis.
2. Possibility of residual confounding due to unknown and unmeasured factors.
3. While the analyses indicate increased health service utilisation among people referred to MERIT, it cannot explain the possible reasons for this increased health service use without further investigation into client experiences with the program.
4. The study did not assess use of primary health services such as general practitioners. Pattern of health service utilisation among MERIT and control groups for primary care may be different compared to ambulance callouts, ED presentation and hospital admission as assessed in this report.
5. The study could not capture use and access to community health services or AOD services offered by non-governmental organisations or private providers.
6. While use of health service is an important indicator of engagement with the system, it may not be the most meaningful outcome for people with alcohol and drug use concerns. Broader outcomes such as quality of life, social connection, and general wellbeing are not captured in this report.

7. Policy and service planning implications

7.1 Support for the importance of MERIT in NSW

The findings of this study further support MERIT as an important component of the NSW Health and criminal justice systems. Evidence of shorter hospital stays and reduced risk of mortality [1], alongside demonstrated reductions in short-term reoffending and imprisonment [1] and favourable cost-effectiveness compared with traditional court processes [19], indicates that MERIT delivers benefits across health, justice, and economic systems.

These findings align with current statewide policies and support the expansion of MERIT across NSW.

7.2 Reinforcing the role of case management

The high level of health service utilisation among people referred to MERIT compared to their matched controls, reinforces the importance of assertive case management, an integral component of the MERIT program. Early identification of health and social needs, proactive linkage to community-based services, and timely transfer of care may reduce reliance on acute health services. Reinforcing the role of case management should be communicated to MERIT clinicians through forums such as the MERIT Community of Practice, the MERIT Model of Care guidance, and broader NSW Health AOD governance structures.

7.3 Ongoing reporting of MERIT program outcomes

The NSW Health Alcohol and Other Drugs Outcomes Register (AoDOR) is a source of linked data, including health service utilisation and mortality data for people accessing AOD services in NSW. This may be a tool in further understanding the impact of MERIT on health outcomes. Although the MERIT program has not significantly changed since program commencement in 2000, there are ongoing policy, social and substance use pattern changes in the community. Continued use of the AoDOR to measure MERIT outcomes will allow assessment of trends on health service utilisation and mortality, supporting continuous program improvement.

7.4 Equity considerations

This study did not examine health service utilisation by individual subgroups, so it is unknown whether the benefits of the MERIT program are equal across different populations. One priority group within both NSW health and justice systems are Aboriginal people, as they experience disproportionately high levels of AOD-related harm and poorer health outcomes.

We were unable to investigate outcomes by Aboriginality, as approval to report this information from the Aboriginal Health and Medical Research Council was not obtained. Future research examining health service utilisation patterns among Aboriginal people referred to MERIT is essential to support equity, inform culturally appropriate service delivery, and ensure that the program meets the needs of Aboriginal participants. This work should be undertaken in partnership with Aboriginal governance bodies and communities.

8. Suggestions for Future Research

Future research opportunities, including options to strengthen the current project, are:

1. To reduce residual confounding in the current analysis, comorbidities and mental health conditions can be included in the matching process when creating matched MERIT and control groups.
2. Assessing the effect of MERIT on potentially preventable and unplanned hospitalisations.
3. Qualitative research examining the perspectives of MERIT participants and program staff to provide insight into help-seeking behaviour, service experiences, and perceived barriers and enablers to care.
4. As MERIT program completion may be linked to better health outcomes and linkage to care, it would be useful to understand the difference between MERIT program completers and non-completers on health service utilisation.
5. Reporting of research findings by Aboriginal status to assess effect of MERIT on this priority population.

9. References

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