ATODA
Alcohol Tobacco & Other Drug Association ACT

The ACT Adult Drug and Alcohol Court
Legislation, Policy and Programs Branch
Justice and Community Safety Directorate
By email to jacslpp@act.gov.au

Re: Supreme Court consultation concerning its document 'A Drug and Alcohol Court for the ACT: issues and draft proposals for consultation'

Dear Colleagues

Thank you for inviting us to participate in this consultation.

The Alcohol Tobacco and Other Drug Association ACT (ATODA) is the peak body for the alcohol, tobacco and other drug (ATOD) sector in the ACT. It seeks to promote health and enhance community well-being through preventing and reducing alcohol-, tobacco- and other drug-related harms.

1. Overarching considerations

We point out that ATODA, and some of our member organisations that provide specialist AOD services to the ACT community, have been fully involved, in partnership with the Justice and Community Safety Directorate, ACT Health and the UNSW Drug Policy Modelling Program, among others, in developing the proposed ACT Drug and Alcohol Court (DAC), and will continue to do so.

This is because we hold the strong view that a pre-requisite for the DAC to be successful (in whatever ways 'success' will be defined) is that it operates as an integral part of the ACT specialist alcohol and other drug service system, rather than operate parallel to it within the justice sector. It will need to be carefully integrated into the rest of the ACT's alcohol and other drug offender diversion system.

We also point out that the justice sector ('corrections' and 'diversion', combined) is currently—prior to the establishment of the DAC—a leading source of referrals to the ACT specialist AOD services: in 2015-16, 30% of referrals came from that source, second only to self-referrals (47%).[1]

[1] Australian Institute of Health and Welfare 2017, *Alcohol and other drug treatment National Minimum Data Set (AODTS NMDS 2015–16)*, AIHW, Supplementary Data Table SC-Clients-states-and-territories.

Problematically, the justice system, despite being the source of such a high proportion of treatment referrals, does not meet the costs of the treatment for the people they refer. This is a form of cost-shifting both within the ACT public service and from the ACT Government to the Commonwealth Government.

These justice referrals are being made to specialist AOD services in the health system that cannot currently meet demand and have waiting lists. ATODA has long advocated for coherence for the planning, funding and delivery of specialist AOD services in the ACT – including across the health and justice systems.

ATODA is concerned that it appears that our involvement in the DAC development process is scheduled to conclude at the end of 2017 – with no known consultation or engagement processes into 2018. We believe, however, that ATODA and others will need to be actively involved well after that date to assist the developers of the DAC to fully understand the ACT's specialist AOD service system into which the DAC will be inserted and to mitigate against unintended consequences (e.g. AOD treatment places for the broader community being reduced).

2. Drug and alcohol courts generally

ATODA is aware of the large volume of research conducted into DACs, and related specialist courts, including the USA and Australian evaluations. We note the oft-cited findings of the Campbell Collaboration systematic review of the topic that concluded:

> *The findings most strongly support the effectiveness of adult drug courts, as even the most rigorous evaluations consistently find reductions in recidivism and these effects generally persist for at least three years. The magnitude of this effect is analogous to a drop in general and drug-related recidivism from 50% for non-participants to approximately 38% for participants.*[2]

On that basis we are generally supportive of the drug court approach, but are aware that many DACs fail to live up to these promises, delivering wasteful and/or negative outcomes. ATODA is aware that the ACT's DAC has the potential to create serious adverse impacts on the ACT's specialist AOD service sector. Based on experiences in other jurisdictions, it is likely that the Court will be an expensive initiative, meaning that careful attention needs to be given to the opportunity costs involved, and to the potential adverse impacts on the rest of the specialist AOD service system. In addition, although economic evaluations may well show that the Court will not be cost-effective, other evaluation models, if implemented well, may identify non-financial positive outcomes of the Court, including enhanced well-being of its participants.

3. The ACT specialist AOD service system

ATODA reminds the Supreme Court Working Group that the ACT AOD specialist service sector is coherent, mapped, and operates as an integrated system with sound partnerships between the sector's government and non-government agencies.

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[2] Mitchell, O, Wilson, DB, Eggers, A & MacKenzie, DL 2012, 'Effects of drug courts on criminal offending and drug use', *Campbell Systematic Reviews*, vol. 2012:4.
And see Mitchell, O, Wilson, DB, Eggers, A & MacKenzie, DL 2012, 'Assessing the effectiveness of drug courts on recidivism: a meta-analytic review of traditional and non-traditional drug courts', *Journal of Criminal Justice*, vol. 40, no. 1, pp. 60-71.

With respect to ACT treatment resources, the current treatment system is full. There is no excess capacity. This means that, if the DAC wants to have its clients treated in either the government or NGO specialist AOD services, it will have to ensure that additional treatment capacity is created and funded. The key principle is, we suggest, the need for a net increase in treatment system capacity so as to be able to adequately service the DAC treatment clients along with those sourced from elsewhere.

In this context, we note for example that Court Alcohol and Drug Assessment Service (CADAS) is struggling to meet current demand. This is a significant impediment to facilitating justice system diversion at present, meaning that CADAS and other specialist AOD services that operate in the justice system cannot be relied upon to support the DAC unless it is specifically resourced to do so.

Another important principle is to maintain the clinical integrity of specialist AOD services - i.e. to place the focus on the treatment needs of the DAC client, rather than on the needs of the justice system for, for example, compliance with the conditions of the SSO/Drug Treatment Order.

The many references to 'abstinence' in the Issues Paper highlight this point, as in contemporary approaches to drug treatment abstinence is sometimes, but importantly not always, the key objective. **It is frequently the case that reducing the harms experienced by AOD-involved offenders is more important than abstinence *per se*.** The many cultural differences that exist between the justice, corrections and ATOD systems - including different goals - need systematic attention in the DAC's development.

Also important is that the DAC operates on the basis of the core principles of ATOD treatment, with the aims of reducing the use of psychoactive substances, reducing harms relating to that use and to societal responses thereto, and increasing the health and well-being of treatment clients and their significant others. Additional key principles underlying ATOD treatment have been promulgated by the US National Institute on Drug Abuse.[3]

In this context, we note the many references to compliance monitoring in the Issues Paper. We see potential problems with this framing and prefer one that focuses on treatment progress rather than compliance monitoring.

ATODA notes that the maximum length that an offender can be supported through the DAC is two years. A person's treatment, continuing care and subsequent 'rehabilitaton', however, can be much longer than that, particularly when we take into account the fact that substance use disorders are typically chronic and relapsing in nature. We suggest that the next version of the Issues Paper deals specifically with the concept of continuing care, including how the DAC will assist clients in accessing support when their Drug Treatment Orders expire.

ATODA would also like to see a discussion, in the next version of the Issues Paper, about the DAC's priority population groups (if any), as we are aware that drug courts in some other jurisdictions fast-track members of some population groups. We are concerned about the ethical considerations in this approach, considering the limited treatment resources that the ACT has in the alcohol and other drugs field. For example, if certain population groups are given priority for resourcing through the DAC, what will be the implications for people seeking treatment on a self-referral basis from the community at large?

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[3] National Institute on Drug Abuse (USA) 2012, *Principles of drug addiction treatment: a research-based guide*, 3rd edn, NIH Publication no. 12–4180, NIDA, Washington, DC, http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment .

4. DAC governance

ATODA suggests that the DAC will benefit from having a reference or steering group, with wide membership, to support and advise it. The importance of this is highlighted by the composition of the Supreme Court Working Group that has drafted the Issues Paper. We see it as problematic that all the members of the Working Group are either members of the Supreme Court or of the ACT public service. Considering the importance, in the ACT ATOD sector, of the non-government treatment and harm reduction agencies, the failure to have them represented on the Working Group has probably limited the Working Group's understandings of the community sector's crucial contributions to ATOD treatment in the ACT.

We are fortunate in the ACT that the peak – ATODA – works with, across and represents both government and non-government specialist AOD services. In this sense we extend our networks to the DAC to ensure it has access to the essential stakeholders it needs.

We were pleased to see a broad representation of specialist AOD services and others at the UNSW Drug Policy Modelling Program consultation on 16 October.

5. The DAC's monitoring and evaluation strategy

ATODA is working closely with the DPMP consultants who are preparing the monitoring and evaluation (M&E) strategy for the DAC. In our view, it will be important that that strategy includes both formative and summative evaluations. We emphasise, however, that it will be quite some years before a summative evaluation that focuses on client outcomes (such as recidivism rates) will be feasible. In the interim, what will probably be required is a continuous flow of evaluative information from the outset, along with governance arrangements to interrogate and respond to that information in a timely manner. The Court will need flexibility to respond to the monitoring data and the findings of the formative evaluation. This flexibility, along with a commitment to use the information flowing from the M&E strategy, should be built into the funding and governance arrangements from the outset.

It will also be important that the DPMP consultants document, in collaboration with stakeholders, the program theory[4] underpinning the DAC, in addition to drafting a program logic statement which we understand is part of their terms of reference. This is because of the point made above: it is likely that people involved in the DAC, coming from diverse disciplinary backgrounds, have potentially conflicting understandings and assumptions about the aetiology of AOD-related offending, and of the causal pathways involved in assisting offenders to improve their well-being, including reducing the incidence of re-offending. Until consensus on this program theory is reached, it is unlikely that it will be possible to develop a widely-acceptable program logic statement.

We note the very short timeframes for DPMP to undertake it consultancy and suggest that additional stakeholder engagement processes are undertaken in 2018.

[4] Funnell, SC & Rogers, PJ 2011, *Purposeful program theory: effective use of theories of change and logic models*, Jossey-Bass, San Francisco, CA.

6. Goals and assumptions

Section 7 of the Issues Paper deals with the 'Purpose of the Drug and Alcohol Court'. There it sets out three aims and sensibly indicates that 'The legislation should provide for priority to be given to rehabilitation and protection of the community as purposes of sentencing when a drug treatment order is being considered'.

We hope that the work that the DPMP consultants are currently doing will clarify the appropriateness of the aim to 'reduce drug dependency of eligible offenders'. This is because there are a range of drug-related harms that AOD-involved offenders experience, and these go far beyond drug dependence.

The second aim focuses upon 'the reintegration of eligible offenders into the community', among other things. Again, work is required to operationalise this as it is unclear what it means. What is meant here by 're-integration'? What 'community' is being referred to?

The third aim includes 'reducing the need for drug dependent people to resort to offending behaviour'. Careful attention needs to be placed on what we know from criminological research about alcohol and other drug use and harms, on the one hand, and criminal careers on the other. The implication here that drug dependence causes offending behaviour is only partially supported by the research literature, as bidirectional relationships exist between these two constructs.[5]

ATODA notes the first paragraph of the Issues Paper which points out that the Parliamentary Agreement includes 'a goal to reduce recidivism by 25% by 2025'. This is a problematic component of the Agreement, one which needs to be carefully operationalised. Some of the questions that need answering, but upon which the current version of the Issues Paper is silent, include the following:

- Which of the many definitions of 'recidivism' is to be used, including self-reported offending compared with offending detected by the justice system? And does 'recidivism' refer here specifically to repeat criminal offending, or to problematic drug use relapse as well?
- What is the base year for the 25% reduction in recidivism by 2025?
- Does the 25% reduction refer to the offending behaviour of identified individuals, or to recidivism at the population level?
- If it refers to individuals, does it refer to those deemed eligible for the DAC, those who enter the DAC program, those who complete the DAC program, others?

7. Other matters

In this final section of the submission, we draw attention to some other matters that are relevant to the contents of the Issues Paper.

- ATODA is pleased to note that Section 16, which covers sanctions, acknowledges that 'Sanctions should be "swift, certain and fair"', and that elsewhere in the Issues Paper reference is made to the South Dakota 24/7 Sobriety and the Hawaii HOPE Probation programs that are largely based on this principle. It seems clear, however, that the legislative and procedural approach outlined in the Issues Paper are unlikely to meet the criteria of swift and certain. ATODA urges the Working Group to review the likely timelines involved from the point where an AOD-involved offender comes to

[5] Teasdale, B & Bradley, MS (eds) 2017, *Preventing crime and violence*, Advances in Prevention Science, Springer Berlin Heidelberg, New York, NY.

attention of police, and the point where they start to receive support through the DAC.

- Working Group members will be aware of the extensive research being conducted both in Australia and abroad into the smart use of technology in dealing with offenders. This includes the Australian research into 'technological incarceration',[6] and the widespread use of this approach in the diverse 24/7 Sobriety approaches used in the USA. It is suggested that these options be carefully considered for the ACT's DAC.

- ATODA suggests that the next version of the Issues Paper include a commitment to ensuring that all treatment plans ordered under the DTO include smoking cessation. This is because the AOD treatment outcomes of improved health and well-being are swamped by the morbidity and premature mortality caused by tobacco smoking if this is not addressed concomitantly.

- DAC information systems should not constitute an un-funded, additional burden on the ACT's specialist ATOD treatment agencies. The DAC information systems should be integrated into the existing ATOD treatment information systems, including the National Minimum Data Set.[7]

- Finally, consent is mentioned briefly on page 26 of the Issues Paper. ATODA suggests, however, that this matter receive considerably greater prominence in the next version. It is a core principle of ATOD treatment that service users consent to all aspects of their treatment. It would be highly problematic if one component of the ACT's drug treatment system, the DAC, took a different approach, one which many would consider unethical.

Thank you again for the opportunity to respond to the Issues Paper. As stated above, ATODA is supportive of the principle of the DAC and is keen to continue to assist those responsible for its development to ensure that this occurs in a way that produces the optimal outcomes for DAC clients and the community - without producing any unintended but potentially predictable adverse outcomes for the ACT's specialist AOD treatment and harm reduction service system.

Yours faithfully

Carrie Fowlie
Chief Executive Officer
Alcohol Tobacco and Other Drug Association ACT (ATODA)
carrie@atoda.org.au
www.atoda.org.au

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[6] Bagaric, M, Hunter, D & Wolf, G 2017, 'Technological incarceration and the end of the prison crisis', *Journal of Criminal Law and Criminology*, vol. 108, no. 1.
[7] https://www.aihw.gov.au/reports-statistics/health-welfare-services/alcohol-other-drug-treatment-services/overview