

Compulsory treatment in Australia

14

ANCD research paper



Compulsory treatment in Australia

a discussion paper on the
compulsory treatment of
individuals dependent on
alcohol and/or other drugs

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Executive summary

Compulsory treatment refers to alcohol and other drug treatment that has a mandate based in legislation and/or government-implemented programs. It refers to a wide range of programs and levels of coercion, from diversion into optional treatment, through to court-ordered treatment where the individual has no choice, such as civil commitment and treatment imposed as part of a sentencing order.

This discussion paper presents a national perspective of the current operation of compulsory alcohol and/or other drug (AOD) treatment, within the context of existing research evidence, ethical considerations and international practice. It is intended to inform ongoing debate on the place of compulsory treatment in Australia. Particular areas of interest are the development, implementation and effectiveness of drug diversion and civil commitment practices.

The key questions addressed by the paper are:

- What are the legislative provisions for commitment of offending and non-offending individuals into treatment in Australia?
- What is current professional practice in Australia in the area of compulsory treatment for AOD issues?
- What is the Australian and worldwide research evidence on compulsory treatment of offending and non-offending individuals for AOD dependence?
- Is there a place for compulsory treatment in Australia? If so, what are the principles that should underpin compulsory treatment?

Drugs, alcohol, crime and treatment represent a huge field of inquiry, within which compulsory treatment occupies a rather specialised place. The current systems of compulsory treatment are relatively young; practices, principles and research evidence are still developing, as the key questions suggest. This paper examines the current state of affairs in Australia, and recommends a way forward.

Discussions around compulsory AOD treatment are well informed by an understanding of numerous interrelated issues from the diverse fields of politics, ethics, human rights, law and research.

The main goals of compulsory treatment are twofold: to reduce substance use and thereby improve health and overall quality of life; and to reduce current and future criminal justice involvement. Compulsory treatment programs aim to reduce economic and social costs associated with problematic AOD use: police and court time, incarceration, public health costs and so forth. From these savings, emotional and further economic benefits are expected to ensue to families and communities.

Civil commitment legislation provides for inebriates and drug-dependent persons to be detained and treated, but generally does not define the aims and expected outcomes of such action. Possible goals include short-term harm reduction, rehabilitation and protecting the interests of the individual and others.

There is much variability in the ways in which compulsory treatment is implemented internationally, with significant differences in levels of legal coercion, the point in proceedings at which it is imposed (for offenders), and in the types of individuals targeted. The evolution of models in Australia has been influenced by United States models and to some extent by those in Europe.

Australia's National Drug Strategy (NDS) aims to 'improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in Australian society'. It is complemented by State and Territory drug strategies, all of which are based on the principle of harm minimisation. Developed under the NDS, the Illicit Drug Diversion Initiative (IDDI) is a collaborative effort by the Council of Australian Governments to achieve a nationally consistent approach to pre-arrest diversion of minor illicit drug offenders into AOD assessment. Civil commitment and diversion at other stages of criminal justice proceedings are determined at the State and Territory level. Thus, there is considerable variability.

X Compulsory treatment involves, to varying degrees, an incursion on the civil liberties of individuals. Thus, considerations about the type of circumstances in which the State may appropriately be permitted to override the fundamental right of the individual to choose his/her own actions, and the form such encroachment can justifiably take, necessarily arise. Restricting the choice of offenders to either processing by the criminal justice system or undertaking treatment is commonly regarded as ethical, as is making treatment decisions for individuals who lack capacity to make decisions for themselves. Matters become less clear and more controversial for situations where individuals suffer only temporary or minimal impairment to their decision-making capacity through alcohol or other drug use, especially where they have not broken the law in any way. Is there a duty of care upon the State, and upon us as concerned and compassionate citizens, to protect the health and safety of others? When might protection of life

justify an infringement on liberty? These are difficult and emotive considerations, discussion of which must be informed by what is known about the effectiveness of proposed interventions. If a person's liberty is to be compromised, if a treatment is to be imposed on them, particularly against their will, it is essential that that intervention be of benefit. The biomedical ethical principle of 'beneficence ... requires that an action produces benefits and that its benefits outweigh its burdens'. Thus, the answers to several questions must be known and weighted: Does compulsory treatment help the individual? Does it help the community? How does compulsion impact upon the individual's motivation to engage in AOD treatment? What negative impacts does it have on the individual and/or community? The research base to inform answers to these questions, however, is young and incomplete.

Coercion is a multifaceted concept. Different methods or models of coercion operate and affect different individuals in different ways, according to their history, relationships and other life experiences. Multiple sources of coercion interplay and may not correspond in predictable ways with the outward appearance of the form and strength of the coercion. Furthermore, the experience of coercion is fluid in nature, changing over time, place and context. The ideal is for a balance to be obtained between personal autonomy, with the individual taking responsibility, and coercive intervention by the State. Drug courts, for example, are intended to be collaborative, cooperative ventures – between State and offender – that encourage practices of self-control and responsibility.

Therapeutic jurisprudence recognises that legal procedures and settings impact upon wellbeing and therefore it endeavours to be problem solving, rather than adversarial in nature. A shift toward therapeutic jurisprudence has occurred in legal systems across the world as a result of changing political, economic and social values, burgeoning prison populations and shifts in intellectual paradigms regarding rehabilitation. Therapeutic approaches to justice are being increasingly mainstreamed in Australia.

Compulsory AOD treatment requires the cooperation of agencies with traditionally different and sometimes conflicting priorities, values and attitudes. This can present a challenge to the skill sets and ethical paradigms within which the judiciary, police, lawyers, corrections workers, health care professionals and even policy makers operate. The extent to which these challenges are met, such as through training and evidence-based best-practice guidelines, impacts upon the success of and public confidence in coercive treatment programs.

There is potential for compulsory AOD treatment to produce unintended negative consequences. Current practices can result in net-widening, displacement from treatment, and discrimination against minority groups.

Diversion

Possibilities exist throughout criminal justice proceedings for offenders to be diverted into AOD treatment. Diversion occurring at the early stages of criminal proceedings (i.e. pre-arrest or pre-trial) generally involves offenders being diverted into treatment as an alternative to being processed any further

by the criminal justice system, while diversion at the later stages (i.e. pre-sentence, post-conviction and pre-release) are ‘additions’, in that the offender must still move through the justice system, while also being diverted into AOD treatment. The most common forms operating in Australia are police pre-arrest diversion schemes operating under the national Illicit Drug Diversion Initiative (IDDI) framework, pre-trial diversion schemes (e.g. MERIT or CREDIT), and drug courts (post-conviction diversion).

Many Australian diversion programs have undergone evaluation; however, methodological and conceptual weaknesses are common (e.g. inadequate follow-up times, use of self-report data unsubstantiated by other data, lack of standardised indicators and data sets) and limit the conclusions that can be drawn.

Furthermore, evidence of net-widening, displacement of voluntary clients from treatment, and indirect discrimination against minority groups (especially Indigenous Australians, females and those from culturally and linguistically diverse backgrounds) remain relevant when considering the evaluations.

Overall, it can be said that there is some evidence that investment in diversion programs has resulted in reduced crime rates and drug use for some participants and lower court and law enforcement costs in some program areas. These programs enjoy sufficient political and community support for considerable expansion in operations to have been observed over recent years. However, the weaknesses and negative outcomes noted need to be addressed for the full potential of these programs to be realised.

Civil commitment

Legislation in four Australian jurisdictions provides for involuntary commitment of non-offenders into AOD assessment and/or treatment. New South Wales, Tasmania and Victoria provide for the civil commitment of persons dependent on alcohol and/or other drugs, while legislation in the Northern Territory enables civil commitment of persons who use alcohol to excess, and compulsory treatment orders for volatile substance abusers. The New South Wales, Victorian and Tasmanian Acts were enacted at a time when confinement and abstinence were popularly understood to be best treatment for alcoholism and drug addiction. Few substantive changes have been made to the Acts over the years, bringing them into some tension with current treatment philosophy and practices. Consequently, all are presently under review.

Criticisms have been levelled at civil commitment processes on numerous grounds. The *Alcoholics and Drug-dependent Persons Act 1968* (Vic) and the *Inebriates Act 1912* (NSW) have been criticised as breaching numerous human rights: liberty; freedom from arbitrary detention; least restrictive treatment; and access to independent, transparent and accountable appeal and review processes. Thus, Australian civil commitment legislation may contravene the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, Principles for the Protection and Care of People with Mental Illness and the Improvement of Mental Health Care, as well as Victoria's Charter of Human Rights and Responsibilities.

On a practical level, both the New South Wales and Victorian Acts have been criticised as inefficient and difficult to utilise and the facilities in which persons are detained

(psychiatric hospitals in New South Wales and non-secure detoxification units in Victoria) when an order is obtained are universally agreed to be inappropriate.

A major criticism pertains to the lack of empirical evidence of effectiveness. While there is some evidence, mainly anecdotal, that civil commitment for short periods can be an effective harm reduction mechanism, there is little evidence to support its effectiveness in rehabilitating or achieving long-term behavioural change. Many argue that depriving an individual of his/her liberty cannot be ethically justified if the intervention is not known to be of benefit. For this reason, there is substantial support in Australia for a model of short-term involuntary care for the purpose of reducing serious harm (e.g. protecting the user in life-threatening situations), restoring decision-making capacity and providing an opportunity to motivate the user to continue treatment on a voluntary basis. There is considerably less support for a longer-term model aimed at rehabilitation. This is well reflected in the New South Wales Standing Committee on Social Issues' comprehensive review of the *Inebriates Act 1912* (NSW).

The Standing Committee (2004) recommended that legislation be enacted to enable short-term (7–14 days) involuntary care of people with severe dependence, for the purpose of protecting their health and safety. In the absence of evidence that civil commitment can effectively address substance dependence in the longer term, the Committee rejected a system aimed at that purpose. It recommended that the aims of short-term care be to provide medical treatment, to stabilise and assess, to restore decision-making capacity and to provide opportunity for engagement in voluntary treatment. To ensure proper use of the legislation, the Committee recommended that four essential criteria be

satisfied for a person to be committed to care: severe dependence; experience or risk of immediate harm to self; lack of capacity to consent to treatment; and existence of an initial treatment plan demonstrating that the intervention will benefit the person. Other safeguards were recommended, including a right of appeal, assessment by two medical examiners (including one addictions medicine specialist), and official visitors to monitor service provision and rights of patients. Supplementary to this framework for involuntary care, the Standing Committee recommended provision for court-ordered outpatient assessment and a non-coercive policy response for individuals with antisocial behaviour and complex needs.

Key informants interviewed in the development of this paper largely supported such a model and raised additional issues for consideration in the development of civil commitment processes. Identified areas of importance include:

- Civil commitment legislation applies to many sufferers of acquired brain injury; however, accommodation is generally the primary need of these individuals, with AOD issues being subsidiary.
- Compulsory treatment of young people does not work.
- Cross-training of mental health and AOD workers is required.
- Coordination and collaboration between voluntary services are often more effective than mandatory processes in meeting the needs of people with AOD dependence.

Key informants recommended that civil commitment processes and protocols be developed paying regard to these factors and placing in prominence the question 'What are the needs of this person?'

Project recommendations

Consideration of the key research questions posed by this project led to a series of recommendations on best practice, nationwide coordination, diversionary practices, civil commitment practices, Indigenous Australians and also on the development of the research base for compulsory treatment. These recommendations are listed below.

Principles of best practice

Compulsory treatment is unique within the broader AOD treatment domain by virtue of its legal origins and context. It involves cross-disciplinary collaboration of a distinctive nature in the treatment of a client group with particular issues associated with and leading to a legal directive to participate in treatment. It can be a controversial field of treatment, impacting as it does on conceptions and experiences of individual rights and State responsibilities.

As diversion programs grow and civil commitment legislation is reviewed, the need for practice guidelines becomes more urgent.

Recommended:

- That evidence-based practice guidelines for compulsory treatment be developed and informed by:
 - existing principles of best practice (e.g. diversion best-practice principles identified by Bull (2005); see section 2.10); principles emerging from forensic workplace training programs, such as in Victoria)
 - drug court guidelines for team members in current operation around Australia

- Alcohol and other Drugs Council of Australia (ADCA) Revised Code of Ethics and the Alcohol and Other Drugs Charter developed by the Australian National Council on Drugs (ANCD) (see section 2.11 and Appendices G and H)
- international and local human rights instruments, e.g. United Nations Principles for the Protection and Care of People with Mental Illness and the Improvement of Mental Health Care and the *Charter of Human Rights and Responsibilities Act 2006* (Vic)
- research as required
- discussions with key stakeholders.
- That processes for establishing evidence-based practice guidelines should incorporate strategies for future dissemination, promotion, development and implementation monitoring.
- That evidence-based practice guidelines be developed and implemented by extensive collaboration and cooperation between federal, State and Territory governments.

Nationwide coordination

Compulsory treatment has developed across Australia largely unguided by a specific integrated strategy. This makes for disparate systems of justice and treatment, and limits large-scale evaluation.

Recommended:

- That a national approach to compulsory treatment including policy guidelines for diversion at all stages of criminal justice proceedings and civil commitment be developed.
- That these guidelines should:
 - clearly set out the potential place of all compulsory treatment programs from police diversion, through court diversion initiatives and drug courts, to civil commitment of non-offenders
 - state the intended outcomes of compulsory treatment
 - be consistent with the mission and goals of existing initiatives, and provide a framework for clarification and revision of their objectives and procedures at a local level
 - be formulated via a systems approach, so that a range of significant factors is considered, including: issues relating to cost and structure of compulsory treatment; issues relating to the clients (e.g. family relationships, employment, accommodation); and issues relating to specific client objectives (e.g. emotional wellbeing, social functioning and social connectedness).

- That national coordination assist to:
 - maintain a centralised, integrated data monitoring system for evaluation purposes
 - conduct rigorous evaluation research in multiple areas, including the development of standardised indicators, measuring real costs and benefits of compulsory treatment, at the individual, programmatic and social levels
 - provide a clearing house for research evidence (e.g. providing information on the effectiveness of different treatment modalities; assessment tools; relevant adaptable findings from the behavioural sciences)
 - develop, disseminate, monitor and review principles of best practice
 - develop and conduct accredited education and training programs
 - facilitate dialogue between the agents of therapeutic jurisprudence, AOD treatment and other key stakeholders
 - promote community and sector awareness.

Nationwide coordination is the underpinning rationale for several of the following recommendations and provides a solid foundation for their implementation.

Diversionary practices in Australia

Diversion programs operate throughout Australia, across all stages of criminal justice proceedings. Pre-arrest and pre-trial diversion initiatives divert offenders away from the criminal justice system and into treatment as an alternative to the offender passing through conventional criminal justice proceedings, while pre-sentence, post-conviction and pre-release diversion programs see offenders diverted into treatment in addition to being dealt with by the criminal justice system.

Exclusionary criteria

Criteria for diversion operate to exclude certain groups intentionally and unintentionally.

Problematic alcohol use is rarely an admission criterion for diversion programs, and compulsory treatment for alcohol use is uncommon.

Recommended:

- That consideration be given to expanding existing diversion programs by amending eligibility criteria to include problematic/dependent¹ alcohol use.
- Alternatively, that separate initiatives be developed for the diversion of individuals with demonstrable alcohol problems, using models based on the New South Wales Rural Alcohol Diversion Pilot Program and the Northern Territory Alcohol Court (which is itself based on the MERIT model).

¹ According to the program type.

Many potential participants are excluded from diversion programs due to the ancillary violent nature of their present charges or past crimes. This exclusion particularly affects Indigenous Australians.

Recommended:

- That provisions excluding certain offenders be further examined in consultation with relevant groups, especially Aboriginals and Torres Strait Islanders.
- That if violence is retained as an excluding factor, the terms ‘violence’ and ‘violent’ be clearly defined and limited to ‘serious violent offences’.

In some jurisdictions, mental illness can render an offender unsuitable for AOD diversion; in others, AOD dependence can render an offender unsuitable for mental health diversion. There is the potential for high numbers of dually diagnosed offenders to fall between the diversion nets.

Recommended:

- That the issue of unsuitability for diversion due to mental illness be revisited and discussed, including discussion and clarification of:
 - whether AOD diversion or mental illness has primary jurisdiction for dual diagnosis clients when these two diversions operate together
 - how the courts may best sit as both a drug court and a mental health court
 - the training needs of magistrates regarding AOD and mental health issues
 - the potential establishment of general problem-solving courts with authority and resources to address multiple issues, including AOD, mental health and homelessness issues.

Eligibility to participate in court diversion programs, and thus have access to prioritised treatment, is usually dependent upon residence within the catchment area of the court. Given the incomplete coverage of drug courts throughout Australia, some offenders are excluded from court diversion by arbitrary virtue of their home address.

Recommended:

- That consideration be given to expanding court diversion programs to all jurisdictions to overcome inequality in sentencing options and thereby access to treatment options. This recommendation is contingent upon stronger evidence becoming available supporting the effectiveness of court diversion programs.

Unintended outcomes

Unintended negative consequences for some people have been observed to result from diversion into AOD treatment.

Diversion programs carry with them the risk of three forms of net-widening (examples of these phenomena have been found in programs across Australia): an increase in people who become subject to criminal justice proceedings and are thus introduced to the criminal justice system; penalties for non-compliance with a diversion order can lead to greater sanctions than would ordinarily have applied to the offence; and individuals may become enmeshed in the treatment system in addition to the criminal justice system.

Recommended:

- That systematic monitoring and evaluation be maintained, including consideration of possible net-widening.
- That guidelines to identify and minimise net-widening be developed.

In a climate where AOD treatment services available to the general community are in short supply and wait lists can be lengthy, it is arguably inappropriate and unfair to give preferential treatment to people referred via the criminal justice system. There is concern that this potential for displacement of voluntary clients creates ‘perverse incentives’ for people to access treatment via the criminal justice system.

Recommended:

- That ongoing monitoring of the demand for and the availability of treatment services in each jurisdiction be a part of the evaluation of diversion programs to avoid displacement of voluntary clients.

Teamwork and training

In recent years, Australian courts have moved towards a more therapeutic model of jurisprudence. This is evidenced by the emergence of numerous pre-trial, pre-sentence and post-conviction diversionary programs, including drug courts and Indigenous sentencing courts. Therapeutic jurisprudence involves, and requires for success, a large shift in the traditional thinking and approaches of participants in the court, health and corrections systems and of offenders themselves.

It requires different professional groups to work as a team, to understand in depth the values, policies, language and procedures of each other, and often to share tasks traditionally within a single professional domain. While knowledge and practices are evolving constantly, there is no nationally recognised training, and no systematic means for sharing learning experiences.

Recommended:

- That the specific skill development needs of professions participating in compulsory treatment programs be identified.
- That protocols that include clear articulation of lines of responsibility be available.
- That principles of best practice be developed and disseminated.
- That an ongoing, cross-disciplinary professional education and training program be developed which could include, in the curriculum: current protocols and procedures of participating professionals; standards of practice; case management strategies; confidentiality and reporting requirements; team-building strategies; offender rehabilitation strategies; the nature of drugs; and circumstances and reasons for their use.
- That a clearing house maintain information and educational materials in these areas.

Civil commitment practices in Australia

Criticisms have been levelled at Australian civil commitment legislation on numerous grounds, including that the Acts reflect an outdated treatment philosophy; lack clear articulation of intended outcomes; breach international human rights laws; are inefficient and difficult to utilise; and do not provide for appropriate detention facilities.

Recommended:

- That civil commitment legislation contain an objects section that clearly states the intended outcomes of the legislation.
- That all jurisdictions work in collaboration towards development of a nationally consistent approach to civil commitment.
- That the short-term model of involuntary care recommended by the New South Wales Standing Committee on Social Issues (2004) be used as a starting point for developing a national approach to civil commitment. Key features:
 - *Duration:* 7–14 days
 - *Target population:* persons with substance dependence who have experienced or are at risk of serious harm, and whose decision-making capacity is considered compromised
 - *Purpose:* stabilisation; comprehensive assessment; restoring decision-making capacity; linking into long-term care (e.g. guardianship); encouraging and linking into voluntary treatment system

- *Criteria:* four criteria must be met before a decision to commit a person to involuntary care can be made:
 1. severe substance dependence, as diagnosed by an internationally recognised tool such as the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM IV); substance dependence or use alone is not sufficient
 2. serious harm to self (including injury, illness and self-neglect) experienced, or immediate risk thereof
 3. lack of capacity to consent to treatment
 4. treatment plan outlining expected benefit and rationale for proposed period of involuntary care.
- *Treatment type:* detoxification in a secure medical facility.
- That alternate models of care be developed to address the needs of people with complex needs and/or antisocial behaviour. In this context, evaluative information on emerging programs to address this group's needs in South Australia and Tasmania as well as the Multiple and Complex Needs Initiative in Victoria might be informative.

Indigenous Australians and compulsory treatment

Though over-represented in the criminal justice system, the participation rates of Indigenous Australians in diversion programs at all levels are generally low.

A small number of programs have been designed especially for Indigenous offenders, and some general programs have undertaken a range of measures to increase and enhance participation of Indigenous offenders. There is some evidence that these programs can increase Indigenous participation rates; however, the number of Indigenous treatment services remains low.

Conversely, civil commitment legislation in some States is used disproportionately against Indigenous Australians. Given the punitive operation of this legislation in practice, despite its intended therapeutic purpose, this is of significant concern. This concern is heightened further when taking into account the dearth of Indigenous AOD services across the country.

Recommended:

- That programs designed specifically to meet the needs of Indigenous Australians be further developed.
- That exploration of effective processes, treatments and models for Indigenous Australians be ongoing.

Bilateral agreements between the federal government and State and Territory governments under the Council of Australian Governments (COAG) National Framework of Principles for Delivering Services to Indigenous Australians may provide a framework for this. Involvement of bodies such as the Office of Indigenous Policy Coordination (OIPC) and Indigenous Coordination Centres (ICCs)² around Australia may be appropriate for nationally consistent implementation of these recommendations.

Research evidence

Overall, there is limited empirical evidence demonstrating the effectiveness of compulsory AOD treatment.

Most evaluative work has examined diversion programs and produced results that are largely weak and inconclusive. In general, indicators have been chosen opportunistically, often because of limited funding, rather than being designed to answer specific policy-related questions. There is, however, some evidence to suggest that some people benefit from compulsory treatment. While the evidence is weak and cannot be said to strongly support the continuation of compulsory treatment programs, neither does it suggest that they are ineffective and should be discontinued. Strong evidence in either direction simply does not exist.

Australian civil commitment legislation has not been evaluated for its effectiveness in rehabilitating or achieving long-term behavioural change; nor have equivalent provisions internationally. There is, however, some evidence – mainly anecdotal – that civil commitment for short periods can be an effective harm reduction mechanism.

Though the type of research being conducted is becoming more rigorous, the effectiveness of compulsory treatment has yet to be strongly demonstrated. There are some data for Australia, but insufficient at present to give us adequate answers to the key questions: Does compulsory treatment work? To what extent? For what groups of people? And how? On the present evidence base, it can be concluded only that compulsory treatment can sometimes be effective in reducing drug use (and crime) for some people.

² ICCs look after most of the federal government's Indigenous programs and negotiate Shared Responsibility Agreements (SRAs) with local Indigenous people and communities (Australian Government, Office of Indigenous Policy Coordination, 2006).

Methodological and conceptual issues

Research in this area consistently exhibits methodological and conceptual weaknesses (e.g. short follow-up periods, inappropriate comparison groups, client motivation overlooked, lack of reliable and valid assessment tools) and these weaknesses have rendered the empirical evidence base, as a whole, largely inconclusive.

Recommended:

- That more rigorous evaluation studies be commissioned, with greater attention paid to sample sizes, comparison groups and follow-up times.
- That consideration be given to the establishment of an integrated database and monitoring system containing information from key agencies (including police, justice, corrections, legal aid and treatment providers) to enable accurate monitoring of diversion and civil commitment outcomes over time.

Standardised indicators

Evaluations of diversion programs often fail to assess program aims and objectives other than reducing recidivism and drug use. Other commonly stated, but rarely evaluated, aims include re-integration of drug-using offenders into the community, improvement of health and social functioning, and reductions in court appearances.

Those aims and objectives that are assessed are measured with a range of indicators of varying validity. Standardised indicators of diversion program outcomes are lacking, and there is no consistency in the measurement of outcomes (e.g. different time periods, detection methods and data collection procedures), such that cross-program comparisons cannot be reliably made.

Recommended:

- That standardised aims, intended outcomes and indicators be developed for and adopted by compulsory treatment programs in the following areas:
 - drug use: level of reduction in drug use expected and indicative of success; time period over which behaviour change is expected to be revealed and sustained; and different reductions for different groups of drug users
 - legal coercion: indicators of type and degree of supervision and monitoring; the role of perceived and actual coercion (legal, formal and informal); rewards and sanctions, team approaches, and the role of suspended sentencing
 - client factors: population demographics; factors determining successful uptake of programs, as well as drop-out and failure; interplay between client motivation, perceived coercion, program components and treatment characteristics
 - program processes: *how* programs 'work', focusing directly on ways to improve quality and functioning
 - recidivism: as measured by subsequent arrest, conviction or imprisonment; the extent to which re-offending is reduced; over what time periods behaviour change is expected to begin, or to be sustained; and different reductions to be expected for different groups of offenders
 - cost-effectiveness: taking into account criminal justice and health care costs and savings; costs of running the drug court, treating and monitoring offenders, imposing sanctions; savings in court time, prison costs, health care, emergency department presentations; other costs and savings.

Types of treatment

Compulsory referral into treatment leads to interventions ranging from residential detoxification, to opiate substitution, to individual counselling, brief education sessions and even meditation classes for lesser forms of dependence. At the same time, very little empirical investigation has been conducted into the relationship between legal coercion and type of treatment. It is not known which aspects of different treatment types (e.g. quality, length, intensity, philosophy) affect outcomes for this client group and the sub-groups within it, nor about the interplay of client factors such as individual client motivation and social support.

Recommended:

- That greater effort be required to build the knowledge base regarding compulsory treatment. This includes collection and analysis of data regarding the nature of treatment(s) that offenders are referred to (such as residential rehabilitation, cognitive behavioural therapies, 12-step self-help groups, therapeutic communities) and subsequent evaluation research to examine: which types of treatment hold the most promise for being effective and cost-effective, and for which groups; the interplay between client motivation, perceived coercion, client characteristics, program components and treatment characteristics; and which models and treatments do magistrates and providers believe to be effective.
- That the treatment experiences of individuals subject to civil commitment orders be researched.

Program provision and processes

Currently, there is a lack of information about how compulsory treatment programs in Australia work, and how they can work better. Such programs are at a stage where more research is needed to develop them in a manner that allows an appropriately empathic response that can also be effective.

Recommended:

- That indicators be developed:
 - to measure the nature, capacity, quality and functioning of programs toward the identification of standards of best practice
 - to help identify those components of program structures and management that are most/least important and how they can be improved.

Identifying factors associated with program graduation

There is some evidence that completion of, or 'graduation' from, a diversion program, especially a drug court program, is associated in Australia with reductions in both recidivism and drug use. Some research has been conducted in Australia to identify predictors of drug court program compliance and termination; however, data are limited.

Recommended:

- That research be accelerated to identify risk factors for diversion program termination or withdrawal, including: type, level and history of AOD dependency and treatment; family and social support networks; accommodation and employment status; and imprisonment history. Questions to be answered include: For which populations do programs work/fail, and why? How can graduation rates be improved? Which types of treatment work best with which clients?

- That a validated ‘early risk assessment tool’ be developed, based on factors for non-graduation, to identify offenders with low probability of diversion program completion. Such an instrument could be used in the early phases of a diversion program, and potentially post-program as well.
- That offenders identified with a low probability of program graduation be given more intensive, targeted support and/or supervision to assist them to graduate.
- That any proposal to exclude those with a low probability of program completion be considered for adoption only if informed by extensive research and supported by a viable alternative for assisting this more difficult group. Outcomes of the new Compulsory Drug Treatment Correctional Centre should be keenly observed to usefully inform any proposed changes.

Standards for follow-up (after-care) treatment

There are some empirical data to suggest that after-care strategies can lead to reductions in drug use and re-offending. After-care is uncommon in diversion programs, but has been recommended for trial in the New South Wales MERIT program, and may be an element that would enrich diversion programs nationwide.

Recommended:

- That pilot programs that include after-care be supported and closely monitored, with a view to making them part of a national strategy.
- That, in considering after-care strategies, the following issues be included: after-care as an optional component; after-care of varying intensity; clearly articulated process and outcome objectives, and evaluation procedures.

Terminology

Several different terms are used in the literature to refer to AOD treatment interventions that are ordered by the courts or police, through power vested by legislation or government-implemented program. Some of these terms do not intuitively or logically link to their definitions. For instance, the term ‘compulsory treatment’ is commonly used to refer to treatment into which individuals are coerced as well as treatment that is mandatory.

Recommended:

- That the term ‘legally coerced treatment’ be considered as an alternative to the more commonly recognised term ‘compulsory treatment’ (as defined and used in this paper). The term ‘legally coerced treatment’ can be used to refer to AOD treatment whose mandate is based in legislation and/or government-implemented program, encompassing the whole range of coercive situations created by legal mechanisms, from diversion at the earliest level of criminal justice proceedings, through to civil commitment of non-offenders.
- That the term ‘compulsory treatment’ then be used to refer only to court-ordered treatment where the individual has no choice, e.g. civil commitment and treatment imposed as part of a sentencing order.

1. Introduction

1.1 Background

Many people who become involved in the criminal justice system are dependent upon, or engaged in, problematic use of alcohol and/or other drugs (AOD). Indeed, the association between drug use and offending behaviour is so well established, with studies around the world demonstrating that high proportions of offenders use illicit substances and that offending behaviour is linked to drug use, that the association has been called 'one of the most reliable results obtainable in criminology' (Welte, Zhang & Wiczorek, 2001). In Australia, typical findings include the following:

- More than one-third (39%) of male adult prisoners in the Drug Use Careers of Offenders study attributed their crime to illicit drugs or alcohol (Makkai & Payne, 2003).³
- Some 55 per cent of all persons imprisoned in Victoria in 2004–05 were serving periods of imprisonment for drug-related offences (Victoria Department of Human Services, 2006) and 48 per cent of Victorian Juvenile Justice clients had drugs and alcohol linked to their offence (Victoria Department of Human Services, 2005b).
- Almost two-thirds (65%) of adult males detained in police lockup for a violent offence, as surveyed by the 1999 Drug Use Monitoring Study, and 82 per cent of those detained for property offences tested positive for amphetamines, benzodiazepines, cannabis, cocaine, methadone or opiates (Makkai & McGregor, 2001).⁴
- Over 80 per cent of prisoners entering custody in New South Wales have a history of AOD abuse (New South Wales Department of Corrective Services, 2001).

- Approximately two-thirds of all first-offenders entering Victorian prisons report a history of substance use directly related to their offending behaviour; for second and subsequent incarcerations, these figures rise to 80 per cent for men and 90 per cent for women (Office of the Correctional Services Commissioner, 2002).
- Over one-quarter (28%) of police detainees involved in a national Australian Institute of Criminology review in 2005 were alcohol-dependent, as per DSM IV criteria (Mouzos, Smith & Hind, 2006).

In part, the drug/crime association is an outcome of the criminalisation of drug use. Clearly, if the offence is possession or use of an illicit substance, there will be a high correlation between crime and use. With regard to property crimes, the association is similarly high due to the high proportion of these crimes committed in an attempt to maintain dependent drug habits. With regard to violent crimes, especially in the home, there is a strong association with alcohol use. In the case of both alcohol and drugs, however, the associations are complex, and influenced by many other factors; causation can be hard to demonstrate.

The relationship between drug or alcohol use and treatment is equally complex. Treatment for problematic or dependent use of drugs or alcohol can be effective in reducing drug use and in reducing criminal behaviour (Spooner, Hall & Mattick, 2001; Stevens et al., 2003, p.5), but there are many factors that impact upon the achievement, or otherwise, of this outcome. Patterns of use and abuse, the nature of treatment, and a web of psychosocial factors interplay to influence treatment outcomes. These interrelationships

³ The DUCO study surveyed 2135 offenders incarcerated in prisons in Queensland, Western Australia, Tasmania and the Northern Territory.

⁴ The DUMA study surveyed 1974 adults detained in lockups in Queensland, Western Australia and New South Wales.

are myriad and complex, resulting in a lack of consistency and certainty in the conclusions that can be drawn from research findings.

Despite the research limitations, the evidence linking drug use and offending behaviour, and the evidence linking treatment with reduced use and crime have been instrumental in creating a supportive climate for the adoption of compulsory treatment programs for offenders in Australia.

Australian legislation providing for the committal of non-offending AOD-dependent persons into treatment has its origins in the late 1800s. Around this time, alcoholism came to be considered a disease, whose cure lay in total abstinence. Moves were therefore made to insert this new medical understanding of alcoholism into the then existing model of punishment for drunkenness. Around the world, inebriates institutions became popular as places to detain and treat the 'physical and pathological as well as the legal, moral and spiritual aspects' of intemperance (Berridge, 2004). As described by J.M. Creed, the originator of the first New South Wales Inebriates Bill, the 'helpless victims of intemperance' could, in such institutions, be protected from themselves, 'guarded from their thirst and restored to a condition in which they would be able to do work and return to the world' (New South Wales Standing Committee on Social Issues, 2004, p.17). Despite benevolent intentions, however, such legislation was essentially punitive in character; it facilitated effective treatment far less than it operated as a mechanism of social control. Civil liberties and treatment effectiveness are inherent concerns in the detention and compulsory treatment of non-offenders (discussed in chapter 2), and remain in the forefront of discussions today.

1.2 Aims of this paper

The purpose of this project, commissioned by the Australian National Council on Drugs (ANCD), was to produce a discussion paper to inform ongoing debate on the place of compulsory treatment in Australia in the 21st century. The aim is to present a national perspective of the current operation of compulsory AOD treatment, within the context of existing research evidence, ethical considerations and international practice. Particular areas of interest are the development, implementation and effectiveness of drug diversion and civil commitment practices. Consideration is given to the current and future role of compulsory AOD treatment in Australia and the underlying principles.

The key questions addressed by this paper are:

- What is the Australian and worldwide research evidence on compulsory treatment of offending and non-offending individuals for AOD dependence?
- What are the legislative provisions for commitment of offending and non-offending individuals into compulsory treatment in Australia?
- What is current professional practice in Australia in the area of compulsory treatment for AOD issues?
- Is there a place for compulsory treatment in Australia? If so, what are the principles that should underpin compulsory treatment?

1.3 Method

Four principal research methods were used: literature review; review of Australian legislation; key informant interviews; and Reference Group consultations. Data were collated by topic area as laid out in this paper.

A draft report summarising the data and conclusions was submitted to members of the Reference Group for their review and suggestions. A draft of the final report was also viewed by the ANCD.

1.3.1 Literature review

This component of the project comprised a review of recent empirical research on compulsory AOD treatment of offending and non-offending individuals. The review included specific evaluations of Australian State-level programs, reviews of international research and related commentaries on compulsory treatment. Searches were conducted using PubMed and the World Wide Web generally, using such search terms as ‘compulsory treatment’, ‘coercion’, ‘effectiveness’, ‘drug diversion’, ‘drug courts’, ‘civil commitment’, ‘ethics’ and ‘civil liberties’.

1.3.2 Review of Australian legislation

A review of the legal framework providing for compulsory treatment at the State, Territory and federal levels was conducted. This entailed internet searches of government websites augmented by telephone and email correspondence with relevant government departments (e.g. State Health Departments,

Departments of Justice, and Departments of the Attorney-General). Relevant legislation was obtained using the Australasian Legal Information Institute’s (AustLII) databases.

1.3.3 Key informant interviews

Semi-structured telephone and face-to-face interviews were conducted with key informants (n = 7), selected for their experience and knowledge in compulsory treatment, and representing a range of disciplines and opinions (see Appendix A). Individuals were selected based on recommendations of the Project Reference Group (see below) and included clinicians, representatives of the courts and consumers. The interviews included questions on ethical issues and outcomes for individuals coerced or compelled into AOD treatment, and on current practices in Australia (see Appendix B).⁵

1.3.4 Reference Group consultation and review

A Project Reference Group (PRG) was established to provide expert advice on the research. The PRG comprised individuals representing key interest areas, including medical, legal, political and consumer (see Appendix C).⁶ Two meetings were held with the PRG. The purpose of the first meeting was to clarify the issues of focus and suggest individuals to contact as key informants. The second meeting was held as a discussion forum to explore, debate and augment findings to date, refine the content and focus of the final paper, and discuss possible recommendations.

- ⁵ Quotes from key informant interviews are referenced ‘KI’ followed by two numbers, representing the unique identifier allocated to each participant, in order to maintain a level of anonymity.
- ⁶ Quotes from PRG members are referenced ‘PRG’, followed by the meeting number (1 or 2) and the unique identifier allocated to each PRG member in order to maintain a level of anonymity.

1.4 Definitions

There are multiple understandings of the key terms used in this paper. Before we discuss compulsory treatment, some time and attention must be given to clarifying words and concepts like ‘coercion’, ‘compulsion’, ‘drugs’, ‘treatment’ and ‘populations’.

1.4.1 Compulsion and coercion

According to the *Concise Oxford Dictionary*, compulsion is ‘the action or state of being forced or obliged to do something’ and coercion is the ‘implicit or explicit persuasion of an unwilling person to do something by using force or threats’.⁷ Compulsion is a dichotomous concept – either a person is compelled, or he/she is not. Coercion, on the other hand, operates by degree, with the amount of coercion exercised and/or experienced by an individual ranging from mild to strong. At the uppermost end of the coercive scale, the distinction between the two concepts can become blurred; the persuasion and threats involved may be considered so great as to amount to force and may thereby be considered in fact to be compulsion.

The concept of coercion in AOD treatment includes three types of social control: informal, formal and legal (Wild, 2006). Informal measures are usually associated with ‘persuasive interpersonal tactics’ used by friends and family (Taxman & Messina, 2002; Wild, 2006). Formal measures include strategies initiated by institutions other than courts,

such as conditional, governmental,⁸ social assistance and employee assistance programs. Legal measures in Australia include civil commitment, court-ordered treatment and diversion programs.

These three forms of social control may be considered on a continuum of State involvement in an individual’s decisions and behaviour, with legal measures representing the greatest State involvement. There is then a range of State involvement or coercion that may be applied and experienced through these legal measures. In some legal situations, individuals may be afforded the choice of undertaking prescribed treatment or choosing instead to be dealt with by the criminal justice system, while in others there may be no choice at all. Some individuals partake in drug treatment programs reluctantly; others are more willing (Taxman & Messina, 2002).

In Australia and overseas, State involvement in the coercion or compulsion of individuals into AOD treatment is referred to variously as ‘civil commitment’, ‘quasi-compulsory treatment’, ‘court-mandated treatment’, ‘coerced treatment’ and, in this discussion paper, ‘compulsory treatment’. The definitions of these terms comprise a range of elements, as shown in Table 1.1.

⁷ <http://dictionary.reference.com/search?q=coercion>;
http://www.askoxford.com/concise_oed/coerce?view=uk

⁸ Recent amendments to the *Children’s Protection Act 1993 (SA)* enable Youth Courts to order parents, guardians and others caring for children to attend drug assessment (s.21(1)(ab)) and undergo treatment and periodic drug testing (s.37(1a)) where a child in their care is considered to be at risk. The effect of these new provisions is to coerce parents and guardians to change their behaviour, under formal threat of losing care of their child(ren).

Table 1.1: Compulsory AOD treatment – common terms and definitions

	Choice	No choice	Offender	Non-offender	Alcohol	Illicit drugs
Civil commitment		✓		✓	✓	✓
Quasi-compulsory treatment	✓	✓	✓			✓
Court-mandated treatment		✓	✓		✓	✓
Coerced treatment	✓		✓	✓	✓	✓
Compulsory treatment	✓	✓	✓	✓	✓	✓

Definitions include:

Civil commitment to drug treatment is defined as the ‘legally sanctioned, involuntary commitment of a non-offender into treatment for drug or alcohol dependence’ (New South Wales Standing Committee on Social Issues, 2004). It pertains to individuals who have committed no offence and allows them no choice in the matter. By comparison, civil commitment in the United States pertains more broadly to offenders and non-offenders, the key criterion being that they are either unwilling or unable to control their substance abuse, or to obtain services on their own (Taxman & Messina, 2002).

Quasi-compulsory treatment is a term typically used in European literature, and is defined as ‘the treatment of drug-dependent offenders that is motivated, ordered, or supervised by the criminal justice system and takes place outside regular prisons’ (Stevens et al., 2005). The offender’s consent to enter treatment is required. Alcohol dependence is generally excluded as a criterion.

Court-mandated treatment is defined by the New South Wales Standing Committee on Social Issues (2004) as ‘the treatment of an offender, required by a court order’. It usually occurs where the offender’s AOD dependence has contributed to the offending behaviour.

Coerced treatment is characterised by the presence of an offence, and some degree of choice, albeit limited, in the individual’s decision to access treatment or face legal sanctions (Klag, O’Callaghan & Creed, 2005).

Compulsory treatment (CT) is defined for the purposes of this discussion paper as AOD treatment that has a mandate based in legislation and/or government-implemented programs. This broad definition is adopted (despite the narrow dictionary definition described above; see 5.6 for further discussion) due to its common usage in the field and general understanding that ‘compulsory treatment’ encompasses a wide range of coercive situations including drug diversion mechanisms, referrals within custodial settings, and civil commitment. It excludes the informal coercive mechanisms of family, friends and social institutions.

1.4.2 Drugs

The term ‘drug’ encompasses many different substances, which can be divided into numerous categories; for example, licit/illicit, prescription/non-prescription, natural/synthetic, psychoactive/non-psychoactive, as well as by pharmacological action, and so forth.

Australia’s National Drug Strategy, which covers a wide range of substances, defines a drug as:

A substance that produces a psychoactive effect; includes tobacco, alcohol, pharmaceutical drugs and illicit drugs ... as well as performance and image-enhancing drugs, and substances such as inhalants and kava. (Ministerial Council on Drug Strategy, 2004, p.21)

In the context of compulsory treatment, programs focus on ‘illicit substances’, which include cannabis, meth/amphetamines, hallucinogens, ecstasy, cocaine, heroin, ketamine and GHB. Very few programs include problematic alcohol use. As we discuss in chapter 3, which describes the compulsory treatment programs in Australia, there is a large investment imbalance in favour of illicit substances. Drug court eligibility in Australia is mostly based on illicit drugs, with only two States including alcohol dependence as an eligibility criterion.⁹ In the other three jurisdictions in which drug courts operate, an individual who is alcohol-dependent will be eligible to attend the drug court only if he/she also has an illicit drug problem.¹⁰ The National Police Illicit Drug Diversion

Initiative (IDDI) operates to divert only illicit drug users away from the courts, for minor use and possession offences. Compulsory treatment for alcohol dependence mainly rests on civil commitment,¹¹ which is uncommon. This is despite the fact that alcohol use causes more harm to more people (New South Wales Standing Committee on Social Issues, 2004).

Definitions of ‘drugs’ are complicated by the various moral views taken of drug use, based on a range of cultural, religious and historical factors.¹² At one end of the spectrum, there are people who consider all drug use to be morally wrong; at the other end are people for whom drug use is a morally neutral or even positive activity. In Australia, a distinction between acceptable and deviant drug use is commonly made, with illicit drugs being considered deviant. Legal drugs (alcohol, tobacco and prescription medications) have long been considered an acceptable part of our culture. However, times are changing (e.g. tobacco smoking is increasingly the subject of public health restriction) and alcohol consumption is coming under greater scrutiny as the far-reaching extent of costs and burdens associated with its use is increasingly recognised. Negative impacts on families, productivity, health and social order challenge society to reconsider long-held beliefs about what constitutes acceptable use of this common and legal substance.

References in this paper to ‘*drugs*’ include illicit drugs only. Alcohol is referred to separately.

⁹ Victorian Drug Courts and the New South Wales Youth Drug and Alcohol Court; see 3.1.4. The Northern Territory Alcohol Courts began operations in July 2006, bringing the total to three jurisdictions.

¹⁰ New South Wales, Queensland, South Australian and Western Australian drug courts; see 3.1.4.

¹¹ Civil commitment is described in detail in section 3.2; it provides for non-offenders to be placed in short-term involuntary treatment.

¹² Refer to Bush and Neutze (2000) for discussion of the moral dimensions of the drug debate.

1.4.3 Treatment

‘Treatment’ is a third term that encompasses many different interpretations. There are many types of treatment and considerable differences of opinion among service providers and other stakeholders (clients, policy makers, funders, etc) about which treatments are best for which type of client, and what successful treatment means (Ritter et al., 2003, p.72).

In Australia, the foundation of AOD treatment is ‘harm minimisation’,¹³ which seeks to prevent anticipated harms and reduce actual harms associated with drug use (Australian Government, 2005). This involves different treatment goals for different individuals. Abstinence from drug use is the goal for some individuals; for others, reduced quantity or frequency of drug use may be considered best, at least at first. Ritter et al. (2003) recommend that the primary goal of drug treatment be to reduce drug use, while facilitating client access to other services to address other needs. There is a diversity of opinion about whether goals ancillary to reducing drug use, such as improved emotional wellbeing and family relationships, should be included as treatment goals.

The treatment itself may include a spectrum of services. Ritter et al. (2003) recommend that the term ‘treatment services’ be reserved only for those more intensive services aimed at changing drug use behaviour (e.g. withdrawal, pharmacotherapies and counselling). This approach, however, would exclude most

harm reduction support services (e.g. outreach, sobering-up shelters, drop-in centres), referrals to other services, and other less intensive activities, as well as education and self-help groups, all of which may be an important part of drug treatment and support overall.

In this report we use the terms ‘*treatment*’ or ‘*treatment interventions*’.¹⁴

1.4.4 Population to be ‘treated’

The population passing through compulsory treatment may be regarded in many ways. The vast majority, an estimated 98 per cent,¹⁵ are ‘offenders’ diverted into treatment after having committed an offence, who will have some choice as to whether they are diverted into treatment, especially for less serious offences. For example, individuals who commit a minor possession offence are given a choice between treatment (often a brief education session) or being charged and going to court.

Non-offenders, on the other hand, may be committed to AOD treatment without any choice in the matter. Legislation in four Australian States enables a court, upon satisfaction of certain criteria, to make an order compelling an AOD-dependent individual, who has not broken the law in any way, to attend and remain at a treatment facility for a specified period of time (see section 3.2).¹⁶ Police may be called upon to enforce such orders.

¹³ Harm minimisation involves three types of strategies: harm reduction, demand reduction and supply reduction. The first two apply to treatment. The reader is referred to <http://www.nationaldrugstrategy.gov.au/> for further information.

¹⁴ See Appendix D for types of AOD treatment interventions accessed under compulsory treatment initiatives.

¹⁵ Consensus estimate, reached at second Project Reference Group meeting, 12 April 2006.

¹⁶ In practice, however, institutions to which individuals in New South Wales and Victoria are civilly committed generally lack the security to detain, let alone enforce any type of treatment (see section 4.3.1.4).

Thus, there are two distinct populations subject to compulsory treatment – offenders, who have some degree of choice (though often constrained) about their involvement in treatment; and non-offenders, who may be compelled into treatment against their will. Though demographic analysis was not a part of this paper, the data suggest that some sub-groups (particularly Indigenous Australians) are under-represented among the diverted offender population and simultaneously over-represented among the population of civilly committed non-offenders (see section 2.9.3).

1.5 Structure of discussion paper

8

This paper comprises four major sections. Discussion begins with key factors associated with compulsory treatment: Australian drug policy and politics, international practices, goals of compulsory treatment, legal theory, civil liberties, research evidence, models of coercion and dependence, cost, unintended outcomes, and ethical guidance in the AOD field. These are all elements to be kept in mind to varying degrees in considering the operation of compulsory treatment, in any of its many forms. They provide theoretical and practical context, and draw attention to issues of complexity and challenge.

Next is a description of the many forms that compulsory treatment takes in Australia. This descriptive section of the paper provides a comprehensive overview of the operation of diversion and civil commitment in each Australian State.

Following is an overview of international and Australian research findings for compulsory treatment. Described in this section are achievements and criticisms of Australian diversion programs and civil commitment legislation, methodological and conceptual problems that characteristically impede research in this area, and suggested areas for improvement that have emerged from these evaluations and reviews.

Finally, the conclusions and recommendations address the primary project questions outlined in section 1.2. These four key research questions opened inquiry to a broad and complex territory and lead to conclusions and recommendations that extend beyond the original questions, to related issues within the broader system of which compulsory treatment is a part.

2. Key factors associated with compulsory AOD treatment

The context of compulsory treatment is a shifting landscape of policy, perceptions and practices in the field of alcohol and other drugs. Any well-informed discussion will need to consider a web of interrelated issues in areas as diverse as policy and politics, international practices, goals of treatment,

legal theory, civil liberties, models of coercion and dependence, cost, unintended outcomes, and ethical guidelines, as well as the research evidence, which comprises a large part of this report. These various factors associated with compulsory treatment are shown in Figure 2.1.

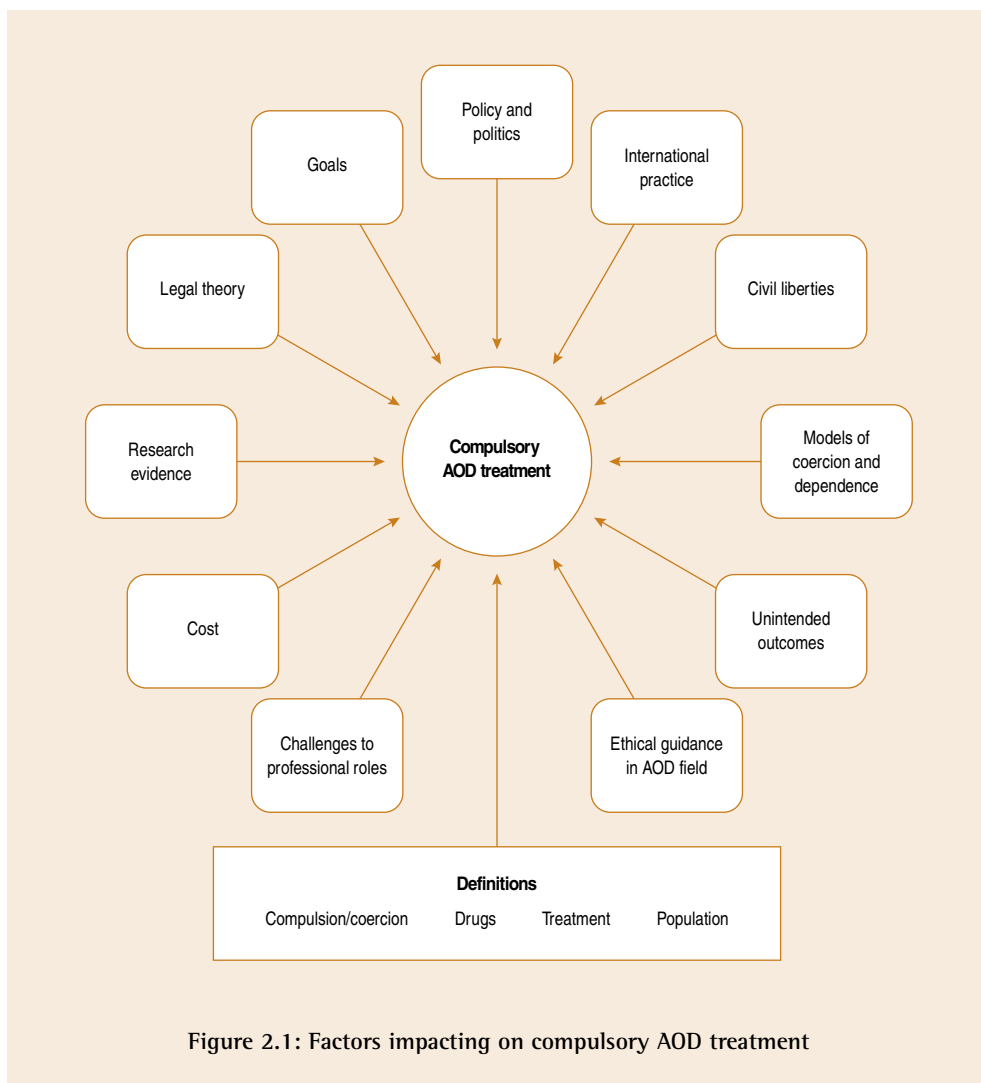


Figure 2.1: Factors impacting on compulsory AOD treatment

2.1 Policy and politics

Principal among [the factors that have a bearing on policy] must be the rationalities of politics, which postulate value-choices and the parameters of the politically possible (e.g. commitment to social justice, recognition of cost/benefit analysis implications and the limitations imposed by public sentiment). (Carson, 2003, p.8)

2.1.1 Australian drug policy 1985–2005

Australia's drug policies are developed by the federal government, under counsel of a complex system of advisory structures. These currently include the Ministerial Council on Drug Strategy (MCDS),¹⁷ the Intergovernmental Committee on Drugs (IGCD), the Australian National Council on Drugs (ANCD), National Expert Advisory Committees, non-government organisations and industry and community groups.¹⁸

A number of policy frameworks have emerged from these bodies to influence the development of drug policy as it stands in Australia today. These include the National Campaign Against Drug Abuse (NCADA), the National Drug Strategy (NDS) and the National Drug Strategic Framework (NDSF).¹⁹

The NCADA was launched in 1985 and provided the framework for cooperation between State and federal governments. It represented a shift in drug policy in Australia towards a focus on harm minimisation. This multifaceted campaign included four major initiatives in the areas of education and prevention, treatment and rehabilitation, research and information, and enforcement and controls. In 1993, the NCADA was repackaged and released as the NDS (1993–97). The NDS was based on six concepts: harm minimisation, social justice, maintenance of controls over supply, an intersectoral approach, international cooperation, and evaluation and accountability. It included a greater emphasis on, and more funding for, the law enforcement aspects of drug policy.

In 1997, the MCDS commissioned an evaluation of the NDS resulting in seven key recommendations to improve its operation (Single & Rohl, 1997). These included: enhancing the involvement and effectiveness of law enforcement in preventing drug-related harm; establishing a dedicated National Drug Strategy unit; extending partnerships between health, law enforcement agencies and non-governmental organisations; harm-minimisation training; creating an Australian National Clearing House on Drugs; and increasing the number of program evaluations, particularly with regard to cost-effectiveness. Following the evaluation, the NDS was re-launched as the National Drug Strategic Framework (NDSF).

¹⁷ The MCDS comprises Commonwealth, State and Territory ministers with responsibility for health and law enforcement portfolios. The purpose of the Council is to collectively determine national policies and programs to reduce the harm caused by drugs.

¹⁸ For further detail, refer to Fitzgerald and Swards (2002), pp.22–23.

¹⁹ Fitzgerald and Swards (2002) provide a comprehensive history of significant events occurring in the development of Australian drug policy between 1901 and 2000.

The NDSF continued the preceding policies and outlined new priorities based on the evaluation. These were carried over into Australia's current drug strategy, *The National Drug Strategy: Australia's Integrated Framework 2004–2009*.

The mission of the current strategy is: 'To improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in Australian society' (Ministerial Council on Drug Strategy, 2004, p.1). The drug strategies of the States and Territories sit within and complement the national strategy. The current NDS identifies eight priority areas and 12 objectives, all of which are supported by a range of federal government initiatives and specific strategies. Current programs include the National Tobacco Strategy, the National Alcohol Strategy, the Aboriginal and Torres Strait Islander Peoples Complementary Action Plan, National School Drug Education Strategy and the National Illicit Drug Strategy (NIDS).

The NIDS was launched in 1997 and, since its inception, has received over \$1 billion funding from the federal government. In 1999, as part of the NIDS, the Illicit Drug Diversion Initiative (IDDI) was established. A national program for the pre-arrest and, in some jurisdictions, pre-trial diversion of minor illicit drug offenders into AOD treatment, the IDDI was consistent with a decision of the Council of Australian Governments (COAG), which 'agreed to work together to put in place a new nationally consistent approach to drugs in the community involving diversion of drug

offenders by police to compulsory assessment' (Australian Government Department of Health and Ageing, 2004b). Through this program, individuals apprehended for use or possession of small quantities of illicit drugs are referred (if they consent to participate in the program) by police to compulsory education, assessment and treatment. In some jurisdictions the courts may divert individuals, such as through the MERIT and CREDIT programs (discussed at 3.1.2).

Resting on 19 principles,²⁰ the IDDI was shaped by pre-arrest diversion programs piloted in the 1990s, such as the Victoria Police Cannabis Cautioning Program.

The IDDI was allocated \$221 million at establishment, and in December 2002 the federal government announced it would provide a further \$215.9 million for a second phase running through to 2007.²¹

The Initiative aims to result in:

- early incentives being given to address drug use, in many cases before the drug user incurs a criminal record
- an increase in the number of illicit drug users diverted into drug education, assessment and treatment
- a reduction in the number of people appearing before the courts for the use or possession of small amounts of illicit drugs (Australian Government Department of Health and Ageing, 2004b).

²⁰ See Appendix E.

²¹ IDDI funding breakdown: 2003–04: \$52.2m; 2004–05: \$53.4m; 2005–06: \$4.6m; 2006–07: \$5.7m.

2.1.2 Politics

Politics is the field within which public policy grows. It influences the priorities of most, if not all, institutions. With reference to AOD, there are many competing interests at play. Drug policy and its implications affect millions of lives and considerable social, financial and ethical issues arise. Furthermore, personal bias, financial interests, political power and public opinion all converge on the conditions of the time.

Australian drug policy was first formed in the early 1980s, in response to increasing drug use. The socially liberal federal government implemented harm minimisation, which may be seen as a therapeutic or compassionate application of the police power of the State. In other times and other countries, punishment is a primary feature of drug policy.

The political climate since that time has changed. A series of public opinion surveys from 1985 to 1995 found that ‘the broader community has had a longstanding ambivalence towards harm minimisation programs, due to the belief that they condone illicit drug use’ (Gunaratnam, 2005, p.5). In 2001, the National Drug Strategy Household Survey (Australian Institute of Health and Welfare, 2002) found that public support was greatest for supply reduction measures (i.e. reducing the production, import and commerce of illegal drugs), followed by demand reduction and harm reduction.²² Thus, State election campaigns have ‘included competing bids as to who will be “tougher” on crime,

rather than who will be smarter on crime’ (King, 2006, p.9). The most recent National Drug Strategy, with its increased emphasis on supply reduction, appears also to reflect this approach (Ministerial Council on Drug Strategy, 2004).

It is not the purpose of this paper to evaluate national drug policy or to consider alternatives. However, it is acknowledged that compulsory treatment operates within this larger system and is therefore subject to the same influences. Politics is alive wherever people gather, and the current debate on drugs is highly political. The evidence about what works is only one policy determinant. Aside from any demonstrated effectiveness in reducing drug use, or in addressing the underlying causes (both of which are goals of the NDS), compulsory treatment should also be viewed as an economic and political measure. Diversion programs hold the potential for saving incarceration costs, which are high.²³ In addition, the implementation of compulsory treatment programs may be a political strategy, as one member of the Project Reference Group noted of drug courts:

It was politically expedient at the time, to be seen to be a reaction to what is seen to be ‘the drug problem’. We’ve started a ‘drug court.’²⁴

²² Participants stated \$50 out of every \$100 spent on illicit drug policy should be directed to law enforcement, \$30 to education and \$20 to treatment.

²³ In 2003–04, expenditure per prisoner per day in Australia was \$162, ranging from \$139 in Queensland to \$261 in the Australian Capital Territory (Australian Institute of Criminology, 2006b).

²⁴ KI06.

2.2 International practice

Compulsory treatment is currently used in many countries, including Britain, the United States, China, the Netherlands, New Zealand, Italy, Sweden, Germany, Canada and Spain. Some legal systems have long been afforded the authority to coerce and/or force individuals into drug treatment; compulsory drug treatment in the form it operates today is largely considered to have had its origins in the United States in the 1920s with morphine maintenance clinics (Klag et al., 2005).

There is much variability in the ways in which compulsory treatment of offenders is implemented internationally, with significant differences in levels of legal coercion, the point in proceedings at which it is imposed, and in the types of offenders targeted. In the United States, the focus of compulsory treatment is on offenders charged with drug use offences, while in Britain and the Netherlands, persistent offenders who may have committed non-drug offences are also targeted. As in Australia, courts in Europe can impose sentences that include a requirement to enter AOD treatment. Most European countries require the offender's consent to enter treatment, though exceptions include Austria, Germany and the Netherlands (Stevens et al., 2005).

By comparison, the approach to compulsory treatment taken by Asian countries, such as China, is much stricter. A drug abuser who has broken the law can be compelled to attend a compulsory rehabilitation centre. Those found to use drugs a second time are sent to drug-rehabilitation-through-labour institutions. According to the Ministry of Public Security, in 2004 China had 583 compulsory drug rehabilitation centres and 165 drug-rehabilitation-through-labour institutions (compared with 247 voluntary drug rehabilitation centres) (Xinhua, 2004).

Like Australia, both New Zealand and Sweden have civil commitment legislation. New Zealand's *Alcoholism and Drug Addiction Act 1966* provides for compulsory detention and treatment of non-offenders for up to two years and is used to commit approximately 200 people per year (New South Wales Standing Committee on Social Issues, 2004). Applications can be made for either voluntary or involuntary commitment. The New Zealand Ministry of Health is currently reviewing the Act (Huriwai, personal communication, 2006).

The Swedish *Care of Alcoholics, Drug Abusers and Abusers of Volatile Solvents (Special Provisions) Act 1988* (1988:870) provides for individuals to be placed in compulsory care in institutions (known as LVM homes) specially intended for the provision of care under the Act, for up to six months or as soon as the purpose of care has been achieved (ss. 20, 22). The objective of compulsory care in an LVM home is not to provide treatment, rather it is to motivate individuals to accept subsequent voluntary treatment for their addiction (European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 2003). The Act is unique in that it imposes a duty on public authorities to notify the Municipal Social Welfare Committee of abusers who may require care, and a duty on the Committee to then investigate and, where appropriate, apply for a care order (ss. 6–12). Approximately 1000 people per year are placed under compulsory care (New South Wales Standing Committee on Social Issues, 2004). A report by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (2003) expressed 'serious misgivings about the practice of subjecting residents to forcible detoxification without offering them alternatives, and, more particularly, without the possibility of taking a free and informed decision to discontinue taking drugs'.

2.3 Goals

As discussed above, the current National Drug Strategy aims ‘to improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in Australian society’ (Ministerial Council on Drug Strategy, 2004, p.1). Harm minimisation is the underlying principle, and encompasses three different types of strategies:

- supply reduction strategies, which aim to disrupt the production and supply of illicit drugs, and the control and regulation of licit substances
- demand reduction strategies to prevent the uptake of harmful drug use, including abstinence-orientated strategies and treatment to reduce drug use
- harm reduction strategies to reduce drug-related harm to individuals and communities.

Federal and State governments, as well as non-government organisations, each develop plans and programs, in their own way, to implement these strategies. Thus, the mechanisms operating to achieve these intentions are many and varied.

Diversion enters AOD treatment under the banner of demand reduction and harm reduction strategies. It includes police and court diversion (the former being by far the most common form of compulsory treatment) and has two main goals in practice:

- reduced substance use, resulting in improved health and overall quality of life, and
- reduced criminal justice involvement in the present and future.

Legislation at a State level, designed to achieve these goals, usually also outlines additional, equally broad missions. For example, an objective of the *Compulsory Drug*

Treatment Correctional Centre Act 2004 (NSW) is to ‘promote reintegration into the community’; the Queensland *Drug Rehabilitation (Court Diversion) Act 2000* aims to ‘reduce health risks to the community associated with drug dependency’.

Re-integration of clients into the community, and improvement of health and social functioning, may however be secondary outcomes. Further, there are few data to consider the extent to which these goals have become operational or have achieved outcomes capable of evaluation. This paper examines the evidence that these broader goals, and the more specific goals, relating to substance use and criminal justice involvement may be achieved by compulsory treatment. Whatever the outcome, there appears to be a widespread assumption that treatment is a better option than prison, which is ‘expensive and ineffective in reducing drug use and crime’ (Hall, 1997, p.12).

As the United States Institute of Medicine report *Treating Drug Problems* has argued:

The most important reason to consider these and related schemes to compel more of the criminal justice system to seek treatment is not that coercion may improve the results of treatment, but that treatment may improve the rather dismal record of plain coercion – particularly imprisonment – in reducing the level of intensity of criminal behaviour that ensues when the coercive grip is released. (Gerstein & Harwood, 1990, p.11)

Civil commitment legislation provides for inebriates and drug-dependent persons to be detained and treated, but generally does not define the aims and expected outcomes of this action. Possible goals include short-term harm reduction, rehabilitation and protecting the interests of others. As we discuss in section 4.3, clarity on this issue is required and necessitates careful consideration of human rights and treatment effectiveness.

2.4 Legal theory – therapeutic jurisprudence

The legal foundation of coercion of offenders into AOD treatment is the notion of ‘therapeutic jurisprudence’, which presumes that legal procedures and settings impact upon wellbeing and can be therapeutic in nature. It is defined by Wexler (1993b) as:

The study of the role of the law as a therapeutic agent. This approach suggests that the law itself can function as a therapist. Legal rules, legal procedures, and the roles of legal actors, principally lawyers and judges, may be viewed as social forces that can produce therapeutic or anti-therapeutic consequences. The prescriptive focus of therapeutic jurisprudence is that, within the important limits set by principles of justice, the law ought to be designed to service more effectively as a therapeutic agent. (p.280)

The principles of therapeutic jurisprudence can be seen operating in drug courts (which first began in the United States in 1989 and in Australia in 1999) and pre-trial diversionary programs (Barnes & Poletti, 2004). Problem-solving courts, such as drug courts, are commonly associated with therapeutic jurisprudence, though not all such courts apply its principles. In court settings, therapeutic jurisprudence involves the use of procedures that promote positive involvement of participants in court processes, including ‘behavioural contracts, applause, graduation ceremonies, positive interaction with participants in court and encouragement from the bench’ (King, 2003). These procedures are believed to have therapeutic effects and foster self-esteem in offenders. Further, they can promote respect for the court and provide a catalyst for positive behavioural change, by assisting individuals to better understand and take responsibility for their undesirable

behaviour. It has been argued that this is one reason people are required to admit and fully disclose their offence as a prerequisite to diversion program participation. Involvement in determining treatment may be seen as the individual taking responsibility and choosing a positive outcome (Taxman & Messina, 2002).

The application of therapeutic jurisprudence to judging has been criticised as taking judges beyond their role as umpire to that of coach, which may threaten public confidence in the justice system:

There, it is said, the judicial officer has descended from the calm, impartial seat of judgement to the frenetic and partial activity of the arena. (King, 2003)

Judges may be seen as undertaking two opposing roles when applying therapeutic jurisprudence to judging: one of control and discipline, and one of helping and advising. Outcomes depend on how, and how well, judges are able to strike the balance between rapport and trust, and seriousness and authority. (See 2.10 for further challenges to the professional roles.)

Several factors have contributed to the shift towards therapeutic jurisprudence, including changing political, economic and social values, burgeoning prison populations and shifts in intellectual paradigms regarding rehabilitation (Jeffries, 2002). Problem-solving approaches have been adopted in numerous countries, including New Zealand, Canada, England, Japan, Norway and several European countries (Hughes & Mosman, 2001). In Australia, problem-solving courts have emerged in response to the specific needs of Indigenous offenders, offenders with problems with drugs, offenders with mental health issues, and offenders who have committed violent acts against their families.

Therapeutic approaches to justice are being increasingly mainstreamed in Australia. This can be seen in such developments as the Victorian Department of Justice's new policy framework that 'consolidates and extends problem solving courts and approaches in the court system' (Victoria Department of Justice, 2006). Judge Roger Dive, of the Sydney Drug Court, has predicted that, over the next 10–15 years, the general court system will adopt therapeutic approaches: 'Therapeutic jurisprudence is the future. It's a no-brainer' (Dive, 2006).

2.5 Civil liberties

In his infamous treatise 'On Liberty', John Stuart Mill describes:

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That principle is, that the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise, or even right ... In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.

This represents a useful starting point for considering the questions:

- In what circumstances is the State permitted to override the fundamental right of the individual to choose his/her own actions?
- What encroachments can be justified?

As described by Mill, interference by an individual with the rights of other citizens justifies the exercise of power over that individual by the State. A range of harms (e.g. mental, social, health, emotional, economic) can be suffered by members of society as a result of the behaviour of individuals within it. To protect society against such harms, Australian governments have legislated to control the likes of gun ownership, smoking in public places and drug use. Drug use is associated with violence, sexual assault and domestic violence, and impacts negatively on families, the workforce and public safety (Loxley et al., 2004). These effects clearly extend into and interfere with the liberty of others, though it should also be pointed out that not all illicit drug use is associated with violence or property crimes and, indeed, most is not. Many users are functional members of society, engaging in recreational use. There is also widespread interest, especially among young people, in exploring states of altered consciousness, and some drugs provide that opportunity. Cannabis and other illicit substances (e.g. ketamine) are also effective in managing pain, both physical and psychological.

The condition of use, the dose and the extent to which other physical, mental and spiritual support is available directly influence the outcome and impact on people other than the user. Many dependent users, it is true, fall into dysfunctional states, and place themselves and those they live and work with at risk of harmful side effects. Many others do not. Thus, legislation that bans drug use, and programs that coerce individuals into treatment can be seen to reflect the State's answer to the question: 'How much damage should society be expected to endure as a result of individuals' alcohol and drug use?' (Klag et al., 2005, p.1781). The individual can be considered to have forfeited some of his/her right to liberty. On this ground,

restricting the choice of offenders to either processing by the criminal justice system or undertaking treatment is widely regarded as ethical (Flaherty, Jousif & Spooner, 2002; Fox, 1992; Spooner et al., 2001).

The State may also legitimately override the autonomy of the individual in situations where individuals lack capacity to make decisions for themselves. Indeed, the State is considered, under the doctrine of *parens patriae*,²⁵ to have a duty to step in and assume responsibility for care in such circumstances. Lord Eldon (Court of Chancery, England) in *Wellesley v Duke of Beaufort* (1827) 4 ER 1078 at 1081 describes the jurisdiction:

It is founded on the obvious necessity that the law should place somewhere the care of individuals who cannot take care of themselves, particularly in cases where it is clear that some care should be thrown around them.

This doctrine has traditionally applied to children and the mentally ill and underpins current guardianship and mental health legislation. It can also justify intervention where an individual's use of alcohol and/or other drugs has permanently impaired their ability to make decisions about their own health and safety. Individuals suffering acquired brain injury, for example, may lack the capacity to make choices about their own wellbeing. A duty of care then arguably falls upon the State to take protective action.

The doctrine of *parens patriae* may also extend to situations where individuals temporarily lack capacity to make choices. By virtue of the impermanence of incapacity, however, additional conditions may need to be met to justify any action by the State that compromises the individual's liberty. The level of harm faced by the individual and the nature of the proposed intervention will be key. An acceptable threshold may be immediate risk of serious harm, attended to by way of a temporary intervention for the purpose of preventing or reducing that harm, and returning decision-making capacity.²⁶ Or perhaps consideration of the principles of beneficence and non-maleficence²⁷ may lead to a conclusion that a longer-term intervention, which aims to rehabilitate, is required to provide an overall benefit to the individual and avoid causing them harm or injury. For example, after a period of detoxification, a person's tolerance may be significantly lowered. Returning that person to their regular environment before relapse prevention skills or support are established may result in a resumption of previous levels of drug use, which could become more harmful or even fatal. This is moving into an area of greater contention.

If a person is capable of making choices, it becomes more complex and challenging to justify situations where the State can deny that choice and force a particular option. The biomedical ethical principle of autonomy states that 'the action of rational persons who have a capacity for autonomous action' (Fry & Hall, 2002, p.137) should be respected. Under this principle, the mere

²⁵ Parental surrogate.

²⁶ This is the form of intervention that the New South Wales Standing Committee on Social Issues (2004) concluded was ethically justifiable. See section 4.3.2.

²⁷ Beneficence is a duty to act in a manner that produces an overall benefit (i.e. benefit of an action outweighs the burden). Non-maleficence is a duty to do no harm.

fact that a person is making decisions that actually or potentially result in harm to him/herself is not grounds for interference with autonomy. Some exceptions to this are easier to justify than others. For example, paternalistic laws that mandate the wearing of seat belts and bike helmets are largely accepted. These laws are minimally intrusive and concern choices that citizens likely consider to be of little import. Legislation that provides for detention and treatment for AOD use, on the other hand, is much less readily accepted, involving, as it may, deprivation of liberty in addition to restrictions on choice of a very personal matter.

In this context, it has been argued that a fundamental right to use drugs exists; that people have an absolute right to decide to ingest potentially harmful drugs (van Ree, 1999). Where a person is exercising free will and choosing to use alcohol or other drugs to their detriment in exercising this right, should the State step in to protect that person from what might be considered 'bad' decisions? One key informant considered the question in this way:

*It is a profoundly perverse thing to let someone rot with their rights on. If someone is habitually lying drunk in the street, do we say that it's his right to drink? That it's our right to turn a blind eye on them?*²⁸

And what of the legality of the drug a person is exercising the right to use? Does the right to use drugs apply only to legal drugs? Should a person be deprived of their liberty for the manner in which they choose to engage in a legal activity? Might restrictions imposed by the State then be seen as a form of social control rather than motivated by benevolence?

This paper does not address whether such a right exists, or what form it might take. However, it is essential to acknowledge that the extent to which such a right is or is not recognised has implications for the way in which harm reduction is defined and implemented. Harm reduction aims to reduce drug-related harm and promote health. However, if there exists a fundamental right to use drugs, when does this right override protection of health, and when should health be protected at the expense of this right? How far might a right to use drugs extend? At what point does a duty of care upon the State, or upon us as concerned and compassionate citizens, override such a right? What should these rights and duties look like? Fry (2005) asks:

Is the right to use drugs only a right in the form in which AOD professionals define it? ... How are we to reconcile, for example, public health interventions that proscribe models of drug use behaviour (e.g. as in the case of supervised injecting facilities, supply reduction initiatives for diverted pharmaceuticals), that may be at odds with drug user defined models that may be less regulatory in spirit and based upon different value sets pertaining to 'risk' and 'harm'?

Discussion around these challenging questions must also be informed by what is known about the effectiveness of proposed interventions – whether they are effective and in what ways. To justify enforced treatment, the answers to several questions must be known and weighted: What does compulsory treatment, in its various forms, achieve? Does it help the individual? Does it help the community? How does compulsion impact upon the individual's motivation to engage in AOD treatment? Does it negate actual

engagement in the treatment process? (These questions are explored in chapter 4.) The importance of the answers to these questions cannot be understated. If a person's liberty is to be compromised, if a treatment is to be imposed on them, particularly against their will, it is essential that that intervention be of benefit. The biomedical ethical principle of beneficence 'requires that an action produces benefits and that its benefits outweigh its burdens' (Fry & Hall, 2002, p.138). If an intervention is not of known benefit, it may be concluded that there is no ethical justification for the burden imposed in depriving an individual of his/her liberty (New South Wales Standing Committee on Social Issues, 2004).

2.6 Research evidence

The research base on compulsory treatment is young and incomplete. The contents of this report are drawn from diverse sources and a wide array of disciplines, including economics, sociology, public health, policy and the law. Chapter 4 describes this literature and its findings; however, as shown in the present chapter, there are many factors influencing policy in this domain – like ethics, economics and politics – and in this context, research evidence, even when it is persuasive, must compete with other influences before it becomes policy.

'There is no doubt that the era of evidence-based policy has, at least in theory, well and truly arrived' (Carson, 2003). Indeed, Carson describes 'what matters is what works' as a 'mantra' adopted by governments in Australia and the United Kingdom.

However, 'evidence-based policy' is not always what it seems. Indeed, it may be that policy is rarely based predominantly on research evidence.

In most cases of social policy, evidence has played only a small role in determining policy ... A myriad of other factors, including ideology, financial stringency, political theory, and intellectual fashion, have been, and continue to be, highly relevant. (Oliver & McDaid, 2002, p.180)

Carson suggests that the terms 'evidence-influenced' or 'evidence-aware' policy more accurately point to the role of evidence in policy development. Furthermore, neither the benefit nor the utility of evidence in forming policy should be presumed. As Carson writes, 'There is a remarkable dearth of evidence to support the proposition that ... evidence-based policy will lead to the delivery of services closer to society's preferences' (Carson, 2003).

We should therefore accept that there is a role for research evidence in policy making (as most governments and researchers do), albeit a 'messy, uncertain, unstable and essentially political' one (K. Young et al., 2002, p.218).

2.7 Models of coercion and dependence

Coercion into AOD treatment, imposed by the legal system, includes a 'range of options of varying degrees of severity across the various stages of criminal justice processing' (Farabee, Prendergast & Anglin, 1998). In relation to criminal matters, coercion may occur pre-arrest, pre-trial, pre-sentence, post-conviction or pre-release, and each pathway takes a different form, and has different effects at each of these stages. In addition, there are civil commitment measures whereby a civil order, rather than a criminal order, compels a non-offender to attend treatment.

Different methods or models of coercion affect different individuals in different ways, and may not correspond in any predictable way with the form and strength of the coercion. Indeed, the subjective experience of coercion is dictated by history, relationships and other life experiences. Informal coercion by family and friends may be effective for one and not another. Legal coercion may be traumatic for one and less significant to another. As noted by one key informant:

There is a lot of compulsion, including compulsion that is informal, and some of that is every bit as powerful as formal compulsion.²⁹

Often the extent and nature of the coercion are not recognised by those applying it:

Coercion is too often assumed and not elaborated on.³⁰

The individual's motives for entering treatment may also vary and motive can impact on outcome. Marlowe et al. (2001) found that clients who entered treatment because of social and financial pressures had better outcomes than clients who identified legal, medical or family pressures as their primary influence. It has also been reported that coercion in its various forms may act as a positive motivation for some people to embrace treatment, while serving only to hinder others (Klag et al., 2005).

One key informant, an ex-offender, draws attention to how experiences of coercion may be fluid in nature, changing over time, place and context, negative at one point and later positive:

Treatment ordered by the court takes from the individual's choices. For me now it's important to have choices. Maybe if I was to relapse and reconsider treatment, then it would be based on me now, but 10 years ago I didn't have the education, self-esteem or sense of worth to do something like that for myself. So I think it was good then that my corrective services officer made those choices for me. I can also see how it could go wrong if a person has their choices and rights taken away from them. If a person is not given the choice of type of treatment or where, then they could end somewhere not suited to them and they could end up worse than before.³¹

There are those who consider that coercion tends to reduce treatment effectiveness. Wild (2006), for example, recommends the rejection of AOD programs that create perceptions of coercion for the individual,

²⁹ KI01.

³⁰ KI06.

³¹ KI02.

noting that ‘influential theories of human motivation and behaviour change support the proposition that perceived coercion is counterproductive’ (p.46).

Typically there is a paradigm set up in the addict's head and it's a paternalistic model that promotes secrecy and duplicity. Typically the addict sides with their addiction – 'me and my drug-ness against you and your control-ness'.³²

Alternatively, coercing individuals into treatment may be regarded as humane and potentially effective. It can be viewed as fulfilment by the State of its duty to protect the life and liberty of individuals in the community due to harm they are causing themselves (see also section 2.5).

Many people die and do really terrible things before they're ready to come to treatment voluntarily and you could very easily have predicted the illness, crime etc.³³

There is very little research that considers these matters involving coercion. The absence of a standardised assessment tool to measure an individual's experience of different forms of coercion into treatment further limits research in this domain (Klag et al., 2005). Young (2002) developed a perception of legal pressure (PLP) measure, which he reported produced scores that co-varied predictably with mandated coercive strategies. Research methodology is discussed in section 4.1.

There have been many models proposed to assist our understanding of problematic drug use, dependence or addiction and consequently there are many associated treatment models. To apply a medical model, drug dependence is viewed as a treatable condition with a physical and biological basis. A psychosocial approach considers the experience and social life of the offender. For all approaches, there is a balance to be found between personal autonomy, with the individual taking responsibility, and the need for State intervention.

Some members of the PRG³⁴ considered the national IDDI to be based on an impoverished view of the autonomy of drug users, whereby individuals are considered to be ‘suffering impairment of healthy volition through drug use, and therefore requiring State intervention’. By contrast, drug courts and pre-trial diversion schemes (see sections 3.1.2 and 3.1.4) may be seen as collaborative, cooperative ventures – between State and offender – encouraging practices of self-control and responsibility.

Models of coercion and dependence clearly influence what is meant by compulsory treatment, and what its applications in the wider world may be.

³² K110.

³³ K110.

³⁴ PRG101.

2.8 Cost

Drug use carries with it individual, social and economic costs and, while the measurement of these is an inexact task, it is considered necessary. Government bodies, in particular, need cost–benefit studies to inform decisions about how to invest resources in drug strategies, and how to evaluate the effectiveness of these strategies. Because of their high costs, alcohol and drugs have attracted attention in this domain.

For example, the cost of heroin use in Victoria, as determined by an inquiry for the Victorian Premier’s Drug Prevention Council, included estimates of the following (Clark et al., 2003, p.1):

- public-funded drug treatment costs
- public-funded health care costs
- other government agency costs (e.g. social security staff cost)
- social security payments to drug users (e.g. disability support and housing)
- loss of income tax revenue
- costs associated with drug-related crime (including policing, law enforcement, the court system, the prison system, community correctional services and the private cost to the victims of crime).

Calculating these cost factors, Clark et al. (2003) conservatively estimated that dependent heroin use in Victoria cost \$845 million per year. Australia-wide estimates by Collins and Lapsley (2002) put the total annual social and economic costs of illicit drug use in Australia in 1998–99 at \$6.1 billion per year, with much of this cost (39% or \$2.4 billion) arising from drug-related crime. These estimates include tangible costs (labour, health care, road accidents and crime) and intangible costs (loss of life and pain and suffering).

The cost savings of some forms of drug programs have been asserted:

There is strong evidence that the social, economic and health costs of illicit drug use can be significantly reduced through harm minimisation policies such as methadone maintenance treatment, supervised injecting facilities and needle and syringe programs. (Loxley et al., 2004)

Establishment of needle and syringe programs in Australia in the late 1980s, for example, is believed to be the single reason for the extremely low rates of HIV among people who inject drugs. (Gunaratnam, 2005, p.3)

Compulsory treatment programs are intended to lead to reductions in the costs of incarceration, which in Australia range from \$99 per day in open prisons in Queensland, to \$287 in secure prisons in the Australian Capital Territory (Black, Dolan & Wodak, 2004), and to savings by way of reduced police and court time. It is arguable, however, that the provision of resources to minor offenders (e.g. via pre-arrest diversion schemes) entails unnecessary expenditure, given rates of re-offending for first-time offenders are low anyway (Freiberg, 2002).

Cost–benefit analysis of civil commitment is a particularly complex task for several reasons. The number of people to whom it applies is very small, so reductions in public health and justice costs (e.g. emergency admissions and police detainment) may be impossible to detect. How are the emotional benefits to families to be measured? How is reduced dependence on charitable organisations, which many of those to whom this legislation applies are dependent on for support and survival, to be measured?

2.9 Unintended outcomes

There is potential for compulsory treatment to produce unintended negative consequences. Current practices can result in net-widening, displacement from treatment, and discrimination against minority groups.

2.9.1 Net-widening

The phenomenon of net-widening is a significant ethical issue associated with compulsory treatment in Australia (Spooner et al., 2001). Net-widening refers to three main situations:

- Wider nets – the number of people subject to criminal justice proceedings increases due to the availability of a diversion option. For example, a person who may previously have been released with an informal warning may be subject to a more formal process due simply to the existence of a diversion program. This may occur in circumstances where there would be insufficient evidence to sustain a charge under conventional proceedings. Similarly, offenders may feel compelled to plead guilty (and, indeed, are required to plead guilty in order to enter some diversion schemes, e.g. pre-trial diversion in South Australia; drug courts in New South Wales, Queensland and Western Australia) to crimes they did not commit, when faced with the choice of diversion to treatment or a possible guilty finding and term of imprisonment or fine (Spooner et al., 2001).

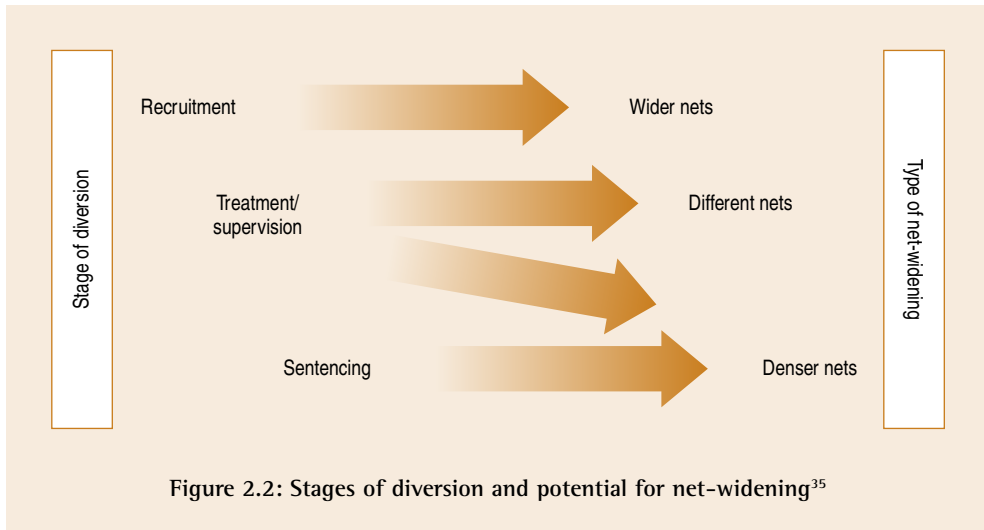
- Denser nets – treatment intervention is more intensive than a court-imposed sanction alone would have been. For example, the penalties for non-compliance with a diversion order may be more serious and onerous or of greater duration than the penalty for the original offence, resulting in an individual being drawn deeper into the criminal justice system than would otherwise have been the case. The level of scrutiny and monitoring may also be greater under a diversionary program.
- Different nets – new services supplement rather than replace existing services, such that an individual becomes enmeshed in the treatment net in addition to the criminal justice net.

Net-widening results in greater restrictions on the liberty of individuals than would otherwise have been the case, had they not been diverted into treatment. As shown in Figure 2.2, there is potential for all three types of net-widening to occur throughout all stages of diversionary programs in Australia.

In considering whether net-widening occurs in the diversion of offenders in Australia, the key question to ask is put succinctly by Roberts and Indermaur (2006):

Do court drug diversion initiatives really divert or simply add levels of complexity and supervision, fostering the growth of the criminal justice system?

Net-widening can also occur under civil commitment legislation if it is used beyond the purposes and persons for whom it was intended (i.e. for the benefit of a small group of AOD-dependent individuals). This legal mechanism can be, and has been, used as a means of controlling individuals who exhibit troublesome or difficult behaviour (New South Wales Standing Committee on Social Issues, 2004). It is of significant concern that a tool of compassionate care can be rendered an instrument of social control.



2.9.2 Treatment shortages and displacement

Another unintended negative outcome that can arise from compulsory treatment programs is the displacement of limited treatment resources available in the community. Through diversion programs, treatment places are allocated preferentially to people coercively referred via the criminal justice system, leaving fewer places for those voluntarily seeking treatment. Similarly, civil commitment provides for immediate admission and can require that such clients be given priority access to treatment (*Alcoholics and Drug-dependent Persons Act 1968* (Vic), s.11). Hall (1997) questions the wisdom of ‘allocating substantial resources to such programs when there is limited provision in the community for the “voluntary” treatment of heroin and other drug dependence’.

While this issue may be overcome by providing separate funding streams to each referral source (Flaherty et al., 2002; Spooner et al., 2001), there is concern (including among PRG members and key informants) about the ability of governments to ensure this. Thus the potential arises for what one key informant calls ‘perverse incentives’:

The problem is she goes along to a drug treatment centre and says, ‘I’m 17 and this is my situation, please help me’ and they say, ‘Have you committed a crime?’ ‘No.’ ‘Are you HIV positive?’ ‘No.’ ‘Are you pregnant?’ ‘No.’ ‘Well, get out of here. Come back when you’re one of the above and we’ll help you, because we’ve got a long list of involuntary treatments and we’ve got to treat the involuntary treatments before the voluntary treatments. So my advice to you is do some shoplifting and then we can give you some help.’ And that’s not just a theoretical risk. I think that’s a real risk.³⁶

³⁵ Adapted from Roberts and Indermaur (2006).

³⁶ KI01.

If people are feeling confused and depressed and they are homeless, and want treatment but [there are long waiting lists in the public system and] they can't afford the private system, often they will plead guilty to gain access to treatment.³⁷

Considerations of fairness and propriety necessarily arise when motivated individuals are denied access to treatment because resources have been diverted to the treatment of others whose motivation and readiness to change may be low, or even non-existent.

2.9.3 Discrimination against minority groups

The structures and processes supporting compulsory treatment generally operate to exclude individuals from minority groups, who may therefore be missing out on any benefits of diversion, such as prioritised treatment and diversion from imprisonment.

Indigenous Australians, though over-represented in the criminal justice system, have low participation rates in diversion programs (Alcohol and other Drugs Council of Australia, 2003b; Siggins Miller Consultants & Catherine Spooner Consulting, 2003). For example, evaluation of the New South Wales Cannabis Cautioning Scheme revealed that Indigenous offenders were much less likely than non-Indigenous offenders to be eligible for cautioning, because of a past violent offence, or because they would not admit to committing an offence (which is a requirement of cautioning). It has been reported that the New South Wales Aboriginal Legal Service advises clients, as a matter of policy, never to admit to any charges at the point

of arrest.³⁸ This well-intentioned advice may be having the unintended consequence of reducing the number of Indigenous offenders to enjoy the potential benefits of pre-arrest diversion. Problems with diversion have also been reported for Indigenous youth, including a scarcity of adequately resourced diversionary options and failure to ensure sufficient community involvement in planning and implementation (Siggins Miller Consultants & Catherine Spooner Consulting, 2003).

People who do not understand English, or who are from countries where admission to drug-related offences can carry grave consequences, are also less likely to be diverted into treatment. Other minority groups with low involvement in compulsory treatment include people with mental health problems, women (Bull, 2003) and people in rural areas (Flaherty et al., 2002). Offenders from these groups tend to proceed through conventional criminal justice channels instead (Spooner et al., 2001). This under-representation appears to be partly due to explicit exclusion criteria, and partly due to unaddressed bias in the application of diversion processes.

Conversely, civil commitment legislation is used disproportionately against minority groups – in particular, Indigenous Australians and people of marginalised socioeconomic status (New South Wales Standing Committee on Social Issues, 2004). Given the punitive operation of this legislation in practice, despite its intended therapeutic purpose, this is of significant concern. This concern is heightened with regard to Indigenous Australians when considering the lack of culturally appropriate services (see section 4.3).

³⁷ K109.

³⁸ PRG206.

2.10 Challenges to professional roles

Compulsory treatment requires the cooperation of agencies with traditionally different and sometimes conflicting priorities, values and attitudes (Klag et al., 2005). For instance, AOD treatment providers are primarily concerned with rehabilitation of consenting users, while the focus of the criminal justice system is traditionally on coercion. Various perspectives need to be balanced for the various parties to successfully work as a team. This may be challenging. For example, police involved in drug courts need to be able to operate in a non-adversarial environment; health professionals need to be able to work within the confines of legal coercion; everyone needs a full understanding of the roles, aims and responsibilities of all parties involved. The World Health Organization advocates a multidisciplinary approach to training; however, at present, there is a dearth of research that evaluates the training received by those working with substance-abusing offenders (Hussain & Cowie, 2005). This is confounded by an absence of recognised training pathways in Australia for court, health and corrections workers involved in AOD program delivery in criminal justice settings.

The success of the drug court really depended on who was sitting at that bar table. It sounds terrible, but if you had the wrong policeman working as prosecutor, there would be no exchange of information. It was not a successful relationship as part of a team. Or if you had a legal aid solicitor bent on getting the best sentence for the client, who couldn't let go of

getting the best deal and become part of the team and learn that the whole team wanted what was best for the client, then again it wouldn't work ... Or the prosecutor might be insistent on a gaol term. We would explain that if the offender goes to the watch-house for three days, their MMT³⁹ could be maintained, whereas if prosecution was going to insist on prison for seven days, MMT would be removed and the client would get very ill. Prosecution came to realise that our recommendations were always health-based. We didn't want to do anything to make the client sicker.⁴⁰

Furthermore, in compulsory treatment programs, there is a degree to which parties are required to take on tasks traditionally within the exclusive realm of others. Judge Neil Milson describes the development of the New South Wales Drug Court:

There has been unusual multi-skilling, with lawyers involved with pharmacotherapy and urinalysis, with nurses addressing the court, with clerical staff becoming quasi-counsellors or computer programmers, and with counsellors having to inform the court when clients admit to a breach of program conditions. (Milson, 2004)

For service providers, the monitoring and reporting required in some compulsory treatment programs, and thus the possibility that boundaries of confidentiality may need to be breached, raise two main concerns: they call into question the ethics of their practice; and they may compromise client trust and rapport, and thereby jeopardise the entire therapeutic relationship.

³⁹ Methadone maintenance treatment.

⁴⁰ K103.

I see lots of dangers in drug treatment becoming an arm of the enforcement process. It gets us into terrible moral and ethical dilemmas ... If I have to advise probation and parole when a client has used drugs or not shown up to an appointment, that means I'm an extension of the probation and parole officer. I'm not anymore a therapeutic treating doctor.⁴¹

Others report that this does not create an ethical tension for them:

*I didn't have any problem with my ethics because the client signed a contract – it was all spelt out to them. It sounded dreadful, that we were saying that the court will know that you will do this, you will be urine-tested, you will live at this address etc. But the alternative was to go and stay in gaol until you've paid for the crime that you committed and if that's three years, then that's where you go. There will be no sex, no cuddles, you won't see your kids as much as you want to, all of those things that we need to keep in the front of our mind when we say someone goes to gaol. And we have to find a way of ethically helping them do what they want to do, which is stay out of gaol and get their lives together ... I think a lot of people feel that ethics is about what we do, but I believe it's about **how** we meet the needs of the client in an ethical manner.⁴²*

One key informant recommended a negotiated process:⁴³

It's not about bullying the client into treatment ... It involves negotiating on those things you can – so you empower the client within a framework which is mandatory.⁴⁴

The ability of individuals to participate jointly with their health service provider in the development of treatment goals and selecting treatment may be diminished where treatment is legally ordered. The coercive means by which the therapeutic relationship comes into being, and the involvement of teams of professionals from different disciplines in case management decisions (as used in many drug courts), potentially weaken the power and scope for the offender client to negotiate the terms of their own treatment. Use of the 'negotiated casework' approach (mentioned above) can alleviate this threat to some extent. However, the attitudes, expertise and experience of all parties involved (the client and judiciary included) will ultimately determine the level of involvement of the offender client in decision making.

The roles of police and the judiciary are extended under compulsory treatment arrangements to include some AOD assessment, and this raises another question: Do police and judges have the expertise to make referrals to treatment interventions that are appropriate for individual offenders? New South Wales police answered this question in the negative in piloting that State's first police diversion

⁴¹ KI01.

⁴² KI03.

⁴³ This key informant adopts Barber's (1991) six-step approach for working with coerced clients, where the counsellor takes on the role of a negotiator or conflict manager.

⁴⁴ KI06.

program.⁴⁵ Imposing a treatment intervention that is inappropriate and ineffective⁴⁶ may set the offender up for ‘diversion program failure’ and a sanction, and police and judges may lack the information and skills to discriminate between various treatment options (Spooner et al., 2001).

How then do they ensure that they are sending offenders to effective treatment? One key informant, a magistrate, recommends that police and judges rely on service providers:⁴⁷

*I don't put my toe on the health side of things – they are the experts in that ... I rely on the health professionals and they rely on me to stage-manage the judicial side of it.*⁴⁸

Defence lawyers involved with drug courts also find they have dual roles – they are engaged to advocate for and support a client on the one hand, but at other times are required, as a member of a drug court team (except in South Australia), to share information that is potentially adverse to their client. King (2006, p.8) describes the challenge:

The use of legislation and guidelines have not been able to satisfactorily resolve these issues and court professionals work their way through these issues on a case-by-case basis in the context of coping with significant case loads.

Some have expressed concern about the effect of the presence of clients whose primary motivation to enter treatment is to avoid criminal sanctions or who have been civilly committed against their will: they may exhibit difficult and challenging behaviour and attitudes that increase stress levels of treatment service staff and negatively influence the motivation of other clients (Brown, 2006, personal communication; Flaherty et al., 2002). Negative impacts on staff and other clients have been noted as a particular difficulty with civil commitment clients sent to non-secure detoxification facilities and to psychiatric wards (see section 4.3.1.4). Conversely, several residential treatment providers who service drug court participants have reported anecdotally that these types of problems occur minimally if at all.⁴⁹

⁴⁵ Large numbers of police refused to divert offenders to a health team (for assessment and treatment intervention) on the grounds that they felt insufficiently skilled and trained to distinguish offenders suitable for diversion, from those who should be charged by conventional processes. This lack of police support for the pilot diversion program was a contributing factor in the decision to limit police diversion to cannabis offences only (KI09).

⁴⁶ Treatment matching is a clinical skill requiring consideration of an individual's stage of change and other personal factors and knowledge of a range of treatment modalities and their availability. Further discussion is beyond the scope of this paper and the reader is referred to literature such as Turning Point Alcohol and Drug Centre's Clinical Treatment Guideline 1: Key principles and practices (Addy, Ritter, Lang et al., 2000).

⁴⁷ Assuming they keep abreast of current treatment practices.

⁴⁸ PRG206.

⁴⁹ Presentation and discussion by Mary Alcorn (National Board of Australasian Therapeutic Communities Association) and Wayne Day (Salvation Army Brisbane Recovery Services Centre) at the Court Drug Diversion Initiatives Conference, Brisbane, 25–26 May 2006.

Professionals involved in compulsory treatment programs face significant challenges to their skills, ethical practices and the very paradigms within which they operate. The extent to which these challenges are addressed has important implications for all involved. The manner in which they should be met and, indeed, whether they should be met at all, are important questions that bear considering.

2.11 Ethical guidance in the AOD field

In the 1990s, several influential best-practice guidelines for diversion were produced, including by the Alcohol and other Drugs Council of Australia (ADCA) and the United States Bureau of Justice Assistance (BJA). These guidelines were written as programs when first being developed, thus they predated program evaluations, yet Bull (2005), in her review of five international best-practice documents published in the United States, Britain and Australia, reported substantial commonality among the principles identified in the different documents, with eight being mentioned in all five papers.⁵⁰ As Table 2.1 shows, key areas requiring attention include eligibility, access, training and partnerships. These areas emerge repeatedly in program evaluations (see section 4.2) and may be used as the basis for developing more general principles of best practices (see section 5.1).

More broadly, ADCA is also responsible for work in the development of ethical guidance for those working in the AOD field. In 2005, it commissioned a project to develop a Code of Ethics for the AOD field. Draft principles have been developed which, while they focus on AOD practice, are also highly relevant for the AOD field generally (including policy making and research).⁵¹ In a related project, the Australian National Council on Drugs has developed an AOD Charter, the purpose of which 'is to develop a broad range of principles and goals that all stakeholders within the AOD sector can draw upon in the development and implementation of AOD policy' (Australian National Council on Drugs, 2006). It is intended that the revised code of ethics will be a companion piece to the AOD Charter.

To some degree, these projects will help address the present overall lack of ethical guidance for those making decisions in the area of compulsory treatment.

⁵⁰ See Appendix F for the 14 most consistently reported principles.

⁵¹ See Appendix G for a summary of the Draft Code of Ethics for the Australian AOD field.

Table 2.1: Principles of best practice for the diversion of drug-related offenders

Principle	
Eligibility	Clear criteria for inclusion complemented by systematic assessment process for eligibility
Access	Programs should be available to those from a diverse range of backgrounds including those with special needs; a range of interventions should be available according to need and seriousness of offence; speedy referral to intervention services
Program monitoring and evaluation	Ongoing monitoring of program delivery and outcomes; effective, efficient systems for data collection and management
Training	Training to be provided to all involved in program delivery, addressing program principles, roles of all participants, drug treatment, and judicial processes
Management, communication, role definition and demarcation issues	Treatment services should be well integrated with criminal justice processes and there should be clearly defined structures and agreed processes that facilitate collaboration and communication
Partnerships	Support is required from all agencies, involving collaboration and communication between health and criminal justice sectors
Documentation	Policies and procedures should be clearly documented to ensure consistency, e.g. eligibility criteria, monitoring compliance, confidentiality protocols
Range of treatment options	A broad range of treatment/intervention options should be available

3. Types of compulsory AOD treatment in Australia

In Australia, a range of programs exists through which individuals may be coerced and compelled, by legal mechanisms, into AOD treatment. They fall into two broad categories: diversion measures and civil commitment.⁵²

3.1 Diversion

Diversion refers to a ‘range of related but relatively exclusive procedures some of which are seen as potential alternatives to “due process”, others as additions to it’ (Williams, 1981, p.3). Diversion possibilities exist throughout criminal justice proceedings, which can be divided into five main stages (Spooner et al., 2001):

- pre-arrest – before a charge is laid
- pre-trial – after a charge is laid, but before the hearing proceeds
- pre-sentence – after conviction, but before sentencing
- post-conviction – as part of sentencing
- prison pre-release – prior to release from incarceration.

Diversion occurring pre-arrest or pre-trial involves offenders being diverted into treatment as an alternative to being processed any further by the criminal justice system. AOD-related offenders are given the option of undergoing treatment or having their criminal offence dealt with by conventional justice proceedings.

Pre-sentence, post-conviction and pre-release diversions are ‘additions’, in that an individual must still move through the justice system, while being diverted into AOD treatment.

Throughout Australia, diversion acts to refer offenders, for a variety of reasons, into other services; mentally ill offenders are diverted into mental health treatment services;⁵³ first-time offenders may be diverted into programs such as defensive driving courses or counselling;⁵⁴ and young offenders may be diverted into conferencing⁵⁵ and community-based programs. References in this paper to ‘diversion’ are limited to diversion to AOD treatment.

Pre-arrest diversion involves minor AOD offenders being diverted by police, at the time the offence is discovered, into education, assessment and treatment. Offenders who consent to participate in pre-arrest diversion schemes can avoid a charge for the drug offence; through full participation in the prescribed education and/or treatment program, offenders are able to expiate

⁵² Compulsory drug treatment in custodial settings may be considered a third category; however, there is only one prison program operating in Australia that can compel prisoners to undergo treatment – the New South Wales Compulsory Drug Treatment Centre (Parklea). As the New South Wales Drug Court is the sole body empowered to issue Compulsory Drug Treatment Orders, the Compulsory Drug Treatment Centre is described with the New South Wales Drug Court at 3.1.4.1. The wide range of voluntary treatments available in Australian prisons is described in Appendix J.

⁵³ For example, the Magistrates Court Diversion Program (SA); Mental Health Court Liaison Service (Vic); Community Court Liaison Service (NSW).

⁵⁴ For example, Criminal Justice Diversion Program (Vic).

⁵⁵ Programs such as the Juvenile Pre-Court Diversion Program (NT) are available in all Australian States and Territories.

their offence.⁵⁶ Offenders who fail to meet their assessment, education and/or treatment obligations under the program may be returned to the criminal justice system and charged with the original offence (Australian Government Department of Health and Ageing, 2004a). These programs are detailed in section 3.1.1.

Pre-trial diversion involves a magistrate referring for assessment a defendant with a demonstrable drug problem and need. A treatment plan is then prepared which is included as a condition of bail. Solicitors and police officers can also make referrals for assessment and defendants themselves (and their families) can self-refer to pre-trial diversion (New South Wales Government, 2002). Pre-trial diversion is described in section 3.1.2.

Pre-sentence diversion generally involves the magistrate or judge delaying sentencing by way of adjournment and releasing the offender for a period to attend AOD treatment. Treatment attendance is then taken into account in sentencing. In New South Wales, the Youth Drug and Alcohol Court uses common law Griffiths Bonds to divert offenders into treatment in this way.⁵⁷ Court diversion programs are described in section 3.1.3.

Post-conviction diversion occurs when a magistrate or judge orders drug treatment as part of a convicted offender's sentence (Spooner et al., 2001). Mechanisms include

general sentencing orders, drug courts, Indigenous sentencing courts and conditional suspended sentences. General sentencing orders may have conditions attached requiring a convicted offender to attend AOD treatment; for example, good behaviour bonds with conditions to enter treatment; and sentencing orders for drink and drug driving offences that cancel the individual's driver's licence and require completion of a drink or drug driver education course (and, in some cases, clinical assessment) as a prerequisite for licence reinstatement.⁵⁸ Drug courts, Indigenous sentencing courts and conditional suspended sentences are described in sections 3.1.4, 3.1.6 and 3.1.7.

Pre-release diversion involves early release of an inmate from prison either into a secure, supervised residential treatment program or into a non-residential structured, supervised treatment program. Examples of pre-release diversion programs operating in Australia are described briefly at 3.1.8 below.

These 'official diversionary programs' (McDonald et al., 1994) have been operating in Australia for over 30 years and represent the predominant form of compulsory treatment. They aim to impact upon offending behaviour by addressing AOD use through coerced treatment and simultaneously⁵⁹ to reduce contact with the justice system (Loxley et al., 2004). Klag et al. (2005) report that diversion programs are an increasingly popular response to the body of evidence linking drug use and offending behaviour.

⁵⁶ An expiated offence is one for which no criminal conviction is recorded.

⁵⁷ The Youth Drug and Alcohol Court is technically a pre-sentence diversion program, but is discussed in 3.1.4 with drug courts due to their similarities.

⁵⁸ Others include: community corrections orders (available in Queensland, South Australia, Tasmania, Victoria and Western Australia); home detention orders (available in New South Wales, Northern Territory, South Australia and Victoria); combined custody and treatment orders (available only in Victoria); intervention program orders (available only in New South Wales).

⁵⁹ For pre-arrest and pre-trial diversion, at least.

Most diversion programs in Australia apply to offenders who use illegal drugs. Alcohol dependence or problematic use seldom renders a person eligible to participate in a diversion program. The exceptions to this include several youth-specific diversion programs (e.g. YOUthinc Underage Alcohol Diversion Pilot Program (Victoria), Juvenile Pre-Court Diversion Program (Northern Territory), Youth Drug and Alcohol Court

(New South Wales)) and three adult diversion programs – the Court Alcohol and Drug Assessment Service (Australian Capital Territory), the Victorian Drug Court and the Northern Territory Alcohol Court (see sections 3.1.2, 3.1.4.4 and 3.1.5).

A summary of diversion options available at each of the five stages of criminal justice proceedings is shown in Figure 3.1.

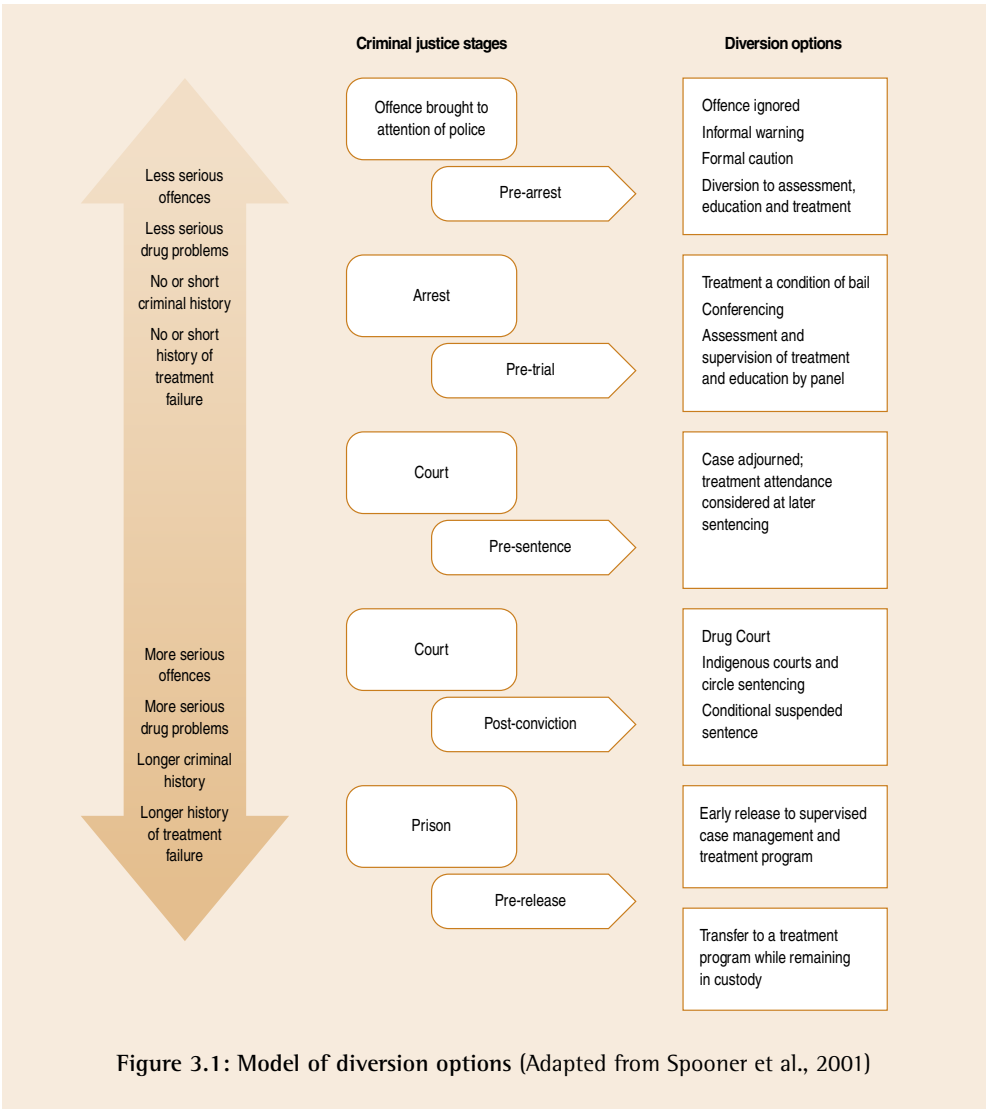


Figure 3.1: Model of diversion options (Adapted from Spooner et al., 2001)

Diversion strategies can potentially target a wide range of offenders. Would-be participants can differ on several dimensions including the length of their offending history, the current offence, and the nature of their substance use (non-problematic through to dependent) (Spooner et al., 2001). The criminal offences to which diversion applies may be directly or indirectly related to AOD use. For example, possession, use and supply are direct drug offences, while drink driving, assault committed while intoxicated, and property crimes committed in order to fund drug use are considered to be related indirectly to drug use. Depending on the parameters of the diversion program in place, all such offences could render a person eligible for diversion (Spooner et al., 2001). The diversity of target populations is reflected in the variety of diversion programs available.

The main diversion initiatives currently available in Australia are outlined below.

3.1.1 Police pre-arrest diversion

Formalised under the Illicit Drug Diversion Initiative (IDDI) (see 2.1.1), pre-arrest diversion is based on the rationale that diversion can:

- reduce illicit drug use and drug-related crime
- reduce costs of drug-related crime and law enforcement
- reduce the number of people appearing before the courts for use or possession of small quantities of illicit drugs, freeing up police and court resources
- assist individuals to take personal responsibility and regain control over their lives, thus leading to safer environments for all Australians and reducing the considerable personal and social costs of AOD use on our communities (Australian Government Department of Health and Ageing, 2004b).

In addition, as pointed out by Spooner et al. (2001), diversion can offer offenders an opportunity to avoid the potential harms that can be associated with the experience of arrest and/or prosecution in the criminal justice system.

Pre-arrest diversion targets illicit drug users who have little or no past contact with the criminal justice system (for drug offences), and who have been apprehended by police for possession and/or use of small quantities of any illicit drug. Such diversion may be considered a form of warning and assistance. Offenders who complete the requirements of the diversion program avoid criminal conviction for that offence entirely. For first offenders, many of whom do not re-offend, pre-arrest diversion may be the least harmful, most effective and efficient response to their behaviour.

In some jurisdictions, diversion is limited to cannabis only (New South Wales adult scheme, Queensland). In the remaining States and Territories (Australian Capital Territory, New South Wales juvenile scheme, Northern Territory, South Australia, Tasmania, Victoria, Western Australia) diversion is available for all minor illicit drug offences.

At the time they are apprehended, eligible offenders are informed of the option to be diverted away from the criminal justice system via participation in a pre-arrest diversion program. This involves being referred for assessment to determine their needs for treatment and/or drug education. In some jurisdictions, offenders are diverted directly into drug education programs. In general, an offender is eligible for diversion if:

- there is sufficient evidence of the offence
- the offender admits to committing the offence
- the offender is using and/or in possession of illicit drugs

- the offender has no history of violence; and
- the offender gives informed consent to participate in diversion (Australian Government Department of Health and Ageing, 2004b).

Pre-arrest diversion programs and schemes operate in every Australian State under the guidelines of the IDDI, thereby ensuring a nationally consistent approach to

diversion. Some flexibility in implementation is afforded, however, recognising that ‘law enforcement, drug assessment, education and treatment service systems are jurisdictionally based and have different legislative, practice and cultural circumstances’ (Australian Government Department of Health and Ageing, 2004a). This flexibility means that diversion schemes vary somewhat across States. State-based diversion schemes are outlined in Table 3.1.

Table 3.1: Australian pre-arrest diversion schemes⁶⁰

Jurisdiction	Pre-arrest diversion scheme	Target group
Australian Capital Territory	Police Early Intervention and Diversion Scheme Australian Federal Police may, at their discretion, and with the offender’s consent, divert an offender for assessment where a treatment plan is negotiated	Offenders in possession of small amounts of illicit drugs, or illicit possession of a licit drug, generally with little or no criminal history or treatment; offence did not involve violence
New South Wales	Adult Cannabis Cautioning Scheme Discretionary police cautioning scheme. Upon second caution, offender must attend counselling and education. Charge dealt with by court if offender fails to complete or if caught again with cannabis Youth Justice Conference Young person and victim of crime agree on a plan, which addresses drug and other problems and may include treatment and counselling; failure or breach results in case being returned to police or court	Adults caught with small amounts of cannabis or equipment for using; ineligible if history of violent, sexual or drug offences Youth under 18 years; minor drug offences

⁶⁰ Some States refer to their pre-arrest diversion arrangements as schemes, while others call them programs. For the sake of consistency, and in keeping with the terminology used in the IDDI, they will be referred to as schemes. Where referring to State-specific, pre-arrest diversion arrangements, the term used in the name of the ‘scheme’ or ‘program’ will be applied.

Jurisdiction	Pre-arrest diversion scheme	Target group
Northern Territory	Cannabis expiation scheme A fine can be paid to expiate a minor cannabis offence	Adults
	Northern Territory Illicit Drug Pre-Court Diversion Program Diversion of first-time offenders into illicit drug assessment, education, counselling and treatment	Juveniles and adults apprehended for use and possession of less than trafficable quantities of illicit drugs (excluding cannabis)
	Juvenile Pre-Court Diversion Program Diversion into drug, alcohol or substance abuse programs	Under 18 years
Queensland	Police Diversion Program Diversion to the Drug Diversion Assessment Program (DDAP) must be offered by police to minor drug offenders (cannabis). Participation in the DDAP involves attendance at a 1–2 hour assessment and education session. Only one diversion is allowed	Adult and juvenile offenders
South Australia	Cannabis Expiation Notice Scheme Simple cannabis offenders are given an expiation notice, together with educational material and information about treatment options	Adults; minor cannabis offences
	Police Drug Diversion Initiative Adult model First and second offenders are referred to a single assessor via the Drug Diversion Line. Diversion is compulsory. Assessor may refer to treatment	Adults; illicit drug offences other than cannabis
	Third and subsequent offenders are referred to the Drug Assessment and Aid Panel for assessment and referral to treatment	

Jurisdiction	Pre-arrest diversion scheme	Target group
South Australia	<p>Young people's model</p> <p>Diversion of 10–17 year olds to drug assessment, education and treatment</p> <p>Diversion of 14–17 year olds to drug assessment, education and treatment</p> <p>Aboriginal Police Drug Diversion Liaison Project</p> <p>An Aboriginal person can elect to be diverted to attend the Aboriginal Drug and Alcohol Council (ADAC) for assessment instead of going to court, being fined and getting a criminal record</p>	<p>Cannabis and/or prescription drug offences</p> <p>Illicit drug offences</p> <p>< 18 years, in possession of small quantities of illicit drugs</p> <p>18 years +, in possession of illicit drugs other than cannabis</p>
Tasmania	<p>Drug Diversion Program</p> <p>Level 1: Cannabis caution – caution and education materials for first-time minor cannabis offenders</p> <p>Level 2: Brief intervention – second-time minor cannabis offenders are issued a Drug Diversion Notice requiring attendance at a brief intervention session</p> <p>Level 3: Assessment and treatment – third-time minor cannabis offenders OR offenders found using or possessing small quantities of other illicit drugs can be charged or issued a Drug Diversion Notice requiring attendance for assessment and one or more follow-up appointments for counselling or other treatment</p>	<p>Drug offenders (adult and juvenile) caught using or possessing small quantities of illicit drugs; people under 18 years must be accompanied by parent/guardian</p>
Victoria	<p>Cannabis cautioning program</p> <p>Mandatory cannabis education (Cautious with Cannabis) on the second (and final) caution, voluntary for first caution. 'Cautious with Cannabis' is a 2-hour interactive group educational session about the effects of cannabis; aims to reduce use</p>	<p>Targets offenders 17 years or over</p>

Jurisdiction	Pre-arrest diversion scheme	Target group
Victoria	<p>Drug Diversion Program</p> <p>Offenders are directed to clinical drug assessment and prescribed drug treatment. Caution is expiated when the offender has attended both the clinical drug assessment and one treatment session</p>	Adults
Western Australia	<p>Cannabis Infringement Notice Scheme</p> <p>Offence expiation by paying a fine or attending a Cannabis Education Session (CES) within 28 days of issue of notice. This scheme replaced the pilot Cannabis Cautioning Mandatory Education Scheme (CCMES) in 2004</p> <p>Police all drug diversion scheme</p> <p>Offenders must attend three counselling sessions, which include AOD assessment, development of an individual treatment plan and commencement of the plan</p>	<p>Adults committing simple cannabis offences</p> <p>Adults committing simple drug offences other than cannabis</p>

3.1.2 Pre-trial diversion

Where an offender is eligible and suitable for release on bail, pre-trial diversion entails the preparation of a treatment plan for the defendant, which is then included as a condition of bail. In some jurisdictions (e.g. Magistrates Early Referral Into Treatment – MERIT), bail conditions will include a requirement to ‘do all things required by the court team’ rather than the details of the treatment plan. The magistrate relies on the expertise of the treatment providers to implement an appropriate plan.

In some jurisdictions program compliance enables an offender to avoid a conviction, while in other jurisdictions it is taken into account by the magistrate at final sentencing. Program non-compliance may constitute

commission of a further offence; non-compliance with bail conditions or failure to appear may result in withdrawal from the diversionary program.

Types of treatment include detoxification, pharmacotherapy treatment, community outpatient treatment and residential rehabilitation.

Intended outcomes of pre-trial diversion programs include:

- decreased drug-related crime by participating defendants during and following program completion
- decreased illicit drug use by participating defendants for the duration of the program and in the post-program period

- improved health and social functioning for the duration of the program and in the post-program period
- increased community protection from drug-related criminal activity
- sentences that reflect the better rehabilitation prospects for successful participants (New South Wales Government, 2002).

As shown in Table 3.2, pre-trial diversionary programs currently operate in the Australian Capital Territory, New South Wales, the Northern Territory, South Australia and Victoria. At the time of writing in 2006, plans were underway for a pilot program to be run in Queensland.

Table 3.2: Overview of Australian pre-trial diversion schemes

Jurisdiction	Pre-trial diversion scheme	Target group
Australian Capital Territory	<p>Court Alcohol and Drug Assessment Service (CADAS)</p> <p>Upon petition for assessment and with consent, the offender is sent for AOD assessment. A treatment plan is formulated and, if deemed appropriate, the magistrate releases the offender on bail to attend treatment. No exclusion criteria apply.</p>	Adults with alcohol or other drug problems
New South Wales	<p>Magistrates Early Referral Into Treatment (MERIT)</p> <p>Operates pre-plea as an intensive three-month drug treatment and case management program. Compliance or non-compliance may be considered at the magistrate's discretion in the determination of final sentence. Persons with current or outstanding offences for violence or sexual assault are excluded, as are those charged with strictly indictable offences and those on other court-ordered treatment programs. 54 courts in NSW operate the MERIT program.</p> <p>Youth Justice Conferencing</p> <p>Police and Children's Court magistrates can refer a young person to conferencing, which results in an outcome plan. Plans can include a requirement to participate in an AOD program. Failure to agree to or adhere to the plan results in the matter being referred back to police or to the Children's Court.</p>	<p>Adults motivated to engage in treatment and rehabilitation for their illicit drug use problem</p> <p>Young offenders aged 10–17 years</p>

Jurisdiction	Pre-trial diversion scheme	Target group
New South Wales	<p>Rural Alcohol Diversion (RAD)</p> <p>Based on the MERIT program, offenders with alcohol abuse or dependence can be diverted as part of the bail process, to receive targeted alcohol treatment (including detoxification, residential rehabilitation, pharmacotherapies). RAD occurs before any pleas are entered and participation is not considered as admission to the offence. The magistrate at the hearing or sentencing considers the treatment report and the implication of compliance or non-compliance is at his/her discretion.</p>	Adults suitable for release on bail who have a demonstrable alcohol problem; no violent or sexual assault offences
Northern Territory	<p>Court Referral and Evaluation for Drug Intervention and Treatment (CREDIT)</p> <p>Magistrate imposes treatment (as recommended by court clinician upon assessment) as part of bail conditions. Participants are referred to existing treatment services. The court reviews progress and takes it into account in sentencing. Located in Alice Springs and Darwin.</p>	Illicit drug users
Queensland	<p>QMERIT to be piloted in 2006</p> <p>QMERIT will be based on the NSW MERIT program. It will enable offenders 'whose drug dependency contributed to their offending behaviour to undergo treatment for their illicit drug use whilst on bail' (Queensland Government, 2003).</p>	Adults dependent in illicit substances
South Australia	<p>Drug Assessment and Aid Panel (DAAP)</p> <p>If the Magistrates Court considers drug assessment appropriate, an individual who has pleaded guilty to a simple offence may be referred to the DAAP for assessment. The DAAP may prescribe treatment and education for up to six months. No conviction is recorded if the offender successfully completes treatment. Non-compliance may result in prosecution.</p>	Offenders who plead guilty to a minor drug offence (other than cannabis)

Jurisdiction	Pre-trial diversion scheme	Target group
South Australia	<p>Court Assessment and Referral Drug Scheme (CARDS)</p> <p>Pilot scheme which enables individuals who have allegedly committed an offence in support of an illicit drug habit, or whilst under the influence of an illicit or licit drug, or are charged with possession or use of an illicit drug, to be referred by a Magistrates Court to a minimum of four sessions of counselling, delivered by a specialist clinician, over a three-month period. Operates pre- and post-plea.</p>	<p>Adults 18 years or over who admit to problematic drug use, consent to participate and are not charged with a serious sexual or violent offence</p>
Victoria ⁶¹	<p>CREDIT⁶²/Bail Support Program</p> <p>Aims to increase the likelihood of bail being granted and successfully completed by linking offenders to appropriate services and treatment via court-based case managers. Treatment progress or completion is considered when sentencing; 3–4 month program.</p> <p>Rural Outreach Diversion Workers (RODW)</p> <p>Provide a link between police, courts, drug treatment agencies and community. With the offender's consent, a magistrate can refer, or police, legal personnel, juvenile justice or schools may make an informal referral.</p>	<p>Any defendant eligible for bail (including violent offenders) who has a problem with illicit substance use and is at risk of committing further offences while on bail</p> <p>Young offenders 25 years and under arrested for a non-drug-related offence but whose drug use is a clear factor in their offending. Living in areas where CREDIT program cannot be accessed</p>

⁶¹ In July–August 2006, the Victorian Government implemented the Court Integrated Services Program (CISP) at three court locations. CISP aims to address the over-representation of people from backgrounds of disadvantage and marginalisation through provision of an integrated service delivery model, guided by principles of therapeutic jurisprudence. It aims to enhance and integrate the CREDIT/Bail Support Program and the Drug Court program. CISP will target offenders with a moderate–high risk of re-offending.

⁶² Also known as Court Referral and Evaluation for Drug Treatment Program.

3.1.3 Pre-sentence diversion

Pre-sentence court diversion programs target first or early offenders and enable them to avoid a criminal record by undertaking conditions, such as AOD treatment. Programs operating in Australia are summarised in Table 3.3.

Table 3.3: Pre-sentence court diversion schemes

Jurisdiction	Pre-sentence diversion scheme	Target group
New South Wales	<p>Youth Drug and Alcohol Court</p> <p>A magistrate can order a young person to attend assessment and, if the young person consents, place them on a Griffiths Bond. Sentencing is deferred for six months and a treatment plan implemented. Participation is considered at sentencing (see 3.1.4.1).</p> <p>Deferred Sentencing</p> <p>Magistrate can defer sentence for 12 months and bail an offender to treatment under <i>Crimes (Sentencing Procedure) Act</i>, s.11.</p>	Juvenile offenders aged 14–18 years with a serious drug or alcohol problem who plead guilty
Queensland	<p>Illicit Drugs Court Diversion Program</p> <p>Any Magistrates Court can place a consenting eligible offender on a recognisance order, which includes a condition to attend a Drug Assessment and Education Session (approx 2.5 hours). No conviction is recorded if session attended. Non-attendance results in offender being sentenced for original offence. Any further treatment offered is voluntary and not included in the recognisance. Diversion may be offered twice. Available in all 106 Queensland Magistrates and Children’s courts.</p>	Juvenile and adult offenders charged with possession of an illicit substance for personal use, who admit the facts and have not been convicted previously of an offence of a sexual or violent nature or an indictable drug offence

Jurisdiction	Pre-sentence diversion scheme	Target group
Victoria	<p>Criminal Justice Diversion Program</p> <p>Any Magistrates Court can, with the prosecutor’s consent, place a consenting eligible offender on a diversion plan. The plan may require attendance at counselling and/or treatment, victim compensation, etc. Charges are adjourned while the diversion plan is undertaken. If all conditions are completed, charges are discharged and the offender avoids a criminal record. If conditions are not completed, the matter is referred back to the court for hearing.</p>	<p>Adult offenders charged with a summary offence (not necessarily a drug offence), who admit the facts</p>
	<p>Deferred Sentencing</p> <p>Any Magistrates Court, upon a finding of guilt, can defer sentence for up to six months with a specific condition to attend drug treatment.</p>	<p>Offenders aged 17–25 years with a drug problem</p>
Western Australia	<p>Pre-sentence Opportunity Program (POP)</p> <p>Eligible offenders are referred at the magistrate’s discretion to a drug counsellor for assessment. Suitable and consenting offenders are placed on remand to attend treatment (usually counselling) for approximately eight weeks. Participation is considered at final sentencing.</p>	<p>Adult offenders with problematic drug use and low-level offending history, who plead guilty</p>
	<p>Young Person’s Opportunity Program (YPOP)</p>	<p>Young people 10–18 years</p>
	<p>Indigenous Diversion Program (IDP)</p> <p>Similar to POP, but involves an Indigenous worker providing assessments and referrals to culturally secure diversion services.</p>	<p>Indigenous offenders</p>

Jurisdiction	Pre-sentence diversion scheme	Target group
Western Australia	<p>Supervised Treatment Intervention Regime (STIR)</p> <p>Eligible offenders are referred at the magistrate's discretion to a drug counsellor for assessment. Suitable and consenting offenders are placed on remand to attend treatment (counselling, withdrawal, residential rehabilitation, etc) for approximately three months. Offenders are case-managed by a team including the magistrate, Community Corrections Officer, prosecution, etc; they must attend court regularly and undergo drug use monitoring. Participation is considered at final sentencing.</p>	Adult offenders with a moderate criminal history and a clear drug use problem who plead guilty

3.1.4 Post-conviction diversion – drug court programs

Drug courts are the principal form of post-conviction diversion whereby a magistrate generally orders drug treatment as part of a convicted offender's sentence. Drug courts were first established in Australia in 1999 and now operate in various forms across five Australian States: New South Wales, Queensland, South Australia, Victoria and Western Australia. In New South Wales, Queensland and Victoria, specific legislation was enacted to permit the establishment of drug courts, while in South Australia and Western Australia, changes were made to existing sentencing legislation to enable the drug court model to proceed.

Goals of the drug courts are typically as follows:

Drug courts aim to divert illicit drug users from incarceration into treatment programs for their addiction. (Australian Institute of Criminology, 2006a)

A drug court is a special court given the responsibility to handle cases involving substance-abusing offenders through comprehensive supervision, drug testing, treatment services and immediate sanctions and incentives. (National Association of Drug Court Professionals, 2000)

Though there is some variation across jurisdictions, to be eligible to be dealt with by an Australian drug court, a defendant must generally:

- plead guilty to the charges laid
- be dependent on drugs (or alcohol in Victoria and New South Wales youth courts only)
- show that his/her drug dependency contributed to commission of the offence(s).

Australian drug courts generally target the more serious offender, where the likely alternative is a term of imprisonment. This contrasts with United States drug courts, most of which target offenders at an earlier stage of drug use and/or offending (Freiberg, 2002). A typical Australian drug court participant has been described as:

*Someone who has very entrenched, poly-substance use history, typically very entrenched offending history and typically with a myriad of presenting issues. There might be some that would argue that their substance use is symptomatic of a whole lot of lifestyle issues.*⁶³

Drug courts generally involve a team of workers – ‘legal, health, law enforcement and correctional professionals’ (Freiberg, 2002, p.285) and the drug court judge. This team is responsible for three main groups of tasks: assessment, treatment, and monitoring and compliance. The team assesses individuals’ eligibility and suitability for participation in the program and, for those considered eligible, formulates and implements treatment plans and program conditions, monitors progress, and recommends changes to treatment and program conditions as required.

Drug courts offer highly structured, intensive treatment options. Drug court orders specify the terms of treatment and supervision, and typically involve intense monitoring and supervision in the early stages of treatment. Orders are adjusted according to the offender’s progress, such that adherence to program requirements is rewarded by reduced obligations and supervision, while failure to meet program requirements involves sanctions such as returning to an earlier phase, where monitoring is more intensive (Freiberg, 2002).

⁶³ KI06.

⁶⁴ KI01.

Drug courts have been described as ‘problem-oriented’ responses to offending behaviour, which focus on finding solutions to the problem of drug-related crimes (Freiberg, 2002). Based on the rationale that it is better to deal with drug-dependent offenders therapeutically rather than punitively, drug courts are part of a nationwide increase in therapeutic jurisprudential measures (Indermaur & Roberts, 2003).

*Drug courts are a part of the transition we are making in reversing the way we have looked at drug use. For so long we used to see it as a criminal justice issue lock, stock, barrel, and now we realise more and more that it is primarily a health and social problem.*⁶⁴

A State-by-State description of drug courts follows.

3.1.4.1 New South Wales drug courts

Adult Drug Court

The New South Wales Drug Court was established under the *Drug Court Act 1998* (NSW) and began operations in 1999. The objectives of the court are outlined in section 3(1) of the Act:

- (a) to reduce the drug dependency of eligible persons
- (b) to promote the re-integration of such drug-dependent persons into the community, and
- (c) to reduce the need for such drug-dependent persons to resort to criminal activity to support their drug dependencies.

The New South Wales Drug Court program is aimed at serious adult offenders, with many entering the program from prison. Local and District Courts must refer adult offenders to the Drug Court if they are dependent on prohibited drugs, reside within the catchment area, are highly likely to be sentenced to full-time imprisonment if convicted, have indicated an intention to plead guilty, and are willing to participate (Indermaur & Roberts, 2003; Johns, 2004).

Offenders are excluded from participating in the Drug Court program if:

- they are charged with an offence involving violent conduct
- they are charged with a sexual offence or an offence punishable under Division 2, Part 2 of the *Drug Misuse and Trafficking Act 1985*, or
- they are suffering from a mental condition that could prevent or restrict participation in the program.

Upon referral to the Drug Court, an offender is remanded in custody in the Drug Court Unit for detoxification and assessment. This process takes up to two weeks, during which time an individual treatment plan (ITP) is developed. The offender then appears in the Drug Court and enters a guilty plea and receives a suspended sentence. Individuals who choose not to enter the program at this stage are sent back to the referring court for sentencing (Johns, 2004).

Participants in the Drug Court progress through three phases of the program over 12 months (or less, if the program is terminated sooner):

1. Initiation phase – participants must reduce drug use and criminal activities, appear in the Drug Court weekly, and submit to drug tests three times per week.
2. Consolidation phase – participants must remain drug- and crime-free, report to the Drug Court once per fortnight, and submit to drug tests twice per week.
3. Re-integration phase – participants are to be ready for employment and must appear before the Drug Court once per month and submit to drug testing twice per week.

The New South Wales Drug Court closely monitors participants as they progress through the three phases and confers rewards for compliance (e.g. reduced frequency of drug testing or treatment) and sanctions (e.g. increased frequency of drug testing and supervision) for non-compliance with the program. Upon termination of a participant's program, the Drug Court reconsiders the initial sentence and usually orders a non-custodial sentence or a custodial sentence where non-compliance has been recorded.

Youth Drug and Alcohol Court⁶⁵

In addition to the Drug Court, the New South Wales Youth Drug and Alcohol Court (YDC) operates within the framework of the *Children's (Criminal Proceedings) Act 1987*.⁶⁶ Young offenders (aged 14–18 years) can be referred to the YDC if:

- they have a serious drug or alcohol problem
- they are suitable for treatment and rehabilitation
- they plead guilty or intend to plead guilty
- they agree to enter into a treatment program while on bail, and
- they are not charged with a sexual offence.

Young offenders can be mandated to attend an assessment session to determine if they are suitable to participate in the YDC program; however, their consent to participate in the YDC program is required. Upon consenting to participate, a young person is placed on what is known as a Griffiths order and sentencing of their matter is deferred for six months. An individual program plan is implemented and includes treatment schedules, regular appointments with the court, and assistance with health, housing and education needs. If the young person continues AOD use, commits other offences, or chooses to end the program early, the program plan may be cancelled and the young person returned to the Children's Court to face their initial charges. After six months on the program, either a young person 'graduates' or an extension of the program may be granted (usually for three or six months). At final

sentencing the magistrate must consider the young offender's participation and progress in the YDC program (Eardley et al., 2004).

Compulsory Drug Treatment Correctional Centre

The Drug Court of New South Wales is also responsible for making Compulsory Drug Treatment Orders for prisoners to participate in the Compulsory Drug Treatment Correctional Centre, located in a special wing of the Parklea Correctional Centre. The *Compulsory Drug Treatment Correctional Centre Act 2004* (NSW) established the Centre, which accommodates 70 inmates and provides supervision of up to 30 offenders in the community (New South Wales Department of Corrective Services, 2006). Johns (2004) states that the Centre 'will target a hard-core group of [male] offenders with long-term drug addiction and an associated life of crime and constant imprisonment'. The objectives of treatment, as stated in section 106B of the Act, are:

- (a) to provide a comprehensive program of compulsory treatment and rehabilitation under judicial supervision for drug-dependent persons who repeatedly resort to criminal activity to support that dependency, and
- (b) to effectively treat those persons for drug dependency, eliminating their illicit drug use while in the program and reducing the likelihood of relapse on release, and
- (c) to promote the re-integration of those persons into the community, and
- (d) to prevent and reduce crime by reducing those persons' need to resort to criminal activity to support their dependency.

⁶⁵ Technically the New South Wales Youth Drug and Alcohol Court is a pre-sentence diversion program, but is discussed here due to similarity with the drug courts. See section 3.1.3.

⁶⁶ As supplemented by Children's Court Practice Direction Nos 18 and 19.

The Drug Court will also supervise the progress of participating prisoners through the custodial and community stages of the program (New South Wales Attorney General's Department, 2006). There are three stages to the approach:

1. Closed detention: treatment in full-time custody (minimum six months)
2. Semi-open detention: kept in custody but allowed to attend employment, training or social programs in the community (minimum six months)
3. Community custody: living in the community in accommodation approved by the Drug Court, under intensive supervision.

As with Drug Court offenders, every participating prisoner must have a drug treatment personal plan, which includes an undertaking not to use any drug other than prescribed drugs.⁶⁷ Sanctions are imposed for non-compliance with treatment plan conditions, and rewards apply for compliance.

3.1.4.2 Queensland drug courts

Drug courts were established in Queensland within the existing Magistrates Court structure, via the *Drug Rehabilitation (Court Diversion) Act 2000 (Qld)*. The first Queensland Drug Court was introduced in 2000 in the south-east of the State, and was followed in 2002 by two further pilot programs in the north (Cairns and Townsville) (Payne, 2005). In August 2005, the Queensland Government announced that the drug courts would be made permanent features of the criminal justice system.

As outlined in section 3(1) of the Act, the court diversion program aims to reduce:

- (a) the level of drug dependency in the community
- (b) the level of criminal activity associated with drug dependency
- (c) health risks to the community associated with drug dependency, and
- (d) pressure on resources in the court and prison systems.

The Queensland Drug Court program targets offenders at the serious end of the offending scale who are likely to be imprisoned. Under section 6(1) of the Act, an offender who pleads guilty to their offence⁶⁸ is eligible to be dealt with by a Drug Court if:

- (a) the offender is 18 years of age or over
- (b) the offender is drug-dependent and that dependency contributed to the commission of the offence
- (c) if convicted, the person would likely be sentenced to imprisonment
- (d) the offender lives within the prescribed areas.

Section 6(3) of the Act states that an offender will not be eligible if:

- (a) the person is serving a term of imprisonment, or
- (b) the person faces a charge for a disqualifying offence (such as violent or sexual offences).

The Queensland Drug Court program requires an offender to request, before sentencing or committal to another court, to be referred for assessment. Participants assessed as suitable then appear before a special Drug Court

⁶⁷ This is mandatory under s.106H of the Act.

⁶⁸ A guilty plea is required by s.15(2)(a) of the Act.

magistrate and are placed on an Intensive Drug Treatment Order (IDRO). This involves three phases of decreasing intensity, and takes approximately 12–18 months to complete.

The IDRO is a form of suspended sentence, which involves intensive supervision and monitoring by the Drug Court. Offenders must participate in an ordered course of drug treatment, which may include methadone maintenance, detoxification and rehabilitation; they must report to a case manager and submit to drug testing at least twice weekly. Sanctions such as imprisonment and community service, and rewards such as reduced community service hours, are used to encourage compliance. Participants may also be required to make restitution, pay compensation, or perform community service or any other task that the magistrate considers will aid rehabilitation. Participants can request to leave the program at any time prior to completion, in which case the original sentence is replaced with a new and final sentence (Payne, 2005).

Upon completion of the program, the Drug Court magistrate reviews the original sentence. Offender participation and any rewards and sanctions are taken into account. A lesser sentence than the original can be imposed by the court and, in most cases, this comprises a non-custodial sentence (Payne, 2005).

3.1.4.3 South Australian drug courts

South Australia introduced its first drug court in the Adelaide Magistrates Court in May 2000. The court was initially introduced as a two-year pilot program and now receives ongoing funding. The South Australian Drug Court was established without the enactment

of specific legislation, utilising instead the remand provisions of the *Bail Act 1985* (SA), which permit wide discretion in sentencing, including deferral of sentence for up to one year (Freiberg, 2004).

The Drug Court program targets offenders with significant drug problems who are likely to be imprisoned. It aims to minimise, or stop, the use of illicit drugs by offenders and prevent, or decrease, any further drug-related offending (Corlett, Skrzypiec & Hunter, 2005). Those charged with major indictable offences or violent offences (or who have a history of violent offences), however, are not eligible to participate in the Drug Court program, operating out of the Adelaide Magistrates Court.

An offender who meets the following criteria is eligible to be dealt with by the South Australian Drug Court:

- committed an offence while 18 years of age or older
- resides within the Adelaide metropolitan area at a residence that is suitable for electronically monitored home detention bail
- the offence charged must be related to his/her drug use and be one for which imprisonment is likely
- be dependent on illicit drugs or have a high probability of returning to drug use due to current abstinence being involuntary or forced
- be willing to participate in the Drug Court program
- plead guilty to both the most serious offence and the majority of offences with which he/she has been charged.

An offender may be referred into the Drug Court program by a member of the police, a magistrate, a legal representative, prosecuting counsel or via self-referral. An individually designed case management plan is formulated for offenders accepted into the program, combining 'intensive judicial supervision, mandatory drug testing and access to treatment/support services to help the drug abusing offender break the[ir] cycle of crime and drug use' (Corlett et al., 2005, p.5). The Drug Court model employed in South Australia involves case managers who provide strict supervision and monitoring of participants and report regularly to the Drug Court magistrate. This is different from the other States where a Drug Court team⁶⁹ monitors and supervises participants.

Bail conditions may include weekly court appearances and regular drug testing. In the initial stages all participants are required to submit to electronically monitored home detention bail. Breach of bail conditions, further drug use or re-offending may attract sanctions, or result in expulsion from the program or imprisonment (South Australia Courts Administration Authority, 2004).

In addition to drug treatment, participants of the South Australian Drug Court program may receive other supports such as education or vocational training, and assistance with accommodation, family relationships and financial issues.

Upon completion or termination of the program, the offender is sentenced and his/her participation in the program is taken into consideration (Australian Institute of Criminology, 2006a).

3.1.4.4 Victoria's drug court

The first Victorian Drug Court began operation at the Dandenong Magistrates Court in 2002 (Victoria Department of Justice, 2005). Established by the *Sentencing (Amendment) Act 2002* (Vic), the court began as a three-year pilot program and continues operating today.

As stated in section 18X of the Act, the purposes of the orders made by the court (Drug Treatment Orders, see below) are:

- (a) to facilitate rehabilitation of the offender
- (b) to take account of an offender's drug or alcohol dependency
- (c) to reduce the level of criminal activity associated with drug or alcohol dependency, and
- (d) to reduce the offender's health risks associated with drug or alcohol dependency.

The court targets individuals who are dependent on drugs or alcohol and whose dependency contributed to the commission of an offence. To be eligible to participate in the Victorian Drug Court (s.18Z):

- The offender must plead guilty.
- The Drug Court must be satisfied on the balance of probabilities that the offender is dependent on drugs or alcohol and that dependency contributed to the commission of the offence.
- The offender must reside within a specified geographical catchment area.

⁶⁹ Drug court teams typically comprise individuals from Health, Legal Aid, Corrective Services, Police, Defence and the magistrate working together and sharing information as a specialist team.

- The offence must be within the jurisdiction of the Magistrates Court and punishable upon conviction by imprisonment.
- Upon conviction, the Drug Court considers that a sentence of imprisonment is appropriate.
- The offender must be willing to consent, in writing, to such an order.

An offender is ineligible to participate in the Victorian Drug Court if one of the offences charged is a sexual offence or an offence involving the infliction of actual bodily harm.

Offenders entering the Victorian Drug Court program are sentenced to a Drug Treatment Order (DTO) for up to two years, with an average duration of 12 months. DTOs progress through three phases: stabilisation, consolidation and re-integration. The goals of the DTO and the activities required to achieve them vary according to the phase of the order. As reflected in the phase names, early phase goals focus on stabilising health, income and accommodation, for example; while later phase goals include remaining crime-free, developing life skills, and gaining employment. The first two phases average 12 weeks in length and the third phase averages 26 weeks.

DTOs also comprise two parts:

1. Custodial part: a custodial sentence not exceeding two years is suspended while the treatment and supervision part of the DTO operates. The custodial sentence may be activated temporarily or permanently for various breaches of treatment and supervision conditions.

2. Treatment and supervision part: this component imposes conditions to address the offender’s dependency. Eight core conditions apply to all DTOs and must be complied with throughout the two-year operation of the order. Core conditions include undergoing specified drug treatment, refraining from committing any further imprisonable offences and attending the Drug Court as required. At least one program condition must also be applied to the DTO. Common program conditions require drug or alcohol testing, attendance at detoxification, and submission to psychological assessment. A system of rewards and sanctions is applied to encourage compliance.

3.1.4.5 Western Australian drug courts

Drug courts began operating in Western Australia in 2000, when the Department of Justice set up the Perth Drug Court as a two-year pilot project within the Court of Petty Sessions.⁷⁰ There are now three drug courts operating in Perth – the Magistrates Court,⁷¹ the District Court and the Children’s Court. The Western Australian drug courts were set up without specific legislation, operating originally under section 16(2) of the *Sentencing Act 1995 (WA)* and now under the *Sentencing Legislation (Amendment and Repeal) Act 2003 (WA)* (see below).

The courts aim to reduce recidivism, re-arrest rates and drug-related crime, and to provide cost savings to the community and the government.

⁷⁰ Equivalent to the Magistrates Courts in other jurisdictions, the Courts of Petty Sessions have jurisdiction to adjudicate and sentence on summary offences and those indictable offences for which summary trial is allowed.

⁷¹ As of May 2005, the Court of Petty Sessions was abolished and is now known as the Magistrates Court.

Offenders can be referred to the Drug Court if:

- they are 18 years of age or over
- they are dependent on an illicit drug
- they are willing to undertake treatment
- they live within the Perth area, and
- they plead guilty to each complaint referred.

Offenders are not eligible to participate if:

- they are a sex offender
- they have a history of violent or sexual assaults
- they are charged with drug trafficking and serious organised drug offences
- they face mandatory imprisonment, or
- they require ongoing intensive psychiatric or psychological treatment. (Crime Research Centre, 2003)

Western Australia's drug courts operate as the third tier of a three-tiered sentencing regime for drug offenders. These are applied according to the severity of the offence and substance use. The three levels include:

1. Brief Intervention Regime: designed for those who have committed minor offences, it includes the Pre-sentence Opportunity Program, the Young Person's Opportunity Program and the Indigenous Diversion Program (see Table 3.3, section 3.1.3).
2. Supervised Treatment Intervention Regime: aimed at people with substance abuse problems who have committed mid-range offences, it requires offenders to attend treatment and rehabilitation (see Table 3.3, section 3.1.3).
3. Drug Court Regime: a more intensive intervention for those whose substance use and offending are more severe. Offenders must undergo judicially case-managed treatment and monitoring which usually involves weekly court appearances.

Until the introduction of the *Sentencing Legislation (Amendment and Repeal) Act 2003 (WA)*, an offender's sentence could be deferred for no more than six months while they undertook treatment under one of the regimes. In practice, this meant the duration of treatment was often even shorter, and possibly too short for optimal treatment outcomes. The 2003 Act, however, provides for pre-sentence orders of up to two years, allowing more intensive treatment to be undertaken (Indermaur & Roberts, 2003; 2005).

Until recently, a therapeutic drug court-style program – the Geraldton Alternative Sentencing Regime (GASR) – aimed to promote the rehabilitation of offenders with substance abuse,⁷² domestic violence and other offending-related problems. Offenders participated in a Court Supervision Regime for 4–6 months, involving participation in an approved treatment agenda with progress reviewed by the court regularly. In higher risk cases, urinalysis and curfews were also to be used. Treatment agendas commonly included AOD counselling (residential and non-residential), medical treatment, vocational guidance, accommodation support, and stress reduction programs (including transcendental meditation). The program ceased due to non-renewal of funding by the Western Australian Government.

⁷² Including alcohol and solvents as well as illicit substances.

3.1.5 Post-conviction diversion – Alcohol Court

The Northern Territory is the first and only jurisdiction in Australia to establish an ‘alcohol court’. Two Alcohol Courts commenced operating (in the Darwin and Alice Springs Magistrates Courts) in July 2006, with specific power to impose alcohol intervention orders and prohibition orders (Northern Territory Government, 2005).

To be eligible to participate in the Alcohol Court, and receive an alcohol intervention order, the offender must:

- be dependent on alcohol (as assessed by the court clinician) and that dependency contributed to commission of the offence charged
- plead guilty or indicate an intention to plead guilty
- be likely to be sentenced to a term of imprisonment, and
- consent to the intervention.

Alcohol intervention orders⁷³ comprise two parts:

1. Custodial part: a prison term of up to two years is suspended partially or fully during the intervention order.

2. Treatment and supervision part: includes core conditions that must be complied with throughout the operation of the intervention order (up to 12 months), including abstinence from alcohol, refraining from committing any further imprisonable offences, undergoing specified treatment and reporting to the Alcohol Court, Correctional Services and the court clinician as required. A system of sanctions and rewards is applied to encourage compliance.

Alcohol intervention orders are very similar to the system of Drug Treatment Orders (DTOs) used in the Victorian Drug Court (see section 3.1.4.4). The Northern Territory Alcohol Court is further similar to the Victorian Drug Court, and also to the New South Wales Youth Drug and Alcohol Court, in that all of these courts may deal with offenders who have serious problems with alcohol and illicit drugs. The main difference in eligibility is that, in the Northern Territory, an offender will not be eligible to be dealt with by the Alcohol Court if dependent on an illicit drug and not dependent on alcohol,⁷⁴ whereas in Victoria and New South Wales, dependence on either is grounds for entry into the program.⁷⁵

⁷³ The first alcohol intervention order made by the court comprised a two-month suspended gaol sentence, required the defendant to attend treatment at the Central Australian Aboriginal Alcohol Programs Unit, and forbade him from approaching his father if he had been drinking (<http://abc.net.au/news/australia/nt/summer/200607/s1692233.htm>).

⁷⁴ In which case they may be eligible for the CREDIT program – see 3.1.2.

⁷⁵ Providing all other eligibility criteria, as outlined at 3.1.4.1 and 3.1.4.4, are met.

The Alcohol Court will also be able to deal with some individuals who have committed lower-level offences that will not attract a term of imprisonment. A prohibition order may be made, incorporated into a sentence or a bail undertaking, if the Alcohol Court is satisfied that:

- the offender is dependent on alcohol (as assessed by the court clinician), and would benefit from withdrawal, a reduction in consumption, or treatment
- the offender has been found guilty or pleaded guilty
- the order is necessary to:
 - protect the offender from severe harm (i.e. physical or neurological harm or significant deterioration or damage to mental condition), or
 - prevent the offender causing a serious risk to the health and safety of others.

Prohibition orders may include requirements such as undergoing specified treatment and reducing or ceasing alcohol use.

3.1.6 Post-conviction diversion – Indigenous sentencing courts

Indigenous sentencing courts, known variously as circle sentencing (in New South Wales) and Koori courts (in Victoria), are another form of specialist court that has evolved in Australia in recent years.⁷⁶ As with drug courts, judicial officers of Indigenous sentencing courts require ‘special knowledge and special personal attributes to be judicial problem-solvers’ (Rottman, 2000).

Indigenous adult offenders who plead guilty to their charge may be diverted away from imprisonment through the alternative sentencing procedures of Indigenous sentencing courts. These courts are presided over by a magistrate who hands down sentencing decisions on the advice of an Indigenous elder or respected person. The role of the elder varies across and within jurisdictions, ranging ‘from briefly addressing the offender about his or her behaviour to having a significant role in determining the sentence and monitoring the offender’s progress’ (Marchetti & Daly, 2004, p.2).

In some jurisdictions (e.g. New South Wales circle sentencing) there is wide community involvement, with the offender’s family and victims sometimes involved in establishing the background to the offence, understanding its effects and deciding by general consensus what should be done to heal the offender and what the sentence plan should comprise.⁷⁷ Thus, Indigenous sentencing courts have been described as a ‘sentencing conversation’ (Harris, 2006, p.14).

⁷⁶ The brief description of Indigenous courts in this section focuses on the operation of circle sentencing as it pertains to offenders with alcohol or other drug problems. The reader is referred to the ‘Circle Sentencing Fact Sheet’ produced by the New South Wales Attorney General’s Department for further information about the broader operation of this alternative procedure.

⁷⁷ Goals for the offender are included in the sentence plan and set as bail conditions, e.g. abstinence from alcohol, attendance at an Indigenous alcohol service.

As at July 2005, Indigenous sentencing courts operated in six Australian States and Territories: the Australian Capital Territory (one court), New South Wales (eight courts), the Northern Territory (one court), Queensland (three courts), South Australia (five courts) and Victoria (four courts) (Marchetti & Daly, 2004).⁷⁸ Victoria is the only jurisdiction to have enacted specific legislation (*Magistrates' Court (Koori Court) Act 2002* (Vic)) for the operation of the Indigenous court.

3.1.7 Post-conviction diversion – conditional suspended sentence

This is 'a sentence of imprisonment imposed on an offender which is not activated' (Sentencing Advisory Council, 2005). It involves a court imposing a term of imprisonment on an offender and ordering 'that all or part of the gaol term be held in suspense for ... the operational period' (Sentencing Advisory Council, 2005).

It is a condition of a suspended sentence order that the offender does not commit another imprisonable offence during the operational period (the set period for which the sentence is suspended). Drug intervention conditions can be attached to suspended sentences by any general court in five Australian jurisdictions: the Australian Capital Territory, New South Wales, the Northern Territory, South Australia and Tasmania. These forms of sentence are known as conditional suspended sentences and are outlined in Table 3.4 below.

Typical drug intervention conditions include requirements that an offender abstain from drugs (as proven by urinalysis), participate in an agreed treatment program, or undertake some other conditions designed to address substance use (Spooner et al., 2001). Breach of the conditions imposed renders the offender liable to serve all or part of the custodial sentence.

Drug courts in New South Wales, Queensland and Victoria operate by way of a form of conditional suspended sentence. However, these differ in that they have a system of sanctions and rewards attached. An offender whose sentence is suspended under a drug court program and who breaches a condition will be sanctioned under that system and will be given several opportunities to comply before being liable to serve all or part of the suspended custodial sentence.

⁷⁸ For full details of locality, court name, establishment date and a brief description of number of elders and courtroom layout, see http://www.gu.edu.au/school/ccj/kdaly_docs/daly_pt2_paper_3b.pdf

Table 3.4: Conditional suspended sentencing – operation and legislation

Jurisdiction	Operation of conditional suspended sentence	Legislation
Australian Capital Territory	Offenders may be required to comply with any conditions ‘the court thinks fit to specify in [a sentencing] order’.	<i>Crimes Act 1900</i> , s.403(1)
New South Wales	Suspended sentences are conditional upon entry into a good behaviour bond. Bonds may contain ‘such other conditions as are specified in the order by which the bond is imposed’ and may include an order to participate in an intervention program, such as a treatment or rehabilitation program.	<i>Crimes (Sentencing Procedure) Act 1999</i> , ss. 12, 95 and 95A
Northern Territory	A court can suspend a sentence of imprisonment ‘subject to such conditions as the court thinks fit’.	Sentencing Act 1995, s.40(2)
South Australia	Suspended sentences are conditional on the offender entering a bond. Bonds can include requirements such as abstinence from drugs and/or alcohol and undergoing psychiatric or medical treatment. Applies only to sentences that have a mandatory minimum sentence.	<i>Crimes (Sentencing) Act 1988</i> , ss. 38 and 42
Tasmania	The court can attach such conditions ‘as the court considers necessary or expedient’ to a suspended sentence.	Sentencing Act 1997, s.24

Source: Sentencing Advisory Council, 2005

3.1.8 Prison pre-release diversion

Pre-release diversion programs are conducted in several prisons in Australia, generally in the form of transitional therapeutic communities. These programs accommodate inmates during the final stage of their sentence (generally three to four months) and aim to reduce recidivism to crime, to reduce relapse to drug use and to increase employment prospects upon release (Costanza, 2003).

A selection of pre-release diversion programs is described below for the purpose of illustrating the types of programs operating in Australia. This list is indicative not exhaustive and the reader is referred to State Corrections Departments for full details of pre-release diversion programs.

In New South Wales, the Ngara Nura Therapeutic Rehabilitation Unit has been in operation at Long Bay Prison since 2000. Male prisoners with a history of AOD-related offences spend three months in the unit prior to release, learning skills to address their drug, alcohol and other issues, to prepare them for release into the community (New South Wales Department of Corrective Services, 2001). Bolwara House Transitional Centre is a pre-release unit for women with histories of AOD use and recidivism. Women spend 3–12 months attending AOD treatment services in the community while living in a semi-secure therapeutic community.

In South Australia, the Adelaide Pre-Release Centre runs a range of programs including rehabilitative programs for male prisoners during the 12 months prior to their release. It is a residential centre located outside the prison, which can accommodate up to 70 male prisoners at a time (Black et al., 2004).

In Victoria, the Bendigo Prison can house up to 85 prisoners in four smaller ‘living communities’ of approximately 20–25 prisoners each. Staff teams working within the communities comprise prison officers, AOD staff and an education or industry representative. The New Horizons program in Victoria caters specifically for younger male prisoners (aged less than 30 years), with serious substance-abuse problems. The first phase of the program involves outdoor education and training in a minimum-security facility near the Fulham Correctional Centre. Phase two operates from a residential community-based facility.

In Western Australia, the Warminda Intensive Intervention Centre is a non-residential centre that provides treatment, education, job training and other programs for youth aged 16–21 years with serious court records. Referrals to the program are made from several sources, including prisons. Where a young person agrees to take part for a minimum of three months in the program, attendance at Warminda may be made a condition of release from prison. Breach of the program’s rules may result in re-incarceration.

Evaluative information regarding the effectiveness of these programs is scarce. A 1996 evaluation of the Bendigo Prison therapeutic community program reported that 62 per cent of graduates did not re-offend within the first 12 months of release. Evaluation results of the Ngara Nura program are pending.

3.2 Civil commitment

Civil commitment is defined as the involuntary commitment of non-offenders into AOD assessment and/or treatment (New South Wales Standing Committee on Social Issues, 2004) and is legislated for in four Australian jurisdictions. Legislation in New South Wales, Tasmania and Victoria provides for the civil commitment of persons dependent on alcohol or other drugs, while legislation in the Northern Territory is confined to the civil commitment of persons who use alcohol to excess and compulsory treatment orders for volatile substance abusers. State and Territory civil commitment legislation is outlined in Table 3.5 below.

3.2.1 *Inebriates Act 1912 (NSW)*

The New South Wales *Inebriates Act 1912* provides for the care, control and treatment of ‘inebriates’, who are defined in section 2 of the Act as persons who habitually use intoxicating liquor or intoxicating or narcotic drugs to excess.

The process for applying for an inebriate’s order is described in section 3(1) of the Act. Applications may be made by defined categories of applicants, including immediate family members, business partners and members of the police force. Applications must include the following:

- affidavit of the applicant that the person is an inebriate
- certificate from a medical practitioner stating that the person is an inebriate.

The person is then summonsed to appear in court, and if, upon personal inspection, the judge or magistrate is satisfied that the person is an inebriate, an order may be made.

Under s.3(1) of the Act, the court may order that the inebriate:

- (d) enter a recognisance or bond requiring abstinence from alcohol/drugs for at least 12 months
- (e) be placed for up to 28 days under the care of a named person
- (f) be placed for up to 12 months⁷⁹ in a licensed institution established under s.9
- (g) be placed for up to 12 months⁸⁰ under the care and charge of an attendant.

Section 3(1)(f) of the Act is the most commonly used provision and, through the operation of s.9, inebriates may be placed in psychiatric hospitals. Psychiatric hospitals were gazetted as temporary places of detention in 1929. However, the original intention that inebriates be placed in purpose-built institutions was not fulfilled, and these psychiatric facilities remain the only place inebriates may be sent.

Although data are incomplete, use of the Act appears to have declined over time and it has rarely been used in recent years. From 2001 to 2004, 37 applications were made, 27 of which resulted in an order, including 17 placing an inebriate in a psychiatric hospital. The lengths of orders ranged from four weeks to seven months and were usually between one and three months in duration (New South Wales Standing Committee on Social Issues, 2004).

⁷⁹ May be extended for further periods up to 12 months.

⁸⁰ May be extended for further periods up to 12 months.

Although the Act is rarely used, its provisions are far-reaching. Orders can also be made for payment of expenses of care, charge and maintenance of the inebriate, from the inebriate's property (s.18) (New South Wales Standing Committee on Social Issues, 2004).

3.2.2 Volatile Substance Abuse Prevention Act 2005 (NT)

The object of the VSAP Act is to provide a legislative framework for the prevention, early intervention and treatment of volatile substance abuse in the Northern Territory. Section 3(2) of the Act outlines six actions that may be taken to achieve this object; s.3(2)(c) is relevant for the purposes of this paper: the Minister for Family and Community Services can apply to the court for an order that 'a person at risk of severe harm' as a result of abuse of volatile substances must participate in a treatment program. The Northern Territory Department of Health and Community Services has stated that court-ordered treatment will apply only to the heaviest or longer-term volatile substance users in the community, though this intention is not articulated within the legislation.

The Minister may be asked to apply for a treatment order only by parties specified in s.33(1), including police officers, health practitioners and family members. If the Minister is satisfied, upon that person's application, that the person may be at risk of severe harm, assessment by a health practitioner may be ordered and, if necessary, a warrant issued to

attend assessment (ss. 34, 35). An assessment will result in an application by the Minister to the court for a treatment order if:

- the assessor indicates that the person is at risk of severe harm (s.34(4))
- a treatment program is recommended (s.34(4))
- the Minister is satisfied the treatment order will be in the best interests of the person (s.34(6)(a)), and
- the person cannot be adequately protected from severe harm by some other means (s.34(6)(b)).

Section 40(3) of the Act specifies that treatment orders last for two months and any number of further orders may be made (s.40(6)). Treatment orders may be made, with or without conditions (s.39(1)(c)). Police or authorised officers may, with a warrant issued under s.41, use reasonable force to enter and search premises, and apprehend and take a person to the place of treatment if they do not take part in their treatment program.

The VSAP Act does not outline any means for orders to be appealed, reviewed or monitored.

The Act came into operation in October 2005 and, as at June 2007, just one person had been ordered to treatment under s.34. All other persons referred for assessment chose to undergo voluntary treatment for volatile substance use (Fong, personal communication, 2007).

3.2.3 *Liquor Act 2004 (NT)*

Section 122 of the Northern Territory *Liquor Act 2004*⁸¹ makes broad provision for the commitment into AOD treatment of persons who use alcohol habitually or excessively. A prohibition order may be made in respect of a person who:

- (a) by the habitual or excessive use of liquor, wastes his means, injures or is likely to injure his health, causes or is likely to cause physical injury to himself or to others, or endangers or interrupts the peace, welfare or happiness of his or another's family;
- (b) on more than three occasions during the preceding six months, has been taken into custody, intoxicated with a drug or alcohol while in a public place or trespassing on private property.

Prohibition orders ban the sale and supply of alcohol to the person subject to the order, and ban that person from licensed premises. In addition, s.122(4) of the Act gives the court power to order a person to attend assessment and a specified program of treatment and rehabilitation at their own expense. Failure to comply with a court order to attend treatment can attract a penalty of up to \$1,000 for the first offence and up to \$2,000, or imprisonment for 12 months, for a second offence.

No initial recommendation from a medical practitioner is required and there are no time limits on treatment; a prohibition order remains in force for 12 months from the date of commencement or any other period (shorter or longer) specified in the order (s.122(3)(a)).

3.2.4 *Alcohol and Drug Dependency Act 1968 (Tas)*

Tasmania's *Alcohol and Drug Dependency Act*, s.27(1), enables the court to order a person who is alcohol- or drug-dependent to be detained for treatment for six months.

Under sections 3 and 4 respectively, a person is deemed to be alcohol-dependent or drug-dependent if he consumes alcohol to excess or takes drugs and –

- (a) is thereby dangerous at times to himself or others or incapable at times of managing himself or his affairs; or
- (b) shows prodromal signs of becoming so dangerous or so incapable.

Applications for an order for detainment must be supported by a recommendation from a medical practitioner. Orders can be renewed for a further six months if the responsible medical officer believes 'that it is necessary in the interests of [the patient's] health or safety or for the protection of other persons' that the patient should continue to be liable to be detained, and furnishes a report to the superintendent of the treatment centre to that effect (s.24).

No information was found regarding use of this section; however, the Act is reportedly under review.

⁸¹ This section is repealed and substituted by the *Antisocial Behaviour (Miscellaneous Amendments) Act 2006*, yet to come into force. The new section 122, Prohibition notices, does not include this broad power to order treatment.

3.2.5 Alcoholics and Drug-dependent Persons Act 1968 (Vic)

The *Alcoholics and Drug-dependent Persons Act* governs the public provision of drug treatment services in Victoria and includes among its objectives: 'to authorise and regulate the detention of some alcoholics and drug-dependent persons for the purposes of assessment and treatment' (Victoria Department of Human Services, 2005b).

Within the Act:

- 'alcoholic' means a person who habitually uses intoxicating liquor to such an extent that he has lost the power of self-control with respect to the use of intoxicating liquor or to such an extent as to endanger the health, safety or welfare of himself or other persons
- 'drug-dependent person' means a person who habitually uses drugs of addiction to such an extent that he has lost the power of self-control with respect to the use of drugs of addiction.

Under section 11 of the Act, the courts are given power to commit a person to an assessment centre (in practice, a detoxification facility) for seven days where a complaint is made that a person is an alcoholic or drug-dependent person, and:

- the complaint is made by a person specified in s.11(2), including immediate family members, business partners and police
- evidence is presented including at least one certificate from a registered medical practitioner, and
- it appears to the court that the person is an alcoholic or drug-dependent person.

No other criteria must be applied, other than that the court is satisfied that the person is an alcoholic or drug-dependent person. There is no right of appeal against section 11 orders.

Where an order has been made under section 11 and the person fails to attend the assessment centre, a warrant can be issued allowing a member of the police force to 'take and convey' the person to the assessment centre (s.11(3)).

A person can be detained at a detoxification facility for a further seven days at the discretion of the medical officer in charge of the facility, or upon further court order (s.11(1)).

Section 12 of the Act gives medical officers in charge of assessment centres the power to commit a person to a treatment centre for an indefinite period, if:

- two registered medical practitioners have certified in writing that the person is an alcoholic or drug-dependent person
- the medical officer in charge of the centre is of the same opinion, and
- the medical officer is satisfied the person is suitable for treatment in a treatment centre.

Persons committed under section 12 are entitled to appeal against their order (s.12(3)).

Section 11 of the Act was used to commit 32 people between 1998 and 2004. Between 1992 and 2004, no individuals were committed under section 12 (Victoria Department of Human Services, 2005b).

Table 3.5: State and Territory civil commitment legislation

Jurisdiction	Legislation	To whom it applies
New South Wales	<i>Inebriates Act 1912</i>	Inebriates – persons who habitually use intoxicating liquor or intoxicating or narcotic drugs to excess
Northern Territory	<i>Volatile Substance Abuse Prevention Act 2005</i>	Persons at risk of severe harm as a result of abuse of volatile substances
Northern Territory	<i>Liquor Act 2004</i> , s.122	Persons who, by the habitual or excessive use of liquor, waste their means, injure or are likely to injure their health, cause or are likely to cause physical injury to themselves or to others, or endanger or interrupt the peace, welfare or happiness of their own or another's family Persons taken into custody three or more times within six months because intoxicated in a public place or while trespassing
Tasmania	<i>Alcohol and Drug Dependency Act 1968</i>	Alcohol- or drug-dependent persons – dangerous at times to self or others or incapable at times of managing himself or his affairs; or shows prodromal signs of becoming so dangerous or so incapable
Victoria	<i>Alcoholics and Drug-dependent Persons Act 1968</i>	Alcoholics – persons who habitually use intoxicating liquor to such an extent that they have lost the power of self-control with respect to the use of intoxicating liquor or to such an extent as to endanger the health, safety or welfare of themselves or other persons Drug-dependent persons – those who habitually use drugs of addiction to such an extent that they have lost the power of self-control with respect to the use of drugs of addiction

	Types of orders	Duration of orders	Current status
	Inebriates orders <ul style="list-style-type: none"> • recognisance or bond requiring abstinence • placed under care • committal to a State institution • placed under care and charge of attendant 	<ul style="list-style-type: none"> • Min 12 months • Up to 28 days • Up to 12 months • Up to 12 months 	Under review
	Treatment order Specially trained staff provide treatment programs that are family-focused and address lifestyle factors	<ul style="list-style-type: none"> • 2 months Any further number of orders may be made	Commenced 9 February 2006
	Prohibition Order <ul style="list-style-type: none"> • sale of alcohol to the individual banned • individual banned from licensed premises • can require assessment, treatment and rehabilitation at person's own expense 	<ul style="list-style-type: none"> • 12 months Any other period (longer or shorter) may be specified	Repealed by <i>Antisocial Behaviour (Miscellaneous Amendments) Act 2006</i> , but operational until this Act comes into force
	Detainment order Detainment in a treatment centre	<ul style="list-style-type: none"> • Up to 6 months Orders can be renewed a further 6 months	Under review
	Section 11 Orders Committal to an AOD assessment centre (detoxification facility) Section 12 Orders Commitment to a treatment centre	<ul style="list-style-type: none"> • 7 days Detention for a further 7 days possible <ul style="list-style-type: none"> • Indefinite period 	Under review

4. Research on compulsory AOD treatment

4.1 International research literature

Compulsory AOD treatment is a controversial and sensitive issue, which has been subject to scientific review and evaluation in many countries. In this chapter we review seminal meta-analyses conducted by Klag et al. (2005) in Australia, Stevens et al. (2005) of the European Institute of Social Services, and Wild (2006) of the University of Alberta, as well as research conducted in the States and Territories of Australia.

Of primary concern in reviewing this material is the methodological challenge of this kind of research. The drugs being used are numerous and of differing types, the using populations are heterogeneous, coercion is applied in different forms, and treatment interventions cover a wide range of activities. The result is a research base characterised by ‘a mixed, inconsistent and inconclusive pattern of results’ (Klag et al., 2005, p.1777).

From a researcher’s perspective, the principal methodological and conceptual problems that have impeded research were summarised by Klag and colleagues (2005) at Queensland’s Griffith University:

- The vast majority of research into legally mandated treatment is non-empirical and research that is empirical rarely involves randomised controlled trials.⁸²
- Most studies assume coercion from the referral source, which ‘ignores the complexity of the coercion construct and has significantly impeded the accurate measurement of the effects of coercion into treatment on treatment process and outcome variables’ (p.1783).

- There is no consistent operational definition of ‘coercion’.
- Many studies assume legally mandated and non-mandated clients are similar at baseline, while there is evidence that this is not justified.
- Coercion is usually presumed to be a dichotomous variable when it is more accurately described as continuous.
- Most studies had follow-up periods shorter than six months, limiting conclusions about long-term effectiveness.

Overall, Klag’s group concluded that most research over the last 30 years had so many weaknesses that the results were inconclusive and that, in order to draw more than the limited conclusion that compulsory treatment can *sometimes* be effective in reducing drug use and crime for *some* people, further information about the factors that lead to success is required.

In his review of key studies and trends in this area, Wild (2006) draws attention to the need for greater sophistication in the way we understand social controls and coercion. Conceptual analysis was used to identify ‘eight implicit assumptions underlying policy, practice and scholarship in this area’, which act as barriers to robust research. For example, coercion is almost invariably equated with referral source (e.g. court referral) in the literature, though this may not be an appropriate explanatory variable; there is a dearth of data on level of coercion, especially as experienced by individuals, and how this interplays with motivation to change. Wild notes that there is an unproven assumption that legal mechanisms of coercion are more

⁸² A Cochrane protocol is currently under development with plans to review randomised controlled trials that compare voluntary treatment for illicit drug use (excluding cannabis use) with coerced or court-ordered treatment (Gowing, personal communication, 2006). The author advised that preliminary literature searches had revealed very few studies.

effective than informal mechanisms, and that despite findings that informal coercion by family members may be more prevalent and more compelling than formal, legal coercive measures, the focus of research has been on the latter. Very little research considers these matters, and Wild (p.42) concludes that this is a reflection of the ‘broader economic and policy contexts of addiction treatment that are rarely analysed’.

A third major review was undertaken by Stevens et al. (2005) as part of the Quasi-Compulsory Treatment (QCT) Europe project. The QCT project aims ‘to create a European evidence-base on quasi-compulsory and compulsory approaches to drug treatment for drug dependent offenders’ (European Institute of Social Services, 2006). An international literature review was conducted and evaluations presented in English, German, French, Italian and Dutch were summarised.⁸³ Stevens et al. (2005) concluded that research in languages other than English showed a wider range of outcomes than the English literature, which tended to present more positive outcomes. They also confirmed the methodological and conceptual problems reported by Klag et al., and similarly recommended that future research look more deeply at the role and interplay of client motivation, perceived coercion, client characteristics and treatment characteristics.

To date only a small amount of research has investigated how the nature of the treatment, client motivation, and the degree of coercion applied impact on treatment outcomes.

Length of treatment is reported to be a consistent predictor of positive treatment outcomes (Maxwell, 2000), with recommended minimum periods of retention in treatment varying considerably from three months (Hough, 2002) to 12 months or more (Scheller & Klein, 1986, cited in Stevens et al., 2003).

Client motivation has a complex interplay with the nature of the coercion, which can act as a timely trigger to move an individual into a stage of greater readiness to change (e.g. from contemplation to preparation).⁸⁴ Stevens et al. (2003) report findings that show coercion can increase motivation; Hall (1997) found that the motivation of legally coerced clients is at least as good as that of voluntary clients. Conversely, some argue that legal coercion may undermine motivation and cause a setback in readiness to change and that autonomy should be protected to enhance therapeutic outcomes (Anderer, 1992; Wexler, 1993a). ‘Influential theories of human motivation and behaviour change support the proposition that perceived coercion is counterproductive’ (Wild, 2006, p.46). There is little understanding of the nature of the complex interplay between all these factors.

Overall, these rigorous scientific reviews point to the conclusion that the empirical evidence for the effectiveness of compulsory treatment is inadequate and inconclusive. Or, in the stronger words of Wild (2006, p.46), ‘proliferation of social control tactics to facilitate addiction treatment is a world-wide social experiment being implemented without a compelling evidence base on its utility’.

⁸³ Reviews of coercion into alcohol treatment were not included.

⁸⁴ Prochaska and DiClemente’s (1986) ‘stages of change’ model include five stages: pre-contemplation, contemplation, preparation, action and maintenance.

4.2 Reviews of Australian diversion programs

There have been several evaluations of Australian compulsory treatment programs for offenders and these are described below. Some of these studies were conducted after the meta-analyses described above.

4.2.1 Police pre-arrest diversion

Formalised under the Illicit Drug Diversion Initiative (IDDI), pre-arrest diversion is based on the rationale that diversion can:

- reduce illicit drug use and drug-related crime
- reduce costs of drug-related crime and law enforcement
- reduce the number of people appearing before the courts for use or possession of small quantities of illicit drugs, freeing up police and court resources
- assist individuals to take personal responsibility and regain control over their lives, thus leading to safer environments for all Australians and reducing the considerable personal and social costs of AOD use on our communities (Australian Government Department of Health and Ageing, 2004b).

The national IDDI was evaluated in 2002, at which time approximately 90 per cent of diversions were police pre-arrest diversions and 10 per cent were pre-trial diversions⁸⁵ through programs such as CREDIT (see 3.1.2) (Alcohol and other Drugs Council of Australia, 2003c). It was found that, across most jurisdictions, diversion rates were approximately one-third of the rates originally projected. Among participants, the main drug for which

they were diverted was cannabis, approximately 75 per cent were males and their average age was mid-late twenties. The evaluators reported that few conclusions could be drawn regarding the effectiveness of the IDDI due to lack of consistent nationwide data and variable start dates of individual programs. This represented a major impediment to the evaluation and urgent action to develop a national minimum data set was recommended. Nonetheless, the evaluators were able to conclude that a number of indicators suggested that the initiative was worthwhile (Alcohol and other Drugs Council of Australia, 2003c). Specifically, studies in two States (Queensland and New South Wales) showed reduced drug use and criminal behaviour in some clients. Service providers were generally supportive of the initiative, as were criminal justice personnel. Police and magistrate acceptance of diversion programs was highlighted by the evaluators as vital to program effectiveness (Health Outcomes International, 2002). This reportedly increased over time, though there remained a need for ongoing training in this area.

Evaluations of several of the individual State pre-arrest diversion schemes have also been reported and are described below. Evaluation of the first three years of the New South Wales Cannabis Cautioning Scheme found a substantial decrease in the numbers of charges laid by police and dealt with by the court, with savings of approximately \$1 million in local court costs and over 18 000 hours of police time (Baker & Goh, 2004).

Evaluation of the Queensland Illicit Drug Diversion Initiative (QIDDI) Police Diversion Program, which reported evidence supporting the continued operation of the program (Hales et al., 2003), suggested that diversion procedures took less or the same time

⁸⁵ It is possible for some courts to divert offenders under the IDDI; for example, through programs such as CREDIT and MERIT (discussed under Pre-trial diversion, 4.2.2).

as referral to court, and courts experienced a 28 per cent reduction in the number of cases adjudicated. The majority of program participants described their assessment and education session under the program as positive and the proportion described as regular drug users reduced from 95 per cent to 74 per cent over six months following participation.⁸⁶ Queensland Police Service and Queensland Health report that, from the program's commencement on 24 June 2001 through to 31 March 2006, over 34 000 offenders accepted an offer of diversion (Ministerial Council on Drug Strategy, 2006).

The South Australian Police Drug Diversion Initiative (PDDI) outcomes evaluation reported some reductions in crime and illicit drug use among individuals diverted (O'Brien, 2006).⁸⁷ Most participants reported at least one positive life change (e.g. personal health, motivation), and a compliance rate of around 80 per cent was found among those diverted on only one occasion, although this decreased with each subsequent diversion. Police support for the PDDI was identified as an area for improvement. For example, almost two-thirds of police reported that, if the initiative were not compulsory, they would not divert certain types of drug users (O'Brien, 2006).

A number of negative consequences have been reported. Baker and Goh (2004) found evidence of net-widening under the New South Wales diversionary scheme, with some offenders participating who would

previously have been dealt with informally. This was also reported in a review of the South Australian Cannabis Expiation Notice Scheme (Flaherty et al., 2002). In addition, both the New South Wales scheme and the QIDDI were found to operate unfavourably for Indigenous persons, who were more frequently excluded from participation, by the eligibility criteria, than non-Indigenous persons (see also 2.9.3) (Baker & Goh, 2004). Under the QIDDI, two diversion criteria (no previous violent offence, and admission of offence) resulted in exclusion of significant numbers of Indigenous people from the program (Hales et al., 2003).

Other minority groups, such as women, people with mental health problems (Bull, 2003), rural offenders (Flaherty et al., 2002) and people from minority, cultural and ethnic groups in general, have been found to be less likely to participate in diversion than to proceed through conventional criminal justice channels (Spooner et al., 2001). That identifiable groups have been found to be excluded from the intended benefits of diversion, such as prioritised treatment and diversion from imprisonment, points to a need for review of criteria for diversion at each State level (Spooner et al., 2001).

Concern has also been expressed that the prospect of a court hearing and possible incarceration may lead individuals to feel compelled to admit to crimes they did not commit (see 2.9.1). However, lower than anticipated diversion program uptake rates,⁸⁸ and reports from PRG members, suggest that

⁸⁶ Due to a small sample size these figures must be read with caution and may be considered indicative of a likely association only.

⁸⁷ It must be noted, however, that these results are taken from a summary of the evaluation, which omits details about sample size, comparison groups and follow-up time periods and does not quantify the changes reported. These results must therefore be read with caution.

⁸⁸ Uptake rates were approximately one-third of original projections for the IDDI as at March 2002 (Alcohol and other Drugs Council of Australia, 2003c).

this does not occur to any significant degree and that offenders frequently choose not to be diverted.

If you actually look at the drug courts or diversion – the number of people who have elected to go into these has been very small. One of the problems with all of these programs is they haven't been able to fill the spots. So at the front end, people do make a choice, even though they're in the criminal justice system, and if you actually look at all of the data, there are more people who choose not to go to drug court than to go, because once you go into drug court you're into serious coercion.⁸⁹

Treatment interventions offered through these types of diversion programs have been criticised as insufficiently flexible for the group of offenders they target:

People in the early part of a drug-using career often choose to be dealt with by the criminal justice system ... the treatment interventions offered seem onerous and out of proportion for this group of offenders ... less intensive interventions are required, interventions that focus more on social support rather than AOD treatment per se.⁹⁰

Overall, there is some evidence that the large investment that governments have made in pre-arrest diversion programs has resulted in reduced crime rates and lower court and law enforcement costs. However, weaknesses and negative outcomes have been noted (including inadequate data sets for full and ongoing evaluation, net-widening and discriminatory operation) which require addressing before the full potential of these programs can be realised.

⁸⁹ PRG102.

⁹⁰ K109.

⁹¹ Similar programs in North America and France have also experienced challenges achieving cooperation between agencies with traditionally different aims and values (Stevens et al., 2003).

4.2.2 Pre-trial diversion

Several jurisdictions operate pre-trial diversion programs including New South Wales, Victoria, South Australia and the Australian Capital Territory. The goals of the New South Wales program are typical of these pre-trial diversion programs, and include:

- decreased drug-related crime by participating defendants during and following program completion
- decreased illicit drug use by participating defendants for the duration of the program and in the post-program period
- improved health and social functioning for the duration of the program and in the post-program period
- increased community protection from drug-related criminal activity
- sentences that reflect better rehabilitation prospects for successful participants.

An evaluation of the Victorian CREDIT pre-trial diversion program reported success in getting offenders into treatment and overall support from magistrates, clinicians and clients, despite initial problems balancing the competing priorities and perspectives of treatment providers and those in the justice system⁹¹ (Heale & Lang, 2001). Effectiveness in reducing recidivism and drug use could not be concluded, however, as treatment was completed by only half (52%) of CREDIT participants and no differences in 12-week re-offending rates were found between CREDIT participants and non-participants.

Evaluation of the New South Wales Magistrates Early Referral Into Treatment (MERIT) pilot program reported slightly lower rates of

recidivism, cost savings, positive health and social outcomes for participants, and high levels of participant satisfaction with the program (Bolitho, Crawford & Flaherty, 2005). It should be noted, however, that this evaluation suffered from the methodological limitations common to evaluations of these types of programs: absence of a randomised control trial, short follow-up times and assumptions about comparability of program graduates and non-graduates (Stevens et al., 2003).

In 2003, magistrates who had participated in the MERIT program were surveyed about their experiences and opinions of the operation and philosophy of the program. With regard to sentencing, some reported that they would give a ‘sentence discount’ or ‘a drop-back in the penalty’ to defendants who had completed the program. Most said that they gave ‘significant’ (35.1%), ‘a great deal’ (21.6%) or ‘considerable’ (13.5%) weight to satisfactory completion of the treatment program in determining sentences (Barnes & Poletti, 2004).

It has been reported that some MERIT clients face difficulties continuing treatment in the public system upon completion of the program:

There is a problem where an individual is put on methadone maintenance treatment [MMT] during MERIT, but then faces difficulty continuing it because there is no seamless transition into public MMT programs, which have long waiting lists.⁹²

⁹² K109.

⁹³ K109.

⁹⁴ MMT patients also face the likelihood of reduced opioid tolerance, further confounding the dangers around resuming drug use (New South Wales Health Department, 1999).

⁹⁵ K109.

⁹⁶ It must be noted that a single key informant raised these two treatment issues and no data to support or refute have been sought. In the context of limited evaluation evidence, they are included here to flag areas that anecdotally are unsatisfactory, and may warrant investigation.

The alternative is to continue treatment in the private sector. However, costs there are prohibitive for most MERIT participants, such that at the end of their three-month MERIT program, they may be forced into a situation where they abruptly terminate MMT.⁹³ The New South Wales Health Department’s MMT clinical practice guidelines (New South Wales Health Department, 1999) advise that this places MMT patients at extremely high risk of relapse to illicit opioid use and state that involuntary withdrawal should take no less than 21 days.⁹⁴

One key informant expressed concern that some MERIT clients may have difficulty accessing appropriate treatment via the program, depending on the treatment knowledge and/or beliefs of the presiding magistrate and the MERIT team:

Some court officials are of the philosophical belief that MMT is not appropriate ... there is an unwillingness to see pharmacotherapy as a legitimate treatment option ... and there is variability between magistrates and MERIT teams themselves.⁹⁵

Two factors were posited:⁹⁶

- Recruiting health professionals into MERIT teams was difficult, such that many are from probation and parole backgrounds so may not have an AOD clinical background.
- It is difficult to get AOD education included in magistrates’ in-service training due to already full training schedules.

There is also anecdotal evidence that some net-widening occurs under the MERIT program:

If people are feeling confused and depressed and homeless, and they want treatment but can't afford the private system, often they will plead guilty to gain access to treatment. Whereas in other situations they may have pleaded not guilty ... Need to expand the program so people can opt in irrespective of plea.⁹⁷

A qualitative evaluation of South Australia's pre-trial diversion programs, known as the Drug Assessment and Aid Program (DAAP), identified equity problems in access. Rural offenders, Indigenous offenders and offenders from different ethnic and cultural backgrounds were identified as being poorly serviced by DAAP, while adolescents were ineligible to participate at all (Biven & Ramsay, 1999, cited in Spooner et al., 2001).

Review of the first year of the pilot Court Assessment and Referral Drug Scheme (CARDS) involved description of the throughput of the scheme. Sixty-five offenders were accepted into the scheme in that time and nearly two-thirds (62.5%) of them completed their four mandated treatment sessions. Of those who completed the scheme, 53 per cent continued treatment on a voluntary basis, suggesting that CARDS may have a positive influence in helping this group of offenders address their drug use issues. Further investigation is required to substantiate this.

There is some evidence of satisfaction and support among those involved in pre-trial programs in Australia. However, evidence that recidivism rates, drug use and costs are reduced is weak. Furthermore, there are data to show that pre-trial diversion programs result in net-widening and that minority groups such as Indigenous Australians, culturally and linguistically diverse (CALD) and female offenders do not enjoy full access to and participation in these programs and their intended benefits (Flaherty et al., 2002).

4.2.3 Drug courts

The Australian Institute of Criminology states that drug courts aim 'to divert illicit drug users from incarceration into treatment programs for their addiction' (Australian Institute of Criminology, 2006a). Freiberg (2002) describes them as a 'problem-oriented' response to offending behaviour, focused on finding solutions to the problem of drug-related offending. Drug courts have an underlying rationale that it is better to deal with drug-dependent offenders therapeutically rather than punitively (Indermaur & Roberts, 2003).

Before reporting on evaluations of State drug court programs, the following comments are offered on three ongoing debates. First, it has been argued that drug courts are unnecessary. Freiberg (2002) contends that the link between drug use and offending is so common and so longstanding that there is no real case for establishing a separate system to deal with drug-using offenders. Instead, all courts should be considered 'drug courts', with the appropriate expertise and resources to respond to drug-related offending, rather than being seen as a specialist area of work.

*Drug courts are not new in the sense that we've always had the power to refer people to treatment. The problem was that there was nowhere to send them, whatever we recommended. The good thing about drug courts is that there has been a huge injection of funds into treatment.*⁹⁸

Freiberg (2002) proposes a flexible range of interventions be available in all parts of the criminal justice system.

Secondly, questions have been raised about the costs associated with drug courts. Some argue that the focus of Australian drug courts on the more serious end of the offending continuum means that fewer resources are available for minor offenders. Conversely, it has been argued that the provision of resources to the less serious offender via pre-arrest diversion schemes may itself be unnecessary, given that re-offending rates for first-time offenders are actually low (Freiberg, 2002). Yet others have argued that specialist drug courts are generally more expensive to run than conventional courts, while proponents assert that these costs have the potential to be offset against the avoided costs of imprisonment and re-offending (Spooner et al., 2001). Cost-effectiveness is discussed, where evaluated, in the drug court reviews outlined below.

The third and related issue pertains to how the success of drug courts should be measured. In general, the two main aims of drug courts are to reduce drug use and reduce re-offending. Other stated goals often include improving health, re-integrating individuals

into the community, and reducing criminal justice costs. The types of issues to consider include:

- What methods of evaluation should be used? The gold standard, randomised controlled trial? Interrupted time series evaluation design? What is an acceptable comparison group?
- How much of a reduction in drug use and re-offending is expected and indicative of success? Over what time period are these behaviour changes expected to be revealed and sustained?
- Which other factors should be measured in determining program success? Improvements in physical and mental health, employment status, accommodation status, family relationships and education, criminal justice costs and savings, impacts on the community, impacts on health services, other factors?
- How do client and treatment program characteristics impact upon success?
- How should negative outcomes (e.g. net-widening) be factored in?

*... those more nebulous areas like health costs and emergency admissions and the like. And how do you measure those? But I think those things, even though they are less measurable and they don't fit neatly within the election cycles of governments, they are also very real and I think they should always be part of the discussion – for example, familial relationships, general health and wellbeing, impact on health services, especially emergency admissions, ability to care for children, general antisocial behaviour.*⁹⁹

⁹⁸ PRG206.

⁹⁹ K106.

4.2.3.1 New South Wales Drug Court

The objectives of the New South Wales Drug Court are outlined in section 3(1) of the *Drug Court Act 1998* (NSW):

- (a) to reduce the drug dependency of eligible persons
- (b) to promote the re-integration of such drug-dependent persons into the community, and
- (c) to reduce the need for such drug-dependent persons to resort to criminal activity to support their drug dependencies.

Participants in the Drug Court progress through the program over 12 months (or less, if the program is terminated sooner). The court closely monitors participants through the process and confers rewards (e.g. reduced frequency of drug testing or treatment) for compliance, and sanctions (e.g. increased frequency of drug testing and supervision) for non-compliance with the program. Upon termination of a participant's program, the Drug Court reconsiders the initial sentence and usually orders a non-custodial sentence or a custodial sentence where non-compliance has been recorded.

The New South Wales Bureau of Crime Statistics and Research conducted a series of evaluations of the New South Wales Drug Court trial. These looked at impacts on health, wellbeing and satisfaction of participants, cost-effectiveness of the court, and predictors of Drug Court program compliance and offending.¹⁰⁰

The health and wellbeing evaluation involved face-to-face interviews with Drug Court participants before program commencement and at four, eight and 12 months into the

program. Among those who completed the program, improvements were found on all measures: health (measured by the SF-36 Short Form Health Survey), social functioning (measured by the Opiate Treatment Index), and drug use (using weekly spending as a proxy measure) (Freeman, 2002). For example, the health of male program participants at 12 months was found to be as high or higher than Australian population norms. Participant satisfaction with the program varied over time, but overall was high. It must be noted, however, that almost two-thirds (62%) of participants were terminated from the program before 12-month completion. It was concluded that the program is effective for participants while they remain on it, but that Drug Court resources could be more efficiently used if retention rates were increased.

Cost-effectiveness evaluation of the New South Wales Drug Court compared recidivism rates of 309 participants with a randomised control group of 191 eligible offenders who proceeded through conventional criminal justice processes (mainly resulting in imprisonment) (Lind et al., 2002). Drug Court participants took significantly longer to re-offend (drug and shop stealing offences) and had significantly lower drug offence rates than the control group. A second set of analyses compared these two groups and a third group – those who terminated from the Drug Court program (43% of original participants). Again those who remained in the program took significantly longer to re-offend and had significantly lower recidivism rates for most offences. This information was combined with cost data (discussed below) to draw conclusions about the cost-effectiveness of the Drug Court.

¹⁰⁰ A process evaluation was also conducted, but is not discussed here.

The daily cost of maintaining an individual on the Drug Court program was estimated at \$143.87. This was less, but not significantly so, than the daily cost (\$151.72) for offenders in the control group, sanctioned by conventional means (Lind et al., 2002). Thus, it was concluded that the Drug Court was ‘as cost-effective as conventional sanctions in delaying the time to the first offence and cost-effective in reducing the frequency of offending’ (Lind et al., 2002, p.62). It is worth noting, however, that using the ideal method for calculating cost-effectiveness (comparing the average cost per episode of treatment with the average cost of sanctioning a control group member), Drug Court costs were found to be greater than for the control group – \$46,224 compared with \$35,334. The researchers noted that the high termination rate meant such calculation was not appropriate and that calculating the daily cost was a more reliable approach. This again pointed to the need to improve retention rates in order to improve the effectiveness of the Drug Court.

It was consistently concluded and recommended in this series of evaluations that the effectiveness of the Drug Court could be improved if it were possible to distinguish those who would benefit from the program from those unsuitable and therefore likely to terminate. Thus, the New South Wales Bureau of Crime Statistics and Research conducted a further study to find factors that would enable early identification of participants at risk of non-compliance with program requirements. The rationale was that these participants could either be given intensive supervision, support and treatment to enhance compliance, or be removed from the program early to reduce the costs they

impose on the program. The Bureau conducted a retrospective study to identify predictors¹⁰¹ of program compliance at six months, offending during months 4–6 and drug use at months 5–6.

- Predictors of program compliance at six months included number of custody episodes, waiver of suspended sanctions, number of bench warrants issued for absconding and number of urine tests provided.
- Predictors of offending during months 4–6 of the program included number of missed program appointments, having been issued a bench warrant for absconding, and having tested positive to both stimulants and opiates during months 2–3 of the program.
- Predictors of opiate and stimulant use at months 5–6 included number of custodial episodes, number of suspended sanctions, and number of missed program appointments.

The Bureau noted several limitations to the study (including that it was retrospective not prospective, the sample size was small ($n = 217$) and the data sets incomplete) and recommended that the information on predictors of program success be used in conjunction with other information about individual program participants for their most effective management.

¹⁰¹ Indicators of program compliance during the first three months.

4.2.3.2 New South Wales Youth Drug and Alcohol Court

A comprehensive evaluation of the Youth Drug and Alcohol Court (YDC) was conducted in 2002. A range of methods was employed, including: 'statistical monitoring of program referral and take-up, participants' characteristics and their progress through the program; process evaluation of the implementation and operation of the program; review of legal issues arising from the YDC's operations; a study of the outcomes of the program for participants, both in terms of their re-offending and their health and social functioning; and an analysis of the costs of running the program' (Eardley et al., 2004, p.3).

Evaluators reported that:

- Graduates were less likely to re-offend than those who did not complete the program.
- Most participants reported that their drug use had decreased compared with use in the three months before entering the program.
- Improvements in mental health over the longer term were reported, particularly among young women and those who graduated from the program.
- Short-term improvements to health were reported.
- Women were a target group for the program, but only a small number were referred. Women who were referred to the program were less likely than young men to be accepted or to agree to participate. Those who did participate were also less likely to complete the program successfully.

- Indigenous youth were less likely than others to participate in the program.
- Satisfaction with the program, the Court and staff was high.

There was some evidence that the YDC may be cost-effective – daily costs of maintaining a young person on the YDC program were estimated at \$359–\$452, compared with a daily cost of approximately \$500 to keep a young person in custody. It was noted, however, that the fact that many young people spend longer on the program than they would in custody, was not factored into the cost analysis. Furthermore, where costs were distributed across program completers only (approximately 37 per cent of those who started the program), the daily costs of the YDC were substantially higher than conventional costs (\$539–\$760). The benefits of the two paths, punishment or therapy, are not the same, however. Investment in treatment also yields the benefit of a young person's healthy future.

Concerns were raised in this study about the legality and fairness of using bail provisions for participants – in particular, the use of sanctions. The evaluators reported that sanctions for non-compliance with YDC program conditions might create a 'two-sentence' procedure, or denser nets (see 2.9.1) in that a young person may be punished while on the program and then punished a second time at sentencing. Consideration of these legal issues was recommended (Eardley et al., 2004).¹⁰²

The evaluators also noted a range of methodological limitations similar to those of most drug court evaluations. These included data that were unavailable in the form or over the necessary periods of time to show whether program outcomes were sustained

¹⁰² Refer to Eardley et al. (2004), pp.142–144, for history and detailed discussion of these legal issues.

and causally related to the intervention. Such limitations have precluded definitive conclusions about the extent of program effectiveness, specifically around program engagement, reductions in offending and drug use, and improvements in health and social functioning (Eardley et al., 2004). Nonetheless, it was concluded that the program has ‘an important, positive impact on the lives of many of those participating’ (Eardley et al., 2004) and its continuation and expansion were recommended.

As with the adult New South Wales Drug Courts, almost two-thirds (63%) of participants in the YDC terminated the program before completion, indicating that there is considerable scope for expanding the reach of the positive impacts of the program.

4.2.3.3 Queensland Drug Court

As outlined in section 3(1) of the *Drug Rehabilitation (Court Diversion) Act 2000* (Qld), the Queensland court diversion program aims to reduce:

- (a) the level of drug dependency in the community
- (b) the level of criminal activity associated with drug dependency
- (c) health risks to the community associated with drug dependency, and
- (d) pressure on resources in the court and prison systems.

Outcome evaluations of the northern and south-eastern Queensland Drug Court programs have been completed. The evaluations measured effectiveness by recidivism rates. However, neither study examined drug use or dependency post-program, and only the north Queensland evaluation looked

at health and social functioning. Furthermore, program completion rates were low: 20 per cent in north Queensland, and 24 per cent in south-east Queensland. Only half of those referred to the Queensland Drug Courts participated in the program. Of these, approximately half were ineligible and half refused to participate, so in the end one-quarter of eligible participants chose not to take part in an intensive drug rehabilitation order (IDRO) (Makkai & Veraar, 2003).

The north Queensland evaluation compared program graduates with two groups – those who terminated early, and those who were referred to the program but refused to participate. Program graduates were significantly less likely to re-offend than those who terminated, and they also took longer to re-offend:

- Among those who terminated, half had re-offended within 71 days; while among program graduates, 634 days elapsed before half had re-offended.¹⁰³
- Overall, participants who terminated the program early had poorer outcomes than either program graduates or those who refused to participate at all, and younger participants were at greater risk of re-offending than older participants (Payne, 2005).

A second measure of re-offending was frequency of re-offending. Among program participants, re-offending rates dropped from 5.1 occasions per 365 free days prior to program entry to 1.8 occasions post-entry. For the refusal comparison group, the rates were 5.9 and 1.6 respectively (Payne, 2005). Thus, reductions were noted regardless of participation in the Drug Court program.

¹⁰³ Refer to Payne (2005) for a full description of the ‘survival analysis’ method used to calculate time to re-offend.

Significant improvements in health and social functioning, as measured by the Short Form Health Survey (SF-36), were also found for participants who completed the program and many graduates reported improved family and social relationships (Payne, 2005).

Comparable recidivism rates were reported in the evaluation of the south-east Queensland Drug Court (Makkai & Veraar, 2003), which compared Drug Court program participants with a group who refused to participate in the program and with a prisoner comparison group. The data showed significant reductions in recidivism for program graduates and a longer time to re-offending for the small number of graduates who do re-offend, compared with both comparison groups (Makkai & Veraar, 2003).

Given the overall low program completion rates, logistic regression analyses were conducted to identify factors that could predict program completion and, conversely, identify issues that might be addressed to increase completion rates. Five significant predictors were found (Makkai & Veraar, 2003):

- community ties, as measured by family support and employment
- commitment to the court, as measured by absconding
- ongoing monitoring by the court, as measured by the frequency of drug testing
- drug use history, as measured by positive opiate urine tests, and
- a greater incentive to succeed, as measured by the length of prior imprisonment sentence.

These studies did not consider the influence of the type of treatment engaged in, while on the Drug Court program, on program completion and recidivism. Indeed, none of the Australian studies has looked at this. Anecdotally, however, it has been reported, 'Some of the better successes in the Diversion program have been when people have got onto pharmacotherapies, as opposed to an abstinence-based approach.'¹⁰⁴

There is some evidence that Queensland Drug Court programs are reaching a group of drug-using offenders who have never before had any AOD treatment.

*For the majority of Drug Court clients, when they met up with us, we were the first treatment providers that they had ever come in contact with ... They'd done lots of gaol time and lots of using and never had any contact with a health worker ever ... There's something really wrong with that.'*¹⁰⁵

There is also anecdotal evidence of some success engaging Indigenous offenders in the program. The importance of linking in with Indigenous communities and gaining trust and respect were highlighted:

*Once we had credibility and recognition, and were able to make use of Indigenous services available, we had some good successes with our young Indigenous males. Before that it was just impossible to have a success. But having the older people to refer the clients to ... trying to get them involved in some way with cultural activities ... they were better off.'*¹⁰⁶

¹⁰⁴ K105.

¹⁰⁵ K103.

¹⁰⁶ K103.

The attitudes and commitment of staff, as well as their ability to work within a multi-disciplinary team, have been highlighted as factors vital to the success of the Drug Court program.

I think it works very well. It works very well because of the people who are involved in it and the belief that they have in it; and the ability to communicate across treatment modalities, across treatment beliefs, across ethical systems. People are willing to share what information they have with a view to keeping that client out of gaol forever. Not just for this time, but to encourage them to make enough changes that they will not go back to gaol.¹⁰⁷

Overall, the evaluations demonstrate that the programs are effective in reducing re-offending for those who complete the program. These positive results contributed to government support for the program, the enactment of legislation (passed in 2006) to make the Drug Court a permanent sentencing option in Queensland, and the provision of additional funding for their expanded operation across the State.

4.2.3.4 South Australian Drug Court

The key aims of the South Australian Drug Court program are:

- to minimise, or stop, the use of illicit drugs by offenders, and
- to prevent, or decrease, any further drug-related offending (Corlett et al., 2005).

A series of studies have reviewed the operation of the Adelaide-based court. In 2006, Skrzypiec (2006) compared participants who completed the program in its first 38 months of operation with those who terminated prior to completion, in order to identify factors

that might explain reasons for early termination. As is common in drug courts in Australia, completion rates were low, with only 26.2 per cent of participants completing the program (see also Western Australia and New South Wales). Over half (55.9%) were terminated from the program, usually for non-compliance, and 17.9 per cent voluntarily withdrew (Skrzypiec, 2006). Program ‘completers’ and ‘terminators’ were compared on numerous variables within categories such as demographics, drug use and offending history. This information was extracted from the Drug Court database (including information collected at the initial assessment interview) and from the databases of criminal justice agencies in South Australia (e.g. South Australian Police Apprehension and Offender History records). Logistic regression analyses found three significant predictors of early termination:

- limited family support
- a criminal history spanning seven years or more
- later onset of alcohol abuse (after 18 years compared with before 18 years).

Whilst the first two variables were consistent with findings in other studies (Crime Research Centre, 2003; Payne, 2005), the meaning of the third predictor was uncertain and Skrzypiec (2006) cautioned its interpretation. Further, it was noted that the overall strength of association of predictors was weak and that there are likely to be unaccounted-for predictive factors. Methodological weaknesses also limit the strength of conclusions that can be drawn, including a small sample size and flaws in the collection of data, which were extracted from various databases.

¹⁰⁷ K103.

In 2004, an evaluation of the South Australian Drug Court was conducted to assess whether it was achieving its aim of preventing or reducing further offending, through the provision of effective interventions and treatment (Corlett et al., 2005).

The review compared the pre- and post-program offending behaviour of 43 individuals who had completed the program at least six months prior to the time of the review. Frequency and severity of post-program offending behaviour were compared with behaviour for an equal period prior to program initiation for each individual and reductions were found in both:

- Almost one-quarter (23.3%) of those who completed the program committed no offences in the post-program period and approximately 80 per cent had lower offending rates.
- Of the 39 individuals who were ‘serious offenders’, just over one-third (35.9%) committed another serious offence in the post-program period; 23.1 per cent of ‘serious offenders’ committed no offences in the post-program period, 33.3 per cent committed minor offences, and 7.7 per cent committed moderate offences.

The absence of a matched or control group for comparison, however, is a major methodological limitation and precluded any inferences of causation. The evaluators were limited to concluding that the results were ‘encouraging’ and suggestive of ‘a positive influence’ (Corlett et al., 2005). The results were further confounded by low completion rates, with less than one-quarter (23.4%) of participants completing the 12-month program¹⁰⁸ (Corlett et al., 2005).

¹⁰⁸ Note that the two studies discussed here were conducted at different times and so report slightly different completion and termination rates; completion rates: 57 per cent terminated, 19 per cent withdrew and 1 per cent died.

¹⁰⁹ Half (51%; 30) were in Phase I, 20 per cent (12) were in Phase II, and one had progressed to Phase III.

4.2.3.5 Victorian Drug Court

Participants in the Victorian Drug Court program are sentenced to a Drug Treatment Order (DTO), the purposes of which are described in s.18X of the *Sentencing (Amendment) Act 2002*:

- (a) to facilitate the rehabilitation of the offender by providing a judicially supervised, therapeutically oriented, integrated drug or alcohol treatment and supervision regime
- (b) to take account of an offender’s drug or alcohol dependency
- (c) to reduce the level of criminal activity associated with drug or alcohol dependency
- (d) to reduce the offender’s health risks associated with drug or alcohol dependency.

The Drug Court aims to protect the community by rehabilitating participants, stabilising their lifestyles and re-integrating them into society.

A series of evaluations of the Victorian Drug Court were completed in 2002–03, including a health and wellbeing evaluation and a cost-effectiveness evaluation. The major proviso to bear in mind in considering these studies is that they were conducted early in the life of the Drug Court and therefore do not include information about re-offending and drug use after program completion. As at the time of the studies, 59 individuals had received DTOs, but none had yet graduated.¹⁰⁹

The health and wellbeing study was a prospective study of 28 Drug Court participants, surveyed at commencement of their DTO and again three and six months post-commencement.¹¹⁰ Participants were reported to experience improved welfare and social functioning and increased social connectedness as a result of participating in the Drug Court program (King, Fletcher et al., 2004). Positive outcomes reported included increased employment rates, reductions in self-reported use of heroin, alcohol, tranquillisers and cigarettes, reductions in self-reported criminal activity, and improvements in physical and mental health. Methodological limitations must, however, be noted: none of the participants had completed the Drug Court program and nearly all were still in phase one at the six-month follow-up; no comparison group was used; and the sample size was small. Thus, conclusions about DTO effectiveness cannot be drawn from these results.

The cost-effectiveness study compared 59 Drug Court participants with 50 offenders convicted of equivalent charges who were sentenced to a term of imprisonment. 'Costs' included direct Drug Court and incarceration costs and 'effectiveness' referred to frequency of offending per unit of time. Analysis of costs and effectiveness, over a period of approximately 14 months, showed the Drug Court to be more expensive than the alternative sentencing option of incarceration, with average daily costs per person of \$193–\$204 compared with \$116–\$166 (King & Hales, 2004). The evaluators noted, however, that these cost estimates were likely inflated by 'start-up' costs of the Drug Court, and concluded that the low recidivism rates of Drug Court participants, compared with

those who were incarcerated, indicated the potential for the Drug Court to become cost-effective over time. It was also noted, however, that the comparison group had a significantly higher offending rate prior to the study, and that this propensity to offend may have biased the results.

Participants in the program spent approximately twice as long in each phase than the anticipated time periods outlined in the Drug Court handbook. Longer program involvement necessarily means higher per capita costs and lower throughput. This was attributed largely to the infancy and evolving nature of the program and the period of learning required to operate in this new area (King, Fletcher et al., 2004). Changes have since been made, procedures refined and guidelines implemented to improve throughput, though the anticipated duration of each phase is still expected to be longer than originally estimated.

Positive findings reported among this series of evaluations led the Victorian Department of Justice (2005) to conclude 'that the benefits of the Drug Court approach far exceed its costs, and that it is more cost-effective than imprisonment in reducing re-offending'. Thus, the Drug Court program was made permanent at the conclusion of its pilot period in June 2005.

¹¹⁰ That is, before program completion.

4.2.3.6 Western Australian Drug Court

The Western Australian justice system provides three different sentencing regimes for drug offenders. These are applied according to the severity of the offence and substance use. The three levels include:

1. Brief Intervention Regime: designed for those who have committed minor cannabis offences, it involves referral to three sessions of drug education.
2. Supervised Treatment Intervention Regime: aimed at people with substance abuse problems who have committed mid-range offences, it requires offenders to attend treatment and rehabilitation.
3. Drug Court Regime: a more intensive intervention for those whose substance use and offending are more severe. Offenders must undergo treatment and monitoring which usually involves weekly court appearances.

Evaluation of the Perth Drug Court pilot program was conducted in 2002. Evaluators conducted quantitative, qualitative and legal analyses, including looking at recidivism rates of offenders referred to the Drug Court, cost-benefit analyses, and perceptions and opinions of stakeholders and workers.

The evaluators found no substantial evidence of reductions in recidivism rates for program participants when comparing them with a range of comparison groups (Crime Research Centre, 2003). It was noted that this may be due to small sample sizes and short follow-up time periods and further recidivism analyses were recommended.

Cost-benefit analysis of the pilot program concluded that the cost of the court was roughly equivalent to conventional processes (Indermaur & Roberts, 2005).

The program was found to be well received by relevant stakeholders including offenders' parents, treatment staff, and service provider organisations (Indermaur & Roberts, 2005). However, a number of concerns were expressed, including the lack of specific legislation to support operation of the Drug Court and a lack of management in the areas of program direction, collaboration and team management, and quality assurance.

There was some evidence that the program led to reduced drug use, with clean urines found for program completers significantly more often than for those who terminated the program or were not accepted into the program (57.5%, 35.7% and 28.9% respectively). This was not a main focus of the evaluation, however.

As with the other drug court evaluations, program completion rates were low – 55.6 per cent. This represented 29.9 per cent of all referrals to the court, as almost half of the people referred to the Drug Court were ineligible to participate. The number of previous arrests was found to be the only significant predictor of successful program completion, such that the fewer previous arrests an individual had, the more likely he/she was to complete the program. From this it was suggested that 'offending history rather than drug use history predicts program completion' (Crime Research Centre, 2003).

The absence of specific legislation governing the operations of the Perth Drug Court has been noted as a potentially undermining factor. The start-up phase of the court, including community awareness and

acceptance, may have been enhanced by the presence of legislation and a degree of vulnerability has been noted in functioning on the basis of protocols rather than legislation:

There are processes that happen in Drug Court that need to be protected by legislation. That whole concept of judicial case management, for instance, where traditionally you have adversaries, prosecution and defence, sitting outside of an open court sitting involved in case management, case planning sessions – where some of the subjects of discussions may be running completely against the norm in an adversarial setting. We engage in that process without any legislative protection. I think it's very vulnerable ... I think if you have specific legislation, it almost defines your business better. I don't think legislation would affect the model we have or the mode of operation. I think it would protect and better define the process. The flipside, of course, is that legislation can tie your hands in many respects.¹¹¹

Evaluators also noted this as a problem: 'The drug court is not able to exercise its full potential because it does not have the power to deliver a comprehensive set of procedures in managing offenders ... To be effective the Western Australian drug court needs to operate within a clearly defined set of guiding parameters derived from legislation' (Crime Research Centre, 2003, p.250).

The importance of sector-wide support in launching new programs was noted:

Never underestimate how influential the ... broader support for the initiative is – whether it's seen as something a bit quirky and 'out there'. If the organisational and political support doesn't exist, you end up focusing on battles for support rather than focusing on the service to the individual.¹¹²

The evaluation looked at recidivism as the main program outcome and took only limited measures of drug use. Other behaviour changes were not reported at all, but have been noted by individuals involved in the Drug Court:

When you see people who get to a point where they make decisions that affect a whole range of things – education, employment, associates, general health etc – they're the profound outcomes that I actually observe. So it's not just their drug use, it's the whole lifestyle that goes with it.¹¹³

Overall, evaluators reported that the Drug Court 'represents a positive and innovative development by the WA Department of Justice that has not only found favour with the treatment community, but has also established very positive partnerships that provide a sound base for the continuing development of community-based approaches to dealing with drug-dependent offenders' (Crime Research Centre, 2003). This conclusion is supported by anecdotal reports of individuals involved:

I think the outcomes are actually quite profound. I personally feel privileged I've been part of something like a drug court.¹¹⁴

¹¹¹ K106.

¹¹² K106.

¹¹³ K106.

¹¹⁴ K106.

A broader, though less formal evaluation was conducted of the Geraldton Alternative Sentencing Regime (GASR). A self-evaluation report of the now-defunct GASR indicated that it promoted wellbeing in various domains of life, with many participants reporting decreased substance abuse and offending, and improvements in physical and psychological wellbeing. In particular, positive outcomes from the use of the transcendental meditation (TM) technique were found (King & Duguid, 2003):

- Participants reported decreased stress levels, anxiety and substance abuse and improved relationships through the practice of TM.
- Community corrections officers involved in the GASR reported that clients practising TM were calmer, less anxious, had clearer thinking and decision-making ability, and more readily engaged in other rehabilitation programs and with their community corrections officer than before their practice commenced.

King (2006) noted that TM might be a particularly useful treatment technique for Indigenous Australians, as meditation is traditionally used in Aboriginal cultures. The GASR was found to provide a healing experience for Aboriginal people who participated.

4.2.4 Indigenous courts

Two of the Victorian Koori Court pilot programs were evaluated from 2002 to 2004. Evaluators described them as being a 're-sounding success' in terms of achieving, amongst other stated aims, reductions in recidivism rates (Harris, 2006). Other reported achievements included: reduced breach rates of community corrections orders; increases in Koori participation in, and ownership of, the administration of law; and strengthening of the Koori community by reinforcing the status of Elders and Respected Persons (Harris, 2006). The evaluators made 19 recommendations, mainly regarding administration and structures of the Koori Court program. Their report also recommended that the programs and services being utilised by the Koori Court (including drug and alcohol treatment programs) be reviewed with regard to their appropriateness (e.g. Indigenous staff or staff trained in cross-cultural awareness) and adequacy of funding.

The New South Wales Circle Sentencing program is currently being evaluated.

4.3 Reviews of civil commitment in Australia

In 2004, the New South Wales Standing Committee on Social Issues conducted a major review of the *Inebriates Act 1912* (NSW). The Committee examined the Act in detail, and received submissions from a broad range of key stakeholders (interest groups, organisations and individuals) on ethical issues, practices and research evidence. This process resulted in a nine-chapter report, which recommended the repeal of the *Inebriates Act 1912* (NSW) and its replacement with a new legislative framework similar to Victoria's *Alcoholics and Drug-dependent Persons Act 1968* and which incorporates elements of the *Mental Health Act 1990* (NSW). The Committee's report contains 55 recommendations which outline criteria, features, safeguards and supportive activities for the proposed new legislation and related frameworks (New South Wales Standing Committee on Social Issues, 2004).

Like the *Inebriates Act 1912* (NSW), the *Alcoholics and Drug-dependent Persons Act 1968* (Vic) has been reviewed extensively over the years, and many shortcomings noted (Swan & Alberti, 2004; Victoria Department of Human Services, 2005b). Despite this, amendments have been minor and have not addressed major consistent criticisms.

A process of review is again underway. In 2005, the Alcohol Policy Unit of the Department of Human Services in Victoria began a review of the *Alcoholics and Drug-dependent Persons Act 1968* (Vic) 'to ascertain its relevance in the current drug treatment climate' (Victoria Department of Human Services, 2005b, p.3). A discussion paper was published and submissions sought from interested parties to inform the development of a final policy position and recommendations on the repeal or amendment of the *Alcoholics and Drug-dependent Persons Act 1968* (Vic). The Department of Human Services received approximately 30 submissions from a range of organisations and individuals; there was no clear consensus as to the recommended future of the Act (Carter, personal communication, 2006).¹¹⁵ At the time of writing this paper, submissions were still under consideration. The Department of Human Services plans to make recommendations to the Victorian Parliament upon reaching a final policy position.

¹¹⁵ Submissions varied widely in their suggestions. See Appendix I for the main features of a selection of recommendations.

4.3.1 Criticisms of the *Inebriates Act 1912 (NSW)* and the *Alcoholics and Drug-dependent Persons Act 1968 (Vic)*

Both the *Inebriates Act 1912 (NSW)* and the *Alcoholics and Drug-dependent Persons Act 1968 (Vic)* have their genesis in the late 1800s, a time when the prevailing treatment philosophy supported confinement as a cure for alcoholism and drug addiction.¹¹⁶ Effective treatment was believed to involve ‘physical, mental and moral rehabilitation’ (Berridge, 2004) and was generally carried out under punitive conditions (i.e. confinement in inebriates asylums). Treatment philosophy has changed much since that time; however, the Acts have changed little in essence and continue instead to reflect beliefs and wisdom that have become outdated and anachronistic.

Their status as ‘historical relics’ (New South Wales Standing Committee on Social Issues, 2004, p.30) underlies many of the criticisms around the Acts. Adopting a structure based on that of chapter 3 of the *Report on the Inebriates Act 1912* (New South Wales Standing Committee on Social Issues, 2004), these criticisms are described briefly below under four categories: evidence of effectiveness, human rights, legal provisions and detention facilities.

4.3.1.1 Evidence of effectiveness

As described in section 4.1, there is insufficient empirical evidence to draw any firm conclusions regarding the effectiveness of compulsory treatment in rehabilitating or achieving long-term behavioural change. Swan and Alberti (2004) in their review of the *Alcoholics and Drug-dependent Persons Act 1968 (Vic)* reported:

There is no available evidence to support or reject compulsory treatment for non-offenders. The [ss.] 11 and 12 provisions of the Act have never been evaluated, nor have equivalent provisions internationally or in Tasmania’s *Alcohol and Drug Dependency Act 1968* and New South Wales’ *Inebriates Act 1912*.

Of the *Alcoholics and Drug-dependent Persons Act 1968 (Vic)*, key informants reported few ‘successful’ cases. It was reported that people rarely engage in treatment, because they either suffer cognitive impairment or are not interested or ready.¹¹⁷ Nonetheless, there are success stories.

People do come back and thank us – they say ‘it’s all a bit hazy, what happened, but thanks and I’m back on my feet.’¹¹⁸

One of my civil commitment clients, once sober, was diagnosed with depression, which he could then receive effective treatment for.¹¹⁹

The New South Wales Standing Committee on Social Issues reported that there was no evidence that involuntary treatment provides

¹¹⁶ The *Inebriates Bill (NSW)* was first introduced into the New South Wales Parliament in 1897 (New South Wales Standing Committee on Social Issues, 2004). The *Alcoholics and Drug-dependent Persons Act 1968 (Vic)* has its origins in the *Inebriates Act 1872 (Vic)* (Victoria Department of Human Services, 2005b).

¹¹⁷ K111.

¹¹⁸ K104.

¹¹⁹ K110.

outcomes exceeding those achieved through voluntary treatment (a possible grounds to justify its use), but rather that it ‘uses the same imperfect [treatment] tools’ (2004, p.88). In the absence of evidence that coercive treatment can produce long-term change, the Committee concluded that it could not ethically recommend a model that had this as its purpose. As described in section 4.3.2 below, the Committee was however satisfied that there is evidence that short-term involuntary care can effectively reduce harm.

Several key informants of this project supported a model for short-term care, noting that ‘the benefits that do occur, occur in the first few weeks.’¹²⁰

4.3.1.2 Human rights

The World Health Organization (WHO) recommends that national legislation that provides for treatment under coercion should be congruent with international human rights conventions, and provide substance abusers with the same protections of rights as are given to mentally ill persons through mental health legislation (Porter, Argandona & Curran, 1999).¹²¹

Both the *Inebriates Act 1912* (NSW) and the *Alcoholics and Drug-dependent Persons Act 1968* (Vic), however, are arguably inconsistent with several international human rights covenants, declarations and principles.

The *Alcoholics and Drug-dependent Persons Act 1968* (Vic) may also contravene rights enshrined in the Victorian Charter of Human Rights and Responsibilities, effective from 1 January 2007.¹²²

A selection of relevant sections is outlined below to demonstrate the types of human rights that these Acts may contravene:¹²³

- Universal Declaration of Human Rights (UDHR)¹²⁴
 - Article 3: Everyone has the right to life, liberty and security of person.
 - Article 9: No one shall be subjected to arbitrary arrest, detention or exile.
- International Covenant on Civil and Political Rights (ICCPR)¹²⁵
 - Article 9: Para 1: Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law.
 - Article 9: Para 4: Anyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court, in order that the court may decide without delay on the lawfulness of his detention and order his release if the detention is not lawful.

¹²⁰ K110.

¹²¹ Legislation protecting the rights of mentally ill patients is guided by the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care: <http://www.unhchr.ch/html/menu3/b/68.htm>.

¹²² The Charter is modelled on the ICCPR and enshrines basic human rights such as freedom of expression, freedom of association, and protection from cruel and degrading treatment.

¹²³ For further sections, the reader is referred to the *Report on the Inebriates Act 1912* (New South Wales Standing Committee on Social Issues, 2004).

¹²⁴ For full Declaration see <http://www.un.org/Overview/rights.html>.

¹²⁵ For full Covenant see http://www.unhchr.ch/html/menu3/b/a_ccpr.htm.

- Principles for the Protection and Care of People with Mental Illness and the Improvement of Mental Health Care¹²⁶
- Principle 9: Para 1: Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.
- Principle 9: Para 4: The treatment of every patient shall be directed towards preserving and enhancing personal autonomy.
- Principle 11: Para 1: No treatment shall be given to a patient without his or her informed consent, except [where] ...

Para 6(b): An independent authority ... is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to the proposed plan of treatment or, if domestic legislation so provides, that, having regard to the patient's own safety or the safety of others, the patient unreasonably withholds such consent; and (c): The independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient's health needs.

Para 8: ... treatment may also be given to any patient without the patient's informed consent if a qualified mental health practitioner authorized by law determines that it is urgently necessary in order to prevent immediate or imminent harm to the patient or to other persons. Such treatment shall not be prolonged beyond the period that is strictly necessary for this purpose.

For detailed discussion of the nature of these contraventions, the reader is referred to the comprehensive work of the New South Wales Standing Committee on Social Issues (2004), and submissions made to the review of the *Alcoholics and Drug-dependent Persons Act 1968* (Vic) (Law Institute of Victoria, 2005; Victorian Alcohol and Drug Association, 2005).

- Victorian Charter of Human Rights and Responsibilities¹²⁷
 - Section 10(c): A person must not be subjected to medical or scientific experimentation or treatment without his or her full, free and informed consent.
 - Section 21: Right to liberty and security of person
 - (1) Every person has the right to liberty and security.
 - (2) A person must not be subjected to arbitrary arrest or detention.
 - (3) A person must not be deprived of his or her liberty except on grounds, and in accordance with procedures, established by law.
 - (7) Any person deprived of liberty by arrest or detention is entitled to apply to a court for a declaration or order regarding the lawfulness of his or her detention.

¹²⁶ For full Principles see <http://www.unhchr.ch/html/menu3/b/68.htm>.

¹²⁷ For full Charter see <http://www.findlaw.com.au/Legislation/docs/57412.doc>.

- Section 7(2): A human right may be subject under law only to such reasonable limits as can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom, and taking into account all relevant factors including –
 - (a) the nature of the right; and
 - (b) the importance of the purpose of the limitation; and
 - (c) the nature and extent of the limitation; and
 - (d) the relationship between the limitation and its purpose; and
 - (e) any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve.

How does the *Alcoholics and Drug-dependent Persons Act 1968* (Vic) sit with this new protection of human rights for all Victorians? The *Alcoholics and Drug-dependent Persons Act 1968* (Vic) allows for individuals to be subjected to treatment without their consent and to be deprived of their liberty – rights specifically protected under sections 10 and 21 of the Charter. It will be for the Supreme Court to determine if these violations of rights are justified. There are several issues here. The court will need to consider whether the purpose of detention is important enough to deprive individuals of these rights (s.7(2) (b)), yet at present the purpose of civil commitment is unclear – it is not stated in the Act. Is the purpose to save lives in the short term? Rehabilitate? Link the person with other services? Clarity on this issue is required.

Once the purpose has been ascertained, the nature of the relationship between that purpose and the act of committing a person involuntarily to a detoxification facility will need to be considered (s.7(2)(d)). Is the relationship appropriate? If the purpose of s.11 of the Act is to save lives in the short term, the answer is more likely to be in the affirmative than if the purpose is to rehabilitate. However, the absence of secure facilities and the lack of evidence for the effectiveness of civil commitment will be influential considerations in reaching a determination. As per s.7(2)(e) of the Charter, it may be that there are less restrictive means for achieving the decided purpose. Less restrictive measures might involve assertive outreach programs and specialist AOD responses within emergency departments of public hospitals, for example, as suggested by the Victorian Alcohol and Drug Association (VAADA) in their response to the *Alcoholics and Drug-dependent Persons Act 1968* (Vic) discussion paper.

4.3.1.3 Legal provisions

The Acts refer to ‘inebriates’, ‘alcoholics’ and ‘drug-dependent persons’. Reflecting the understanding and approach of the time the legislation was enacted, these terms have been criticised as value-laden and outdated. Furthermore, the definitions of these terms are extremely broad, and include no criteria to assist in the legal determination of whom they properly include or exclude. For example, there is no requirement that the magistrate consider whether the person is capable of giving free and informed consent to treatment or is unreasonably withholding such consent, as is required under the United Nations Principles for the Protection of People with Mental Illness.¹²⁸ This breadth and vagueness leave the Acts open to abuse,

¹²⁸ Principle 11. For full Principles see <http://www.unhchr.ch/html/menu3/b/68.htm>.

and may therefore render them inconsistent with international laws that protect against arbitrary detention.

Key informants relayed instances of inappropriate orders being made – situations where family or police used civil commitment legislation to take care of a ‘nuisance’. They reported difficulties associated with inappropriately made orders and also noted problems with the wording of the *Alcoholics and Drug-dependent Persons Act 1968* (Vic).

There was one case of a young man who was a frequent binge drinker, and had been repeatedly annoying the police. A section 11 order was obtained. He arrived at the [detoxification] unit totally sober with two police officers, who insisted he have a bed because ‘it’s a court requirement’, however no beds were available. The Chief Magistrate interceded and said the young man could be ordered to attend as a day patient for the seven days. The Act does not specify, but implies, that the treatment is inpatient.¹²⁹

Involuntary clients can disrupt an entire program. People become very frustrated and it is incredibly demoralising for staff.¹³⁰

The New South Wales and Victorian civil commitment Acts empower a magistrate to commit an ‘inebriate’, ‘alcoholic’ or ‘drug-dependent person’ with minimal medical involvement: a medical certificate from one medical practitioner, who need not be from the treatment agency, or even a specialist, is sufficient under section 11 of the *Alcoholics and Drug-dependent Persons Act 1968* (Vic) and under section 3 of the *Inebriates*

Act 1912 (NSW); magistrates have no guidelines in determining the appropriate length of an order (NSW); and clinicians have no power to discharge. This may result in treatment being prolonged beyond a period that is strictly necessary, and hence in violation of the Principles for the Protection of People with Mental Illness.¹³¹

A health professional should be deciding or advising, not the magistrates. Under the Mental Health Act any doctor can recommend compulsory treatment. Then at the mental health service a specialist can make a more seasoned assessment and may recommend another course of action. This is a better model and would work for the current section 11 – a doctor could screen and ‘enact’ compulsory attendance pending assessment by a ‘tertiary referral centre.’¹³²

The *Alcoholics and Drug-dependent Persons Act 1968* (Vic) lacks independent, transparent and accountable appeal and review processes. There is no right of appeal against section 11 orders (in breach of Article 9 of the ICCPR); there is no requirement that treatment outcome reports be provided to the court; and no official visitor has ever been appointed under section 8 of the Act to inspect treatment centres. The *Inebriates Act 1912* (NSW) includes limited rights of appeal, but otherwise similarly lacks review procedures.

Section 11 of the *Alcoholics and Drug-dependent Persons Act 1968* (Vic) allows for a broad range of people to bring a complaint. Inclusion of business partners has been heavily criticised.

Both Acts have been criticised as inefficient and difficult to utilise. For example, a complaint under the *Alcoholics and Drug-*

¹²⁹ KI04.

¹³⁰ KI11.

¹³¹ Principle 11.

¹³² KI04.

dependent Persons Act 1968 (Vic) must be supported by at least one certificate from a registered medical practitioner who has examined the person within 48 hours; however, there is no provision for compulsory assessment. That the Acts are problematic is evidenced by the low number of orders made – approximately five to eleven orders per year (New South Wales Standing Committee on Social Issues, 2004; Swan & Alberti, 2004).

4.3.1.4 Detention facilities

*One of the biggest problems of providing compulsory treatment is finding appropriate sites where there is balance between it being a therapeutic and custodial environment. This is not done very well at all at the moment.*¹³³

The nature of the facilities in which persons are to be detained is a source of criticism under both Acts.

Section 9 of the *Inebriates Act 1912* (NSW) provides for the designation of certain psychiatric hospitals as ‘institutions for the reception, control, and treatment of inebriates.’ The New South Wales Standing Committee on Social Issues (2004) reported universal agreement that psychiatric hospitals are inappropriate settings for several reasons: they do not offer specialised AOD services; potential harm to the ‘inebriate’, mentally ill patients, and staff; and exacerbation of existing bed shortages.

Several problems arise under the *Alcoholics and Drug-dependent Persons Act 1968* (Vic): in practice, people subject to a section 11 order are sent to a withdrawal facility; however, these are not secure units and they do not have the capacity to detain (this has negative cost implications as ‘revolving door’ attendance wastes the time and money of courts, police and service providers);

key informants have reported that police follow-up of absconding clients is inconsistent and often given low priority; section 11 clients have been reported to abscond and return to the withdrawal unit intoxicated and thus can be disruptive of other clients and their treatment, as well as sometimes being aggressive and violent (Swan & Alberti, 2004); and under s.18(2), an employee at a treatment or assessment centre commits an offence if they allow a detained person to quit or escape from such centre.

Civil commitment legislation provides for immediate admission and can require that committed clients be given priority access to treatment. As a result, motivated voluntary individuals may be denied access to treatment because resources have been diverted to the treatment of others whose motivation and readiness to change may be low, or even non-existent. Key informants involved in review of the *Alcoholics and Drug-dependent Persons Act 1968* (Vic) reported that section 11 orders are sometimes sought by families as a means of bypassing waiting lists for treatment in the voluntary system (Swan & Alberti, 2004). This is an inappropriate use of the *Alcoholics and Drug-dependent Persons Act 1968* (Vic), which reflects very real shortages of available services (see section 2.9.2 of this paper).

The New South Wales Standing Committee on Social Issues also reported concerns that detention facilities are unable to provide culturally appropriate services for Indigenous Australians and that the type of available detention contravenes recommendations of the Aboriginal Deaths in Custody Commission (New South Wales Standing Committee on Social Issues, 2004). This issue is especially serious given the disproportionately high use of the *Inebriates Act 1912* (NSW) with this cultural group.

¹³³ K109.

4.3.2 Future of civil commitment legislation?

4.3.2.1 Recommendations of the New South Wales Standing Committee on Social Issues

The New South Wales Standing Committee on Social Issues (2004) recommended:

That the Government establish a system of short-term involuntary care for people with substance dependence who have experienced or are at risk of serious harm, and whose decision making capacity is considered to be compromised, for the purpose of protecting the person's health and safety. (Recommendation 2)

Key features of this short-term model of involuntary care are described in chapter 7 of the Committee's report and are outlined below.

Key features of short-term model of involuntary care

Duration: 7–14 days

Target population: persons with substance dependence who have experienced or are at risk of serious harm, and whose decision-making capacity is considered compromised

Purpose: primary purpose is to protect health and safety

Constituent aims include:

- stabilisation – address immediate health needs; detoxification
- assessment – comprehensive assessment of physical, psychological and social needs; may include neuropsychological assessment
- restore decision-making capacity, or where restoration not possible (e.g. due to acquired brain injury), link the person with long-term care, such as through guardianship measures
- opportunity to engage with voluntary treatment system – provide information about and links to longer-term treatment options, develop post-discharge treatment plan and strongly encourage uptake

Criteria: four criteria must be met before a decision to commit a person to involuntary care can be made:

1. severe substance dependence, as diagnosed by internationally recognised tool such as the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM IV); substance dependence or use alone is not sufficient
2. serious harm to self (including injury, illness and self-neglect) experienced, or immediate risk thereof
3. lack of capacity to consent to treatment, and
4. treatment plan outlining expected benefit and rationale for proposed period of involuntary care.

Treatment type: detoxification in a secure medical facility.

Within the new legislative framework that it proposed, the Committee noted the need for a second model of care to address the needs of people with complex needs and/or antisocial behaviour. The Committee recommended a non-coercive system that incorporates elements of the *Human Services (Complex Needs) Act 2003* (Vic) (recommendation 27). This Act underpins the Victorian Multiple and Complex Needs (MACN) Initiative, which aims:

- to stabilise housing, health, social connection and safety issues
- to pursue planned and consistent therapeutic goals for each individual
- to provide a platform for long-term engagement in the service system (Victoria Department of Human Services, 2005).

The MACN Initiative provides specialist intervention for persons 16 years and over with MACN, including alcoholics and drug-dependent persons,¹³⁴ by way of multi-disciplinary assessment, development of care plans, and intensive case management. The Initiative commenced in 2002–03 and is currently being evaluated. This evaluation may provide important information for both the Victorian and New South Wales governments, and indeed any Australian government, in considering the future of civil commitment legislation. In so far as it provides information about the effectiveness of this Initiative for people less than 18 years, the evaluation will be particularly useful.¹³⁵

The Committee recommended that the needs of Indigenous Australians and of culturally and linguistically diverse (CALD) communities be recognised and incorporated into the new legislative model to be implemented (recommendations 34 and 35).

To underpin the new legislative framework, the Committee also proposed a new service framework, key elements of which are: evidence-based services and treatment guidelines; integrated service delivery; and investment in specific services (New South Wales Standing Committee on Social Issues, 2004). Specific services for investment include support for families and carers, and programs and supported accommodation for people with acquired brain injury.¹³⁶

The proposed changes are comprehensive and need to be well resourced to be effective. Addressing concerns that limited resources risk being diverted away from voluntary clients (see section 2.9.2 of this paper), the Committee recommended additional resources to fund the new system.

¹³⁴ As defined under the *Alcoholics and Drug-dependent Persons Act 1968* (Vic).

¹³⁵ The New South Wales Standing Committee on Social Issues noted that there is a lack of information available as to how best to meet the needs of young people, and expressed concern that its proposed short-term model of involuntary care may not do so.

¹³⁶ See chapter 8 of the Committee's report for details of the proposed framework.

4.4 Recommendations of key informants

In developing this discussion paper, contributions were sought from key informants knowledgeable in the field of compulsory treatment (see section 1.3.3). Comment on civil commitment was provided by several professionals experienced in treating committed clients in New South Wales and Victoria, and/or involved in legislative review and policy development (see Appendix A). In addition to the issues raised by the New South Wales Standing Committee on Social Issues, these key informants noted several further points:

- Many of the people to whom civil commitment legislation applies suffer from acquired brain injury. These individuals need secure and stable accommodation, and for their physical and mental needs to be met, more than they need great investment in AOD issues specifically.
- Compulsory treatment of young people does not work. To address youth AOD issues: parents need education about youth drug use, including how to set boundaries; greater investment in early identification of risky behaviour is required; and young people need access to developmentally appropriate treatment that addresses multiple needs.
- Coordination and collaboration between voluntary services in many cases are more effective in meeting the needs of people with AOD dependence than mandatory processes.
- Protocols must be care-driven; the primary question must remain: 'What are the needs of this person?'
- Any model needs to acknowledge that the 'hit rate' will be low; multiple relapses will occur; it may be possible to effect beneficial outcomes only for a small proportion of this challenging group.
- Cross-training of mental health and AOD workers is required; clear articulation of responsibility; avoidance of mental health and AOD silos.
- AOD specialists must be involved in decisions around involuntary detention as early as possible, preferably at first assessment before detention is ordered.

5. Conclusions and recommendations

This review was designed to inform discussion on compulsory treatment in Australia of offending and non-offending individuals deemed to be dependent on alcohol and/or other drugs.

The four primary research questions opened inquiry to a broad and complex territory, with the result that these findings reach beyond the original questions, to related issues within the broader system of which compulsory treatment is a part.

5.1 The place of compulsory treatment in Australia

Compulsory treatment has taken a firm place in Australia. There are State and national diversion initiatives throughout the country, operating at every stage of criminal justice proceedings and civil commitment legislation in force in four States. Despite its prevalence, there is currently no comprehensive national policy on how compulsory treatment, in its many forms, is to be conducted; rather, a web of national, State and local codes and practices. For the most part, programs have developed and operate independently of one another, without any overarching or consistent standards or objectives.

There appears to be a distinct need for an entity empowered to liaise between programs, help them share experiences, conduct collaborative research, develop common objectives and standards of conduct, collaborate on professional training, and develop standardised indicators for evaluation.

5.1.1 Principles of best practice

Compulsory treatment is unique within the broader AOD treatment domain by virtue of its legal origins and context. It involves cross-disciplinary collaboration of a distinctive nature in the treatment of a client group

with particular issues associated with and leading to a legal directive to participate in treatment. It can be a controversial field of treatment, impacting as it does on conceptions and experiences of individual rights and State responsibilities.

As such, it is apposite that evidence-based practice guidelines be developed. In addition to directing practice, such guidelines can, like a code of ethics, facilitate dialogue and ongoing development.

As diversion programs grow and civil commitment legislation is reviewed, the need for practice guidelines becomes more urgent. This paper summarises some of the elements required, albeit based on limited research. In particular, such guidelines should include provisions regarding criteria for eligibility, coercion methods and models of treatment. The process of developing functional guidelines based on experience and data requires input from multiple key stakeholders. Increased monitoring and evaluation, as recommended below, can enhance this process.

Recommended:

- That evidence-based practice guidelines for compulsory treatment be developed and informed by:
 - existing principles of best practice (e.g. diversion best-practice principles identified by Bull (2005); see section 2.10); principles emerging from forensic workplace training programs, such as in Victoria
 - drug court guidelines for team members in current operation around Australia
 - Alcohol and other Drugs Council of Australia Revised Code of Ethics and the Alcohol and Other Drugs Charter developed by the Australian National Council on Drugs (ANCD) (see section 2.11 and Appendices G and H)

- international and local human rights instruments, e.g. United Nations Principles for the Protection and Care of People with Mental Illness and the Improvement of Mental Health Care and the *Charter of Human Rights and Responsibilities Act 2006* (Vic)
- research as required
- discussions with key stakeholders.
- That processes for establishing evidence-based practice guidelines should incorporate strategies for future dissemination, promotion, development and implementation monitoring.
- That evidence-based practice guidelines be developed and implemented by extensive collaboration and cooperation between federal, State and Territory governments.

5.1.2 Nationwide coordination

The mission of the National Drug Strategy is 'to improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in Australian society'. This is a broad mandate. Within this broad intent, compulsory treatment has developed across Australia largely unguided by a specific integrated strategy. This makes for disparate systems of justice and treatment, and limits large-scale evaluation.

The national Illicit Drug Diversion Initiative (IDDI) is an exception to this, having been effected by extensive collaboration and cooperation between federal, State and Territory governments. The goals of the IDDI are to 'increase incentives for drug users to identify and treat their illicit drug use early, decrease the social impact of illicit drug use within the

community and to prevent a new generation of drug users committing drug-related crime from emerging in Australia, therefore leading to safer environments for all Australians'. The goals of other individual initiatives and programs generally include more specific objectives, commonly relating to reductions in re-offending rates and drug use. Secondary objectives, such as saving public funds otherwise expended in the criminal justice system, may also be considered legitimate goals of compulsory treatment.

The IDDI was the product of and catalyst for partnership. It led to increased communication and planning across portfolios within each level of government (Health Outcomes International, 2002) and, by creating such a climate, has the potential to facilitate future collaboration on related issues.

Recommended:

- That a national approach to compulsory treatment including policy guidelines for diversion at all stages of criminal justice proceedings and civil commitment be developed.
- That these guidelines should:
 - clearly set out the potential place of all compulsory treatment programs from police diversion, through court diversion initiatives and drug courts, to civil commitment of non-offenders
 - state the intended outcomes of compulsory treatment
 - be consistent with the mission and goals of existing initiatives, and provide a framework for clarification and revision of their objectives and procedures at a local level

- be formulated via a systems approach, so that a range of significant factors is considered, including: issues relating to cost and structure of compulsory treatment; issues relating to the clients (e.g. family relationships, employment, accommodation); and issues relating to specific client objectives (e.g. emotional wellbeing, social functioning and social connectedness).
- That national coordination assist to:
 - maintain a centralised, integrated data monitoring system for evaluation purposes
 - conduct rigorous evaluation research in multiple areas, including the development of standardised indicators, measuring real costs and benefits of compulsory treatment, at the individual, programmatic and social levels
 - provide a clearing house for research evidence (e.g. providing information on effectiveness of different treatment modalities; assessment tools; relevant adaptable findings from the behavioural sciences)
 - develop, disseminate, monitor and review principles of best practice
 - develop and conduct accredited education and training programs
 - facilitate dialogue between the agents of therapeutic jurisprudence, AOD treatment and other key stakeholders
 - promote community and sector awareness.

Nationwide coordination is the underpinning rationale for several of the following recommendations and provides a solid foundation for their implementation.

5.2 Diversionary practices in Australia

5.2.1 Overview

Diversion programs operate throughout Australia, across all stages of criminal justice proceedings. Pre-arrest and pre-trial diversion initiatives divert offenders away from the criminal justice system and into treatment as an alternative to the offender passing through conventional criminal justice proceedings, while pre-sentence, post-conviction and pre-release diversion programs see offenders diverted into treatment in addition to being dealt with by the criminal justice system.

Under the national Illicit Drug Diversion Initiative, pre-arrest diversion programs operate in an essentially consistent manner, across every Australian State and Territory. Diversion initiatives operating at other stages of proceedings are not coordinated by national strategy, and thus operate in various forms in several, but not all, States and Territories. Table 5.1 provides a snapshot of diversion programs across the country.

Table 5.1: Summary of compulsory alcohol and other drug treatment programs in Australia

Jurisdiction	Pre-arrest	Pre-trial	Pre-sentence
Australian Capital Territory	✓	CADAS	×
New South Wales	✓	MERIT RAD Youth conferencing	Youth AOD Court Deferred sentencing
Northern Territory	✓	CREDIT	×
Queensland	✓	QMERIT	Illicit Drug Court Diversion Program
South Australia	✓	DAAP CARDS	×
Tasmania	✓	×	×
Victoria	✓	CREDIT/Bail support	Criminal Justice Diversion Program Deferred sentencing
Western Australia	✓	×	Pre-sentence Opportunity Program Young Person's Opportunity Program Indigenous Diversion Program Supervised Treatment Intervention Regime

	Post-conviction			Pre-release	Civil commitment
	Drug courts	Indigenous courts	Suspended sentence		
	×	✓	✓	×	×
Adult Drug Court	✓	✓	✓	✓	✓
Youth Drug And Alcohol Court					
Compulsory Treatment Correctional Centre					
Alcohol Court	✓	✓	✓	✓ ¹³⁷ (but AOD content unknown)	✓ ¹³⁷
Queensland Drug Court	✓	×	×	✓	×
South Australian Drug Court	✓	✓	✓	✓	×
	×	×	✓	✓	✓
Victorian Drug Court (includes alcohol dependency)	✓	×	×	✓	✓
Western Australian Drug Court	×	×	×	✓	×

¹³⁷ *Liquor Act 2004* to be repealed; treatment orders made under the *Volatile Substance Abuse Prevention Act 2005* may or may not be residential.

5.2.2 Exclusionary criteria

Criteria for diversion operate to exclude certain groups intentionally and unintentionally.

5.2.2.1 Alcohol exclusion

Problematic alcohol use is rarely an admission criterion for diversion programs, and compulsory treatment related to alcohol is uncommon. The focus of compulsory treatment, and thus of this paper, is illicit drugs, even though legal drugs impose a higher cost on society in terms of money, morbidity and mortality. Collins and Lapsley (2002) estimated that only 5 per cent of total health care costs associated with 'drug abuse' in Australia in 1999 were attributable to illicit drug use, while some 80 per cent were attributable to tobacco, and 16 per cent to alcohol. There are clear associations between alcohol use and crime, with high levels of alcohol dependence and heavy use found among police detainees (Mouzos et al., 2006). In the current (2006) climate of growing awareness that considerable alcohol use is not only a nationally accepted pastime but also places a significant health, social and financial burden on individuals and society, review of this issue is timely.

Recommended:

- That consideration be given to expanding existing diversion programs by amending eligibility criteria to include problematic/dependent¹³⁸ alcohol use.
- Alternatively, that separate initiatives be developed for the diversion of individuals with demonstrable alcohol problems, using models based on the New South Wales Rural Alcohol Diversion Pilot Program and the Northern Territory Alcohol Court (which is itself based on the MERIT model).

5.2.2.2 Violence exclusion

Many potential participants are excluded from diversion programs due to the ancillary violent nature of their present charges or past crimes. This exclusion particularly affects Indigenous Australians. Some jurisdictions are reviewing the suitability of this excluding criterion, and are considering amendment such that minor violent offences will not exclude an offender from participating in a diversion program (as with the Northern Territory's CREDIT program).

Furthermore, what constitutes 'violent' varies across jurisdictions and is open to variable interpretation within jurisdictions.

Recommended:

- That provisions excluding certain offenders be further examined in consultation with relevant groups, especially Aboriginals and Torres Strait Islanders.
- That if violence is retained as an excluding factor, the terms 'violence' and 'violent' be clearly defined and limited to 'serious violent offences'.

5.2.2.3 Unsuitability for diversion due to mental illness

Dual diagnosis of AOD/mental health problems is common. In some jurisdictions, mental illness can render an offender unsuitable for AOD diversion; in others, AOD dependence can render an offender unsuitable for mental health diversion. There is the potential for high numbers of dually diagnosed offenders to fall between the diversion nets.

¹³⁸ According to the program type.

Recommended:

- That the issue of unsuitability for diversion due to mental illness be revisited and discussed, including discussion and clarification of:
 - whether AOD diversion or mental illness has primary jurisdiction for dual diagnosis clients when these two diversions operate together
 - how the courts may best sit as both a drug court and a mental health court
 - the training needs of magistrates regarding AOD and mental health issues
 - the potential establishment of general problem-solving courts with authority and resources to address multiple issues, including AOD, mental health and homelessness issues.

5.2.2.4 Non-residency exclusion

Eligibility to participate in court diversion programs, and thus have access to prioritised treatment, is usually dependent upon residence within the catchment area of the court. Given the incomplete coverage of drug courts throughout Australia, some offenders are excluded from court diversion by arbitrary virtue of their home address.

Recommended:

- That consideration be given to expanding court diversion programs to all jurisdictions to overcome inequality in sentencing options and thereby access to treatment options. This recommendation is contingent upon stronger evidence becoming available supporting the effectiveness of court diversion programs.

5.2.3 Unintended outcomes

Unintended negative consequences for some people have been observed to result from diversion into AOD treatment.

5.2.3.1 Net-widening

Diversion programs carry with them the risk of three forms of net-widening (examples of these phenomena have been found in programs across Australia): an increase in people who become subject to criminal justice proceedings and are thus introduced to the criminal justice system; penalties for non-compliance with a diversion order can lead to greater sanctions than would ordinarily have applied to the offence; and individuals may become enmeshed in the treatment system in addition to the criminal justice system. These raise ethical issues in relation to policy and cost.

Recommended:

- That systematic monitoring and evaluation be maintained, including consideration of possible net-widening.
- That guidelines to identify and minimise net-widening be developed.

5.2.3.2 Treatment shortages and displacement

In a climate where AOD treatment services available to the general community are in short supply and wait lists can be lengthy, it is arguably inappropriate and unfair to give preferential treatment to people referred via the criminal justice system. There is concern that this potential for displacement of voluntary clients creates 'perverse incentives' for people to access treatment via the criminal justice system.

Recommended:

- That ongoing monitoring of the demand for and the availability of treatment services in each jurisdiction be a part of the evaluation of diversion programs to avoid displacement of voluntary clients.

5.2.4 Teamwork and training

In recent years, Australian courts have moved towards a more therapeutic model of jurisprudence (Jeffries, 2002), as evidenced by the emergence of numerous pre-trial, pre-sentence and post-conviction diversionary programs (including drug courts and Indigenous sentencing courts). Therapeutic jurisprudence involves, and requires for success, a large shift in the traditional thinking and approaches of players in the court, health and corrections systems and of offenders themselves. It requires different professional groups to work as a team, to understand in depth the values, policies, language and procedures of each other, and often to share tasks traditionally within a single professional domain.

Rising use of the therapeutic model has involved large and increasing numbers of professionals in compulsory treatment programs (including the judiciary, police, lawyers, corrections workers, health care professionals and policy makers) and, thus, in working in closer cooperation with other groups of professionals with varied goals, priorities and responsibilities. Practices are evolving and the knowledge surrounding these new practices is changing and growing constantly. Challenges and lessons are ongoing.

At present, there is no universally recognised training, and no coordinated means for sharing learning experiences and consistently and systematically addressing challenges that arise. This raises important ethical questions: Do professionals have the skills and expertise to properly undertake tasks under the therapeutic model, including tasks from different disciplines? To what extent should professionals from different disciplines be undertaking tasks of other disciplines? How does this affect their ability to undertake their own roles? What guidelines and training should be provided?

Recommended:

- That the specific skill development needs of professions participating in compulsory treatment programs be identified.
- That protocols that include clear articulation of lines of responsibility be available.
- That principles of best practice be developed and disseminated.
- That an ongoing, cross-disciplinary professional education and training program be developed that could include in the curriculum: current protocols and procedures of participating professionals; standards of practice; case management strategies; confidentiality and reporting requirements; team-building strategies; offender rehabilitation strategies; the nature of drugs; and circumstances and reasons for use.
- That a clearing house maintain information and educational materials in these areas.

5.3 Civil commitment practices in Australia

Four Australian jurisdictions have legislated for involuntary commitment of non-offenders into AOD assessment and/or treatment. New South Wales, Tasmania and Victoria provide for the civil commitment of persons dependent on alcohol and/or other drugs, while legislation in the Northern Territory enables compulsory treatment orders for volatile substance abusers and civil commitment¹³⁹ of persons who use alcohol to excess. There is no national consistency in the development or implementation of this legislation.

Criticisms have been levelled at Australian civil commitment legislation on numerous grounds. Underlying much of this criticism is the fact that the New South Wales, Victorian and Tasmanian Acts are all products of a time when the prevailing treatment philosophy supported confinement as a cure for alcoholism and drug addiction. Few substantive changes have been made to the Acts over the years, such that they still reflect this outdated view.

Australian civil commitment legislation is also problematic for a lack of clear articulation of intended outcomes. The long titles of the Acts state that they provide for the ‘care’, ‘control’ and ‘treatment’ of those dependent on alcohol and/or other drugs, but further detail is lacking. It is not specified whether the legislation aims to achieve long-term rehabilitation or short-term harm reduction and/or related aims, such as linkages to voluntary AOD treatment services. This lack of specificity hinders evaluation, for it is difficult to assess the effectiveness of an initiative in achieving its objectives when these are not clearly identified.

The *Alcoholics and Drug-dependent Persons Act 1968* (Vic) and the *Inebriates Act 1912* (NSW) have also been criticised as breaching international human rights laws:

- Broad definitions of ‘alcoholic’, ‘inebriate’ and ‘drug-dependent person’, in conjunction with the absence of criteria to guide the legal determination of whom these Acts apply to, may render the Acts broad and vague to a degree that detention under them could be considered arbitrary and therefore in breach of the International Covenant on Civil and Political Rights (ICCPR), United Nations Principles for the Protection and Care of People with Mental Illness and the Improvement of Mental Health Care, and the Victorian Charter of Human Rights and Responsibilities.
- There is no right of appeal against section 11 orders made under the *Alcoholics and Drug-dependent Persons Act 1968* (Vic) and, under the *Inebriates Act 1912* (NSW), appeal is possible only with the leave of the Court of Appeal. It can thus be considered that persons civilly committed are denied access to independent, transparent and accountable appeal and review processes, in breach of international laws such as the ICCPR (Article 9).
- In New South Wales, where longer-term committal is possible, magistrates are given no guidelines in determining the appropriate length of an order. At the same time clinicians have no power to discharge. This combination may result in treatment being prolonged beyond a period that is strictly necessary, hence violating the Principles for the Protection and Care of People with Mental Illness.

¹³⁹ Though the latter will no longer be possible upon proclamation of the *Antisocial Behaviour (Miscellaneous Amendments) Act 2006* (NT) which repeals section 122 of the *Liquor Act 2004* (NT) which provided for civil commitment.

On a practical level, both Acts have been criticised as inefficient and difficult to utilise. The *Alcoholics and Drug-dependent Persons Act 1968* (Vic), for example, requires at least one certificate from a registered medical practitioner who has examined the person within 48 hours in support of a complaint; however, there is no provision for compulsory assessment. The low number of orders made to date provides evidence that the Acts are problematic.

The nature of the facilities in which persons are detained under these Acts is a further source of criticism. In Victoria, the compulsory nature of detention under a civil commitment order is undermined through use of non-secure withdrawal facilities. In New South Wales, 'inebriates' are committed to secure facilities; however, these are psychiatric hospitals, which are not equipped to provide specialised AOD services. Placement in these institutions carries substantial risk of harm to the 'inebriate' and mentally ill patients, and furthermore exacerbates existing bed shortages.

In its comprehensive review of the *Inebriates Act 1912* (NSW), the New South Wales Standing Committee on Social Issues (2004) recommended that legislation be enacted to enable short-term (7–14 days) involuntary care of people with severe dependence, for the purpose of protecting their health and safety. Such legislation would aim to provide medical treatment, stabilisation and comprehensive assessment, restore decision-making capacity and provide opportunity for engagement in voluntary treatment. Where decision making cannot be restored due to cognitive impairment, guardianship would be required. The Committee recommended that four essential criteria be satisfied for a person to be committed to care: severe dependence; experience or risk of immediate harm to self; lack of capacity to consent to treatment; and

existence of an initial treatment plan that demonstrates the intervention will benefit the person. Other recommended safeguards include a right of appeal, assessment by two medical examiners (including one addictions medicine specialist), magisterial review within three days, official visitors to monitor service provision and rights of patients, education for magistrates, and an information and education strategy targeting practitioners.

Supplementary to this framework for involuntary care, the Committee recommended provision for court-ordered outpatient assessment and a non-coercive policy response for individuals with antisocial behaviour and complex needs. To this end, it recommended that elements of the Victorian *Human Services (Complex Needs) Act 2003* be considered for inclusion in the proposed new legislation.

Recommended:

- That civil commitment legislation contain an objects section that clearly states the intended outcomes of the legislation.
- That all jurisdictions work in collaboration towards development of a nationally consistent approach to civil commitment.
- That the short-term model of involuntary care recommended by the New South Wales Standing Committee on Social Issues be used as a starting point for developing a national approach to civil commitment. Key features:
 - *Duration:* 7–14 days
 - *Target population:* persons with substance dependence who have experienced or are at risk of serious harm, and whose decision-making capacity is considered compromised

- *Purpose*: stabilisation; comprehensive assessment; restoring decision-making capacity; linking into long-term care (e.g. guardianship); encouraging and linking into voluntary treatment system
- *Criteria*: four criteria must be met before a decision to commit a person to involuntary care can be made:
 1. severe substance dependence, as diagnosed by an internationally recognised tool such as the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM IV); substance dependence or use alone is not sufficient
 2. serious harm to self (including injury, illness and self-neglect) experienced, or immediate risk thereof
 3. lack of capacity to consent to treatment
 4. treatment plan outlining expected benefit and rationale for proposed period of involuntary care.
- *Treatment type*: detoxification in a secure medical facility.
- That alternate models of care be developed to address the needs of people with complex needs and/or antisocial behaviour. In this context, evaluative information on emerging programs to address this group's needs in South Australia and Tasmania as well as the Multiple and Complex Needs Initiative in Victoria might be informative.

5.4 Indigenous Australians and compulsory treatment

Though over-represented in the criminal justice system, the participation rates of Indigenous Australians in diversion programs at all levels are generally low. A small number of programs have been designed especially for Indigenous offenders, and some general programs have undertaken a range of measures to increase and enhance participation of Indigenous offenders. There is some evidence that these programs can increase Indigenous participation rates; however, the number of Indigenous treatment services remains low.

Conversely, civil commitment legislation in some States is used disproportionately against Indigenous Australians. Given the punitive operation of this legislation in practice, despite its intended therapeutic purpose, this is of significant concern. This concern is heightened further when taking into account the dearth of Indigenous AOD services across the country.

Recommended:

- That programs designed specifically to meet the needs of Indigenous Australians be further developed.
- That exploration of effective processes, treatments and models for Indigenous Australians be ongoing.

Bilateral agreements between the federal government and State and Territory governments under the Council of Australian Governments' National Framework of Principles for Delivering Services to Indigenous Australians may support these recommendations. Involvement of bodies such as the Office of Indigenous Policy Coordination (OIPC) and Indigenous Coordination Centres (ICCs)¹⁴⁰ around Australia may be appropriate for nationally consistent implementation of these recommendations.

5.5 Research evidence

Overall, there is limited empirical evidence demonstrating the effectiveness of compulsory AOD treatment.

Most evaluative work has examined diversion programs and produced results that are largely weak and inconclusive. In general, indicators have been chosen opportunistically, often because of limited funding, rather than being designed to answer specific policy-related questions. There is, however, some evidence to suggest that some people benefit from compulsory treatment. While the evidence is weak and cannot be said to strongly support the continuation of compulsory treatment programs, neither does it suggest that they are ineffective and should be discontinued. Strong evidence in either direction simply does not exist.

Australian civil commitment legislation has not been evaluated for its effectiveness in rehabilitating or achieving long-term behavioural change; nor have equivalent provisions internationally. Many argue that depriving an individual of his/her liberty cannot be

ethically justified if the intervention is not known to be of benefit, and therefore oppose civil commitment on this ground. There is, however, some evidence – mainly anecdotal – that civil commitment for short periods can be an effective harm reduction mechanism. Thus there is considerable support for a model of short-term involuntary care, one that incorporates safeguards by way of strict eligibility criteria, conforms to human rights obligations and operates for the purposes of reducing serious harm (e.g. protecting the user in life-threatening situations), restoring decision-making capacity and providing an opportunity to motivate the user to continue treatment on a voluntary basis. In the absence of supporting evidence, there is considerably less support for a longer-term model aimed at rehabilitation.

Though the type of research being conducted is becoming more rigorous, the effectiveness of compulsory treatment has yet to be strongly demonstrated. There are some data for Australia, but insufficient at present to give us adequate answers to the key questions: Does compulsory treatment work? To what extent? For what groups of people? And how? On the present evidence base, it can be concluded only that compulsory treatment can sometimes be effective in reducing drug use (and crime) for some people.

In the absence of strong research data, the de facto existence of compulsory treatment initiatives must presumably be based on other factors, such as politics, perceived cost-effectiveness, beliefs about civil duties, and utilitarian value.

¹⁴⁰ ICCs look after most of the federal government's Indigenous programs and negotiate Shared Responsibility Agreements (SRAs) with local Indigenous people and communities (Australian Government, Office of Indigenous Policy Coordination, 2006).

5.5.1 Methodological and conceptual issues

Research in this area consistently exhibits methodological and conceptual weaknesses (e.g. short follow-up periods, inappropriate comparison groups, client motivation overlooked, lack of reliable and valid assessment tools) which have rendered the empirical evidence base, as a whole, largely inconclusive.

Recommended:

- That more rigorous evaluation studies be commissioned, with greater attention paid to sample sizes, comparison groups, and follow-up times.
- That consideration be given to the establishment of an integrated database and monitoring system containing information from key agencies (including police, justice, corrections, legal aid and treatment providers) to enable accurate monitoring of diversion and civil commitment outcomes over time.

5.5.2 Standardised indicators

Evaluations of diversion programs often fail to assess program aims and objectives other than reducing recidivism and drug use. Other commonly stated, but rarely evaluated, aims include re-integration of drug-using offenders into the community, improvement of health and social functioning, and reductions in court appearances.

Those aims and objectives that are assessed are measured with a range of indicators of varying validity. Standardised indicators of diversion program outcomes are lacking, and there is no consistency in the measurement of outcomes (e.g. different time periods, detection methods and data collection procedures), such that cross-program comparisons cannot be reliably made.

Recommended:

- That standardised aims, intended outcomes and indicators be developed for and adopted by compulsory treatment programs in the following areas:
 - drug use: level of reduction in drug use expected and indicative of success; time period over which behaviour change is expected to be revealed and sustained; and different reductions for different groups of drug users
 - legal coercion: indicators of type and degree of supervision and monitoring; the role of perceived and actual coercion (legal, formal and informal); rewards and sanctions, team approaches, and the role of suspended sentencing
 - client factors: population demographics; factors determining successful uptake of programs, as well as drop-out and failure; interplay between client motivation, perceived coercion, program components and treatment characteristics
 - program processes: *how* programs 'work', focusing directly on ways to improve quality and functioning
 - recidivism: as measured by subsequent arrest, conviction or imprisonment; the extent to which re-offending is reduced; over what time periods behaviour change is expected to begin, or to be sustained; and different reductions to be expected for different groups of offenders
 - cost-effectiveness: taking into account criminal justice and health care costs and savings; costs of running the drug court, treating and monitoring offenders, imposing sanctions; savings in court time, prison costs, health care, emergency department presentations; other costs and savings.

5.5.3 Types of treatment

Treatment for substance abuse is a vast field, with many (sometimes competing) models, depending on who is involved, in what context and at what cost. Compulsory referral into treatment leads to interventions ranging from residential detoxification, to opiate substitution, to individual counselling, brief education sessions and even meditation classes for lesser forms of dependence. At the same time, very little empirical investigation has been conducted into the relationship between legal coercion and type of treatment. It is not known which aspects of different treatment types (e.g. quality, length, intensity, philosophy) affect outcomes for this client group and the sub-groups within it, nor about the interplay of client factors such as individual client motivation and social support.

There is also a lack of information about the extent to which magistrates and police are informed about current treatment practices and their effectiveness.

Recommended:

- That greater effort be required to build the knowledge base regarding compulsory treatment. This includes collection and analysis of data regarding the nature of treatment(s) that offenders are referred to (such as residential rehabilitation, cognitive behavioural therapies, 12-step self-help groups, therapeutic communities) and subsequent evaluation research to examine: which types of treatment hold the most promise for being effective and cost-effective, and for which groups; the interplay between client motivation, perceived coercion, client characteristics, program components and treatment characteristics; and which models and treatments do magistrates and providers believe to be effective.
- That the treatment experiences of individuals subject to civil commitment orders be researched.

5.5.4 Program provision and processes

Currently, there is a lack of information about how compulsory treatment programs in Australia work, and how they can work better. Such programs are at a stage where more research is needed to develop them in a manner that allows an appropriately empathic response that can also be effective.

Recommended:

- That indicators be developed:
 - to measure the nature, capacity, quality and functioning of programs toward the identification of standards of best practice
 - to help identify those components of program structures and management that are most/least important and how they can be improved.

5.5.5 Identifying factors associated with program graduation

There is some evidence that completion of, or 'graduation' from, a diversion program, especially a drug court program, is associated in Australia with reductions in both recidivism and drug use. Low rates of compliance and graduation render the considerable amounts of time, effort and money spent on diversion programs a less than optimal investment. Graduation rates are consistently low, ranging from 20 to 56 per cent for drug courts.

Some research has been conducted in Australia to identify predictors of drug court program compliance and termination. Data are limited, but factors include: family support; length of criminal career; previous terms of imprisonment; gender; appointment attendance; and urine test provision.

Recommended:

- That research be accelerated to identify risk factors for diversion program termination or withdrawal, including: type, level and history of AOD dependency and treatment; family and social support networks; accommodation and employment status; and imprisonment history. Questions to be answered include: For which populations do programs work/fail, and why? How can graduation rates be improved? Which types of treatment work best with which clients?
- That a validated 'early risk assessment tool' be developed, based on factors for non-graduation, to identify offenders with low probability of diversion program completion. Such an instrument could be used in the early phases of a diversion program, and potentially post-program as well.
- That offenders identified with a low probability of program graduation be given more intensive, targeted support and/or supervision to assist them to graduate.
- That any proposal to exclude those with a low probability of program completion be considered for adoption only if informed by extensive research and supported by a viable alternative for assisting this more difficult group. Outcomes of the new Compulsory Drug Treatment Correctional Centre should be keenly observed to usefully inform any proposed changes.

5.5.6 Standards for follow-up (after-care) treatment

Drug treatment usually involves a therapeutic process in which reasons for AOD use and abuse are brought to light between the client and his or her therapeutic guide. This can be a lengthy process, as the client develops the trust and confidence to explore their personal history and comes to understand dysfunctional patterns that have developed. It is thus not surprising that after-care strategies, which extend treatment to allow this process to unfold, tend to improve AOD treatment outcomes. Again, the literature is limited, but there are some empirical data to suggest that after-care strategies may lead to reductions in drug use and re-offending. After-care has been recommended for trial in the New South Wales MERIT program, and may be an element that would enrich diversion programs nationwide.

Recommended:

- That pilot programs that include after-care be supported and closely monitored, with a view to making them part of a national strategy.
- That, in considering after-care strategies, the following issues be included: after-care as an optional component; after-care of varying intensity; clearly articulated process and outcome objectives, and evaluation procedures.

5.6 Terminology

Several different terms are used in the literature to refer to AOD treatment interventions that are ordered by the courts or police, through power vested by legislation or government-implemented program. The term ‘compulsory treatment’ has been adopted in this paper as the phrase most commonly used by those working in this field in Australia. On its face, however, this term does not intuitively link to the broad definition it is given and the current study has led the researchers to conclude that its usage is problematic. ‘Compulsory treatment’ leads the layperson to expect forced or mandatory treatment. It does not logically lead one to expect that reference is also being made to programs that individuals can choose not to participate in. The word ‘compulsory’ carries connotations of control and intrusion upon civil liberties that, while perhaps welcome for some, are likely to be counterproductive to the development of broad public understanding of, and support for, these types of programs.

Recommended:

- That the term ‘legally coerced treatment’ be considered as an alternative to the more commonly recognised term ‘compulsory treatment’ (as defined and used in this paper). The term ‘legally coerced treatment’ can be used to refer to AOD treatment whose mandate is based in legislation and/or government-implemented program, encompassing the whole range of coercive situations created by legal mechanisms, from diversion at the earliest level of criminal justice proceedings, through to civil commitment of non-offenders.
- That the term ‘compulsory treatment’ then be used to refer only to court-ordered treatment where the individual has no choice, e.g. civil commitment and treatment imposed as part of a sentencing order.

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7. Appendices

Appendix A: Key informants

Name	Position and organisation
Consumer	Diverted into compulsory treatment via Magistrates Court, ACT
Marie Blake	ATODS Nursing Unit Manager, Queensland Health
Maureen Hanly	Director, Clinical & Nursing Services, NSW Justice Health
Dr Stephen Jurd	Psychiatrist, Director of Post-Graduate Training in Psychiatry, Northern Sydney Central Area Health Service
Michael Lodge	Executive Officer, NSW Users and AIDS Association Inc
Dr Michael McDonough	AOD clinician, Western Hospital, Melbourne
Lynton Piggott	Team leader, Perth Drug Court CATS team
Professor Greg Whelan	Medical Defence Association of Victoria Ltd
Dr Alex Wodak	AOD clinician, St Vincent's Hospital, Sydney

Appendix B: Questions for key informants

1. What is your occupation?
2. Please describe your involvement in compulsory treatment of individuals dependent on alcohol and/or other drugs.
 - a. Type of compulsory treatment, i.e. civil commitment, diversion and/or treatment in custody
 - b. Settings
 - c. Frequency
 - d. Types of treatment (Is supported accommodation ever mandated?)
 - e. Types of dependent individuals, i.e. nature of drug use, age, gender
 - f. Legislation under which it arises
3. In your experience, what are the outcomes for individuals treated compulsorily?
 - a. Specifically pertaining to:
 - i. Drug/alcohol use
 - ii. Recidivism
 - iii. Health, family, employment
 - b. Positive outcomes
 - c. Negative outcomes
 - d. What are the main factors influencing positive and negative outcomes? Factors around legal mandate to treatment (monitoring, urinalysis etc) vs regular treatment factors (e.g. treatment type, nature of client's A&D use, service proficiency, individual client readiness to change)
4. What outcomes (positive and negative) do you see for other people?
 - a. Families/friends
 - b. Other treatment service users
5. Is compulsory treatment necessary? For whom? Explain.
6. What types of ethical issues are associated with compulsory treatment? Discuss.
7. As a _____ professional, what types of issues arise for you in relation to coercing people into treatment? Please explain.
8. How well do you think the current system of compulsory treatment works in your State?
 - a. What changes would you suggest?
 - b. Why?
9. Are there any other comments you would like to make regarding compulsory drug and alcohol treatment in Australia?

Appendix C: Project Reference Group

Name	Position and organisation
Silvia Alberti	Associate Director, Community Partnerships and Capacity Building, Turning Point Alcohol and Drug Centre
Inez Dussuyer	Team Leader and Investigation Officer, Ombudsman's Office Victoria
Craig Fry	Senior Research Fellow, Turning Point Alcohol and Drug Centre; Fellow, Department of Public Health, University of Melbourne
Jeff Linden	Senior Magistrate, Lismore Court Circuit, MERIT; Member, Australian National Council on Drugs
Annie Madden	Director, Australian Injecting & Illicit Drug Users League
Dr Toni Makkai	Director, Australian Institute of Criminology
Professor John Saunders	Professor of Alcohol and Drug Studies, University of Queensland; Member, Australian National Council on Drugs
Dr Adam Sutton	Associate Professor, Department of Criminology, Melbourne University

Appendix D: Types of AOD treatment interventions accessed under compulsory treatment programs

Many forms of AOD treatment interventions are accessed under compulsory treatment programs. Interventions available in Australia include education, counselling, self-help and peer support programs, withdrawal treatment, post-withdrawal residential support, and pharmacotherapy treatment. These interventions vary in their level of intensity and reflect the full continuum of treatment as it pertains to primary, secondary and tertiary AOD interventions.

Education

The commonest form of treatment intervention is the delivery of information regarding the potential harms associated with AOD use. The instruction may be based on one of many curricula, depending on the region, type of drug and other factors. This process is a common and essential component of all compulsory treatment in Australia. Education typically represents the focus of pre-arrest diversion schemes, and is an important element of pre-trial, pre-sentence, post-conviction and pre-release diversion, as well as of custodial AOD treatment and civil commitment. Educational resource materials are frequently provided to participants.

Counselling

Though counselling takes many different forms across Australian jurisdictions, the main aims are to support and encourage emotional and behavioural change, and to refer clients

for help with other issues they may be facing. The counsellor–client relationship, if successful, supports a process of lifestyle adjustment and encourages the development of skills to cope with factors that trigger drug use, and thereby reduces use (Ritter & Lee, 2003). Counselling services are delivered by a range of health professionals in settings such as specialist AOD agencies, community health centres, hospital-based AOD services and other generalist health and welfare services (Australian Institute of Health and Welfare, 2005).

According to guidelines published by the Best Practice in Alcohol and Other Drug Interventions Working Group (2000),¹⁴¹ general counselling should include:

- linking clients with appropriate services
- anticipating and developing strategies with the client to cope with difficulties before they arise
- specific evidence-based interventions where appropriate (e.g. goal setting, cognitive behavioural therapy, motivational enhancement therapy, problem solving)
- focusing on positive internal and external resources and successes as well as problems and disabilities
- consideration of the wider picture and helping the client on a practical level (e.g. with food, finances, housing), and
- where appropriate, involving key supportive others to improve the possibilities of behaviour change outside the therapeutic environment.

Counselling typically incorporates the use of tools such as cognitive behaviour therapy (CBT), contingency management and motivational interviewing, and aims to provide

¹⁴¹ Comprising representatives of the WA Drug Abuse Strategy Office, Next Step Specialist Drug and Alcohol Services, Western Australian Network of Alcohol and Other Drug Agencies, and Edith Cowan University.

clients with coping and living skills to function in their environment. Specific techniques of CBT include social skills training, stress management, anger management and behavioural self-management. After-care or ongoing follow-up sessions are common components of these programs (Alcohol and other Drugs Council of Australia, 2003a; National Centre for Education and Training on Addiction, 2004).

A system of rewards and punishments may be used to encourage a targeted behaviour. This is contingency management (CM), which is based on principles of reinforcement. In AOD treatment, the target behaviour is typically abstinence or treatment attendance and the emphasis is on rewarding compliance rather than punishing non-compliance (Cameron & Ritter, 2005). Rewards are of three main types (tangible, social and treatment) and their delivery increases the longer the target behaviour is maintained. It is the aim of CM to produce behaviour change that will be maintained when the reward system is removed. Contingency management is a significant component of compulsory treatments in Australia.

Motivational interviewing (MI) is another counselling technique used to enhance intrinsic motivation to change by exploring ambivalence and considering possibilities for change. It encourages clients to take responsibility for their decisions and prepares them for change. Motivational interviewing focuses on the attitude and values of the participant, exploring the positive and negative consequences of drug use, while facilitating decision making towards positive behaviour change (Addy & Ritter, 2000; National Centre for Education and Training on Addiction, 2004).

Counselling interventions, incorporating tools such as CBT, CM and MI, are frequently utilised as part of compulsory AOD treatment in Australia. Counselling is presently utilised as an element of pre-arrest, pre-trial, pre-sentence, post-conviction and pre-release diversion, as well as in AOD treatment delivered in custodial settings and during civil commitment.

A brief intervention refers to any intervention that involves a short duration (up to two hours) of professional time in an attempt to change drug use (National Centre for Education and Training on Addiction, 2004). It is based on the principle that a person can manage their own drug use and associated issues if they are provided with the appropriate information or other interventions at the right time (Australian Drug Foundation, 2001).

Brief interventions usually comprise five components:

- providing feedback about the behaviour (in this case, drug use)
- recommending a change in behaviour
- presenting options to facilitate the change
- checking and responding to the client's reaction
- providing follow-up care.

Brief interventions are frequently utilised as part of compulsory treatment in Australia. They may represent the entirety of a treatment episode or one of a number of components as part of a broader AOD treatment package. For example, pre-arrest diversion schemes utilise short treatment sessions as stand-alone, sole interventions, while post-withdrawal support programs may utilise brief interventions as just one element of a wide spectrum of treatment interventions during a course of treatment.

Self-help and peer support

Self-help and peer support groups provide opportunities for mutual aid and support to primary drug users as well as to those affected by the drug use of another person. Self-help groups can be categorised into 12-step and non-12-step self-help groups. Both types of group can provide an avenue for people to share similar experiences and gain an insight into their drug use. Twelve-step self-help groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and Marijuana Anonymous (MA) are based on 12-step recovery principles. The 12 steps highlight the importance of reconstructing relationships with other people and emphasise the principle that the individual has power to change. Some self-help groups (such as AA) advocate abstinence, based on the view that dependence is a disease for which there is no cure (National Centre for Education and Training on Addiction, 2004; Ritter & Lee, 2003).

Non-12-step self-help groups share many common features with 12-step fellowships, although the former typically refrain from postulating concepts such as ‘powerlessness’ over AOD problems. Both groups emphasise regular meetings as an essential way to help people emotionally and intellectually in their understanding of, and attitudes towards, their problem. Members listen to, and participate in, often unstructured discussions and share their experiences, information and coping strategies (Katz, 1993).

Self Management and Recovery Treatment (SMART) is a peer-managed, CBT-based, self-help group which teaches practical skills for achieving abstinence from addictive behaviour (substance use or other activities) (SMART

Recovery, 2006). Skills are built around four key areas: building and maintaining motivation; coping with cravings; problem solving; and gaining a lifestyle balance aimed at supporting abstinence. SMART was introduced in New South Wales in 2002, after operating in the United States for 15 years. Groups run in both community and custodial settings in New South Wales and Queensland.¹⁴²

The advantages of self-help treatment include accessibility, wide availability, low cost, promotion of social networks that are not centred on drug use, and high levels of peer support (Alcohol and other Drugs Council of Australia, 2003a).

The goal of peer support is to provide mutual support and information through sharing personal experiences. Peer support is useful for individuals who have experienced difficulties with AOD use. Individuals with personal experience of AOD use generally provide support and information (Community Offenders Advice and Treatment Service, 2006). A variety of areas may be discussed, such as healthier lifestyle options, advocacy services and linkages with a range of health and welfare services (Victoria Department of Human Services, 1997).

Self-help and peer support groups are mutual aid interventions that are available to clients of compulsory treatment programs. These interventions are part of the spectrum of AOD support that offenders may be directed to attend, in consultation and negotiation with their clinician.

¹⁴² No information about the operation of this program in other States was found.

Withdrawal services

Detoxification, or withdrawal, refers to the removal of toxic levels of AOD from a person's body. This process may take a number of days or weeks and may occur in a variety of settings including general hospital, specialist AOD units (residential withdrawal), outpatient clinics and an individual's home (community-based withdrawal). Depending on the type of drug and amount used, people may experience withdrawal symptoms. Typical symptoms include nausea, sweating and insomnia, and in some instances pharmacological treatments can be administered to ease symptoms and assist the process.

Withdrawal programs operate differently across the Australian States and Territories. Variation exists in the level of medical and nursing supervision and pharmacotherapy available. While AOD withdrawal can be a treatment in itself, it is generally considered a precursor to participation in other treatment programs (Australian Drug Foundation, 2001; Australian Institute of Health and Welfare, 2005; O'Brien, 2004). Residential and community-based withdrawal programs are outlined below.

Residential withdrawal services typically provide 24-hour support, pharmacotherapy and medical care over a period of treatment. Admission criteria vary considerably throughout Australia, although Baker and Goh (2004) list the following as a guide to commonly included criteria: 'a complicated withdrawal is anticipated ..., medical complications ... are evident, significant psychiatric complications ..., an unfavourable home environment ... and multiple failed attempts at ambulatory detoxification'. Length of stay should be as long as is needed by the individual to resolve all withdrawal symptoms (Baker & Goh, 2004), though it is commonly limited to one week.

Community-based withdrawal incorporates outpatient and home-based withdrawal. These detoxification services are appropriate for clients who have a withdrawal syndrome that can be managed without admission to a residential service. Community-based services are suitable for people who have a withdrawal syndrome of mild to moderate severity who require gradual reductions in drug use. Treatment involves attendance at a series of intensive, individual outpatient consultations over a short period, followed by ongoing counselling and support to complete the withdrawal (North Coast Area Health Service, 2005; Victoria Department of Human Services, 1997).

In cases where the withdrawal syndrome is of mild to moderate severity and support from a family member or friend is available, a person may undergo drug withdrawal from home. In general, registered nurses provide home-based withdrawal services, with the support of a medical practitioner (Victoria Department of Human Services, 1997; Western Australia Drug and Alcohol Office, 2006). Daily home visits are made to assist with the withdrawal process and to provide support and education to the client and supporting family member.

In Victoria, rural withdrawal services are available to assist rural and remote clients through drug withdrawal. Rural withdrawal combines a short-term hospital stay (where required) with a period of home-based withdrawal provided by general practitioners and community health services. Typically, follow-up is managed through community-based treatment services, and clients are linked into ongoing services through those community-based treatment services (Victoria Department of Human Services, 1997; 2004).

Individuals can be ordered into residential withdrawal treatment by way of civil commitment orders in New South Wales, the Northern Territory, Tasmania and Victoria, and into residential or community-based withdrawal treatment under pre-trial¹⁴³ and post-conviction (drug courts¹⁴⁴ and suspended sentencing¹⁴⁵) diversion programs in all jurisdictions in which they operate.

Post-withdrawal residential services incorporate residential rehabilitation, therapeutic community and AOD supported accommodation programs. These programs assist clients to make sustainable changes to their AOD use and related behaviours and prepare them for re-integration into the community.

Residential rehabilitation services provide a 24-hour, staffed treatment program in a community-based setting. Such services are:

... based on the principle that a structured drug-free residential setting provides an appropriate context to address the underlying causes of addictive behaviour. These programs assist the client to develop appropriate skills and attitudes to make positive changes towards a dependence free lifestyle. (New South Wales Health Department, 2000, p.44)

Residential rehabilitation programs target people who are typically long-term users, suffer the more severe consequences of harm related to AOD, whose social networks support continued drug use and whose home circumstances are unsupportive of non-residential treatment. Prior to entering residential rehabilitation, clients will have commonly undergone a withdrawal program or other AOD treatment/rehabilitation programs (Dale & Marsh, 2000; Victoria Department of Human Services, 1997).

Participation in residential rehabilitation can be required under several diversion programs, most typically by way of drug court orders (Queensland, South Australia, Victoria and Western Australia) and conditions of suspended sentences (Australian Capital Territory, New South Wales, Northern Territory, South Australia and Tasmania). Pre-arrest diversion orders in some jurisdictions (e.g. Australian Capital Territory and Victoria) can also compel attendance at residential rehabilitation.

Therapeutic communities provide a long-term (usually at least three months), highly structured, self-help residential treatment for drug users (National Centre for Education and Training on Addiction, 2004; O'Brien, 2004). Therapeutic communities aim to assist clients to achieve personal growth, aided by the understanding and care of fellow

¹⁴³ MERIT in New South Wales; CREDIT/Bail Support program in Victoria; DAAP in South Australia; CADAS in the Australian Capital Territory.

¹⁴⁴ Drug courts operate in New South Wales, Queensland, South Australia, Victoria and Western Australia. See 3.1.4, Drug courts, for further information.

¹⁴⁵ Suspended sentencing is available in the Australian Capital Territory, New South Wales, the Northern Territory, South Australia and Tasmania. See 3.1.7, Conditional suspended sentencing, for further information.

community members (Australian Drug Foundation, 2001). In broad terms, therapeutic communities:

- focus on the social, psychological and behavioural dimensions that precede and arise from substance abuse
- provide a safe supportive environment for individuals to experience and respond to emotions and gain understanding of issues relating to their drug use
- encourage change and personal development through a combination of therapeutic involvement between residents and staff and among residents and through living in a caring and challenging community
- take a multidimensional approach to treatment, which involves therapy, education, values and skills development (Australasian Therapeutic Communities Association, 2002, p.6).

As with residential rehabilitation, the use of orders to attend a therapeutic community is most commonly linked to post-conviction diversion: drug court orders in New South Wales, Queensland, South Australia, Victoria and Western Australia; and conditions of suspended sentences in the Australian Capital Territory, New South Wales, the Northern Territory, South Australia and Tasmania.

Supported accommodation services seek to provide residential accommodation (usually public housing) to clients who have undergone a drug withdrawal program or who require assistance in controlling their AOD use (O'Brien, 2004). In Victoria, for example, a client may stay in AOD supported accommodation for a period of one to 12 months. Key components of supported accommodation include skills acquisition, counselling, personal care activities and relapse prevention. Ultimately this service aims to provide a supportive environment to help clients strengthen their recovery and reintegrate into community living (Victoria Department of Human Services, 1997).

Supported accommodation services represent just one component of an AOD intervention that may be a negotiated part of an offender's AOD treatment plan. The establishment of participants in a stable housing environment provides a supportive environment in which a number of other AOD interventions can occur. In Victoria, pre-arrest diversion orders can include a requirement to attend supported accommodation.

Pharmacotherapy

Pharmacotherapy involves the use of prescribed medication to treat drug dependence by reducing or controlling withdrawal symptoms and drug cravings or blocking the effects of specific drugs. Pharmacotherapies are most commonly combined with counselling to broaden, enhance and extend treatment outcomes (Carroll, 1996). There are two main types of pharmacotherapy treatment:

- reduction therapy, where the aim is to reduce the quantity of all drugs used, and
- maintenance therapy or substitution treatment, which aims to stabilise the user by prescribing a less harmful drug (Australian Institute of Health and Welfare, 2005).

Pharmacotherapy treatments can be administered by pharmacies, public and private clinics, general practitioners, or hospitals. The main types of medication available in Australia for pharmacotherapy treatment include methadone, buprenorphine and naltrexone.

Methadone is referred to as the 'gold standard' form of treatment for heroin dependence. Methadone is a synthetic drug that mimics some of the effects of heroin. It is dispensed in a syrup form via a pharmacist and the effects generally last 24 hours. Subsequently, clients need to receive treatment on a daily basis if they are to benefit from the treatment. Methadone has the capacity to reduce some of the high-risk behaviours associated with heroin and ease withdrawal symptoms (Australian Drug Foundation, 2001; Australian Institute of Health and Welfare, 2005).

Buprenorphine (also called Subutex) is a synthetic, partial opioid antagonist, meaning that it blocks the effects of heroin. Unlike methadone, the duration of effect may last up to three days with regular dosing. It is provided in tablet form and is dissolved under the tongue (Australian Institute of Health and Welfare, 2005; National Centre for Education and Training on Addiction, 2004). Research has found that it has the potential to reduce illicit opioid use, retain clients in treatment, and prevent or alleviate withdrawal symptoms when withdrawing from heroin and methadone (Alcohol and other Drugs Council of Australia, 2003a). Suboxone is a new formulation that combines naloxone with buprenorphine for the purpose of reducing the potential for misuse of buprenorphine. It has recently become available in Australia.

Naltrexone may be prescribed to assist clients remain drug-free after withdrawing from heroin or other opioids. In addition, it can be used to support abstinence or harm-reduction measures for alcohol-dependent clients. Naltrexone is usually administered in an oral form, one to three days apart, depending on dose (Australian Drug Foundation, 2001; Australian Institute of Health and Welfare, 2005).

Pharmacotherapies are increasingly available within custodial settings in Australia and are available in prisons in every State (though not every prison in every State). Pharmacotherapy is also a treatment option available under several diversionary programs, including under pre-arrest diversion programs in the Australian Capital Territory and Victoria, pre-trial diversion programs such as MERIT in New South Wales, and all post-conviction diversion drug court programs.

Holistic approaches

In countries such as Holland, Norway and the United States, there is growing evidence that dependencies and depression can be caused or exacerbated by stress, habitual negative thought patterns, poor nutrition and inadequate exercise. This has considerable implication for all forms of care including treatment relating to substance abuse. Providing instruction in stress reduction techniques and meditation, a fresh healthy diet consistent with national guidelines, and a regular regime of physical exercise can be important additions to psychological and other forms of support and treatment currently available. Transcendental meditation has been taught to participants in the Geraldton Alternative Sentencing Regime (GASR) in Western Australia, as part of their court-approved treatment programs, with the aim of addressing offenders' problems with stress and enhancing their self-development.

Alternative therapies, including acupuncture, massage, naturopathy, homeopathy and meditation classes, may all be useful complements to treatment. Likewise, various forms of community service can be an effective adjunct to treatment.

Treatment in custodial settings

Education programs are the least intensive and most common programs delivered in Australian prisons and usually also include elements of behaviour therapy. Sessions are typically conducted with small groups and in general involve the delivery of information and the opportunity to discuss arguments for and against treatment. They usually include exploration of the costs and benefits of drug use for the individual, identify situations of high risk for use, and teach strategies to reduce use within a broader harm minimisation framework. Some aim specifically to increase problem recognition and motivation to enter treatment (Health Outcomes International et al., 2000).

Non-residential AOD treatment programs operate in prisons in each State. Non-residential programs target a diverse range of groups, in terms of severity of substance use problems and stage of custodial sentence and most commonly include a range of counselling techniques such as 'individual, group or family counselling, peer group support, vocational therapy and cognitive therapy' (Forensic Psychology Research Group, 2003). Such programs range in duration from brief interventions, to programs spanning the duration of an offender's sentence. Elements that may be incorporated into such programs include motivational enhancement, education about the link between substance use and offending, relapse prevention, skill development, and transition to the community.

A detailed description of AOD programs in Australian custodial settings is contained in Appendix J.

Appendix E: National principles of the Illicit Drug Diversion Initiative

These principles were formulated by the Ministerial Council on Drug Strategy to underpin the development of a nationally consistent approach to diversion of illicit drug users from the criminal justice system into education, assessment and treatment.

Principle 1	The approach should operate within a broad national framework, which allows jurisdictional flexibility within available resources.
Principle 2	The approach should be structured as far as possible on a 'whole of state' basis, progressively implemented, according to identified priority areas.
Principle 3	The approach is contingent upon a strong working relationship between the criminal justice system and health, consistent with the principles and partnerships set out in the National Drug Strategic Framework 1998–99 to 2002–03.
Principle 4	The approach will recognise the needs of local communities and of illicit drug users with special requirements, such as Indigenous Australians.
Principle 5	The approach should be linked with other systems, such as employment, training and housing, with mainstream Commonwealth, State and Territory (hereafter 'State') programs considering options for prioritising and assisting access by illicit drug users who have been diverted.
Principle 6	The approach should, wherever possible, build on existing structures and practices to ensure value for money within the spirit of the COAG Communiqué.
Principle 7	Implementation of the approach is dependent upon police being appropriately empowered and should take account of its impact on existing legislation/practices/programmes to ensure positive outcomes.
Principle 8	Diversion programmes must be sustainable, based on sound design, engage stakeholders, including the local community, and invest in workforce development.
Principle 9	Any diversion strategy implemented at the jurisdictional level, under the COAG initiative, will take account of the needs of juvenile and adult offenders.
Principle 10	The approach will build on collaborative relationships, while acknowledging a clear delineation of roles between police who divert, and health professionals who assess and treat.

Principle 11	Coordinated police diversion requires a clear understanding of procedures and protocols to be followed for the management of the diversion process.
Principle 12	Successful implementation will require each jurisdiction to assess the impact of diversion on police service operations and resources.
Principle 13	Police will continue current public health practices with respect to emergency situations and limiting the spread of blood-borne diseases in accordance with the principles set out in the National Drug Strategic Framework 1998–99 to 2002–03.
Principle 14	The approach should offer a range of appropriate and best practice drug treatment services.
Principle 15	Required treatment participation should not be disproportionately more onerous for the individual than the criminal justice system alternatives.
Principle 16	The approach must include post-intervention support (e.g. discharge planning, planned follow-up and appropriate referrals to a range of services).
Principle 17	The approach must acknowledge an ongoing commitment to the training/education needs of all stakeholders involved in the diversionary process, including police.
Principle 18	The approach must be monitored and evaluated to inform best practice and continuous improvement and reflect the intent of the COAG Communiqué and the goals of the national drug strategy.
Principle 19	The approach will be responsive to changing circumstances and emerging needs.

Source: Australian Government Department of Health and Ageing, 2004c.

Appendix F: Principles of best practice for diversion

Bull (2005, p.227) reviewed five best-practice documents¹⁴⁶ and, from these, outlined 14 principles consistently recommended to guide best practice for the diversion of drug-related offenders:

1. Philosophy – all involved in the diversion program should have a shared understanding of and commitment to philosophical foundations of the program.
2. Eligibility – clear criteria for inclusion complemented by systematic assessment process for eligibility.
3. Access – programs should be available to those from a diverse range of backgrounds including those with special needs; a range of interventions should be available according to need and seriousness of offence; speedy referral to intervention services.
4. Client rights – to be observed; participation only with informed consent; diversion must not be more intrusive than the traditional criminal justice system response.
5. Compliance monitoring/judicial review – clearly defined procedures to monitor compliance, including specific criteria of success and failure, with swift sanctions, consistently applied.
6. Program monitoring and evaluation – ongoing monitoring of program delivery and outcomes; effective, efficient systems for data collection and management.
7. Training – to be provided to all involved in program delivery, addressing program principles, roles of all participants, drug treatment, and judicial processes.
8. Management, communication, role definition and demarcation – treatment services should be well integrated with criminal justice processes; clearly defined structures and agreed processes that facilitate collaboration and communication.
9. Partnerships – support from all agencies involved (collaboration and communication between health and criminal justice sectors).
10. Documentation – policies and procedures clearly documented to ensure consistency (e.g. eligibility criteria, monitoring compliance, confidentiality protocols).
11. Legislation – program to have sound legislative basis.
12. Range of treatment options – a broad range of treatment/intervention options should be available.
13. Social support and follow-up – programs to address co-existing issues (such as employment, housing, family) and after-care to be available.
14. Funding – sufficient, sustained and dedicated and covering all elements of the program.

¹⁴⁶ Improving intersectoral impact in drug use offending cases: Expert Working Group (1999) (UN); defining drug courts – the key components: National Association of Drug Court Professionals (1997) (USA); principles of best practice in drug diversion programs: Alcohol and other Drugs Council of Australia (1996) (Australia); ten TASC (treatment accountability for safer communities) critical elements: Bureau of Justice Assistance (1992) (USA); arrest referral – a guide to principles and practice: Russell and Davidson (2002) (Scotland).

Appendix G: Summary of Draft Code of Ethics for Australian Alcohol and Other Drug Field

(Fry, 2005)

Equity and access are important in service provision

Clients should have ready access to the services they need and receive equal treatment for equal need (non-discriminatory). This is particularly important for people who have dual or multiple problems, as they are often referred from one service to another without receiving appropriate treatment. Access and equity can be promoted through a non-discriminatory approach to all service users, significant others and community stakeholders, and by consideration of cultural, physical, religious, economic and social needs.

Services should be responsive to the individual's needs

Services should be relevant and responsive to the individual needs of the client. They should be appropriate for the client's gender, social circumstances, ethnic and cultural background and take into account any other problems or disabilities the person may have (for example, mental illness; intellectual, physical or sensory disability; brain injury; or chronic illness). The client's values, expectations and belief systems should be respected. Providing opportunities for clients and former clients to participate in the planning, development, management and evaluation of services will help ensure that services are relevant and responsive to clients.

Services should be responsive to community needs

In recognising that individual health and wellbeing are relational concepts dependent upon the place and practices of individuals as members of communities, AOD services have a responsibility to consider the broader community needs that may exist in relation to service operation.

Services should be effective

Services should strive to deliver positive outcomes for the client. The overall effectiveness of services should be measured from the perspective of the clients, and include consideration of ethics and values alongside other traditional outcome measures. Services should hold regular planning and evaluation sessions. Programs that are not effective should be revised and amended so they do provide a positive outcome.

A commitment to community consultation and consumer involvement

Purposive consumer consultation and involvement can enhance health service design, quality, outcomes and community acceptance. Community consultation should be built into the formative processes that guide what we actually do. Implicit in this is the notion of community/consumer/client expertise *on their own* values and interests as a positive territory of authority in relation to planning and implementing AOD innovations.

AOD research should proceed on the basis of ethics committee approval

Consistent with peak ethics guidelines (e.g. National Health and Medical Research Council (NHMRC), Australasian Evaluation Society), research projects (including quality assurance (QA) and evaluation) involving human participants should be submitted to the appropriate level of ethics committee review prior to conduct.

Services should be cost-efficient

Services should be efficient and use the available resources to achieve the best possible effect.

Privacy and confidentiality should be maintained

Privacy and confidentiality are vital in any area of human service. However, they are even more important in the alcohol and other drug (AOD) field. The illegal nature of some drug use and the stigma associated with drug dependency mean that confidentiality is a key issue for clients.

Training and professional development should reinforce ethical standards

Ongoing training and professional development are crucial to maintain high ethical standards. Increased funding needs to be devoted to this area to ensure that all staff have opportunities to develop their skills and awareness of ethical issues.

Stress and workload issues contribute to poor ethical standards

Breaches of ethics often occur when workers are under a high level of stress or have an impossible workload. Under these conditions it is difficult for staff to maintain appropriate ethical and professional standards. Such breaches are unacceptable. It is incumbent upon management to ensure that staff have a reasonable workload and suitable working conditions and that appropriate procedures, including support and training for workers, are followed when such breaches do occur.

The client/worker relationship is of critical importance

A good relationship between the client and the worker is extremely important in achieving positive outcomes for the client. Services are most effective when the relationship is collaborative and focuses on working together to solve problems. Like any human relationship, the relationship between a client and a worker is complex. It is not appropriate for workers and clients to engage in any kind of sexual or financial relationship, as this will breach the therapeutic relationship they have developed. The welfare of clients and the general public, and integrity of the profession take precedence over self-interest and over the interests of members' employers and colleagues.

Advocacy in relation to public policy and public health outcomes is important

AOD practitioners, in adopting a stance of equality and social justice in relation to alcohol and other drug use and consequences, have a responsibility to engage in ongoing debate and advocacy around drug policy reform issues and the social goals of other reforms to improve health and wellbeing of clients. In performing an advocacy role, AOD practitioners should strive to draw from a wide range of resources in relation to knowledge access and protection, science, ethics, practice and communication.

Ethics engagement

All AOD practitioners should be able to engage with the moral and ethical basis of drug use and its outcomes (both positive and negative). Ethical issues and value questions are as important in drug policy, practice and research as other clinical, empirical and political concerns. The AOD workforce has an obligation to consider the ethical, social and political dimensions of proposed programs and interventions, and, in doing so, to seek the value perspectives and participation of all groups whose interests are affected. This requires an awareness of existing peak charters, codes and guidelines relevant to questions of ethics and values (e.g. ANCD Alcohol and Other Drugs Charter, ADCA Code of Ethics, relevant professional codes, National Health and Medical Research Council research ethics guidelines). It also warrants a preparedness to consider guides to decision-making processes around ethical challenges, and the consideration of ethics in the evaluation of self-practice and innovations in the AOD field (e.g. research, policy, treatment). The responsibility of ethics engagement exists for all sectors of the AOD workforce, including treatment, outreach, education and training, policy, research, administration, law enforcement, health promotion, prevention, primary care etc.

Appendix H: The Australian Alcohol and Other Drugs Charter

(Australian National Council on Drugs, 2006)

Purpose of the Charter

The Alcohol and Other Drugs Charter sets out the guiding principles, expectations and goals with regard to drugs. The Charter outlines rights and responsibilities with regard to drug use and the development and implementation of policies and programs, at all community levels and for different settings and sectors. These include people in general, children and young persons, parents and care givers, drug users, health care and welfare providers, law enforcement and corrections personnel, education personnel, government and community organisations, policy makers and program providers, and alcohol and tobacco producers, retailers and servers.

The Australian Alcohol and Other Drugs Charter

- 1.1 *Determined* to give priority to protecting public health, safety and social welfare in Australia.
- 1.2 *Recognising* that the harm done by illicit drugs, certain pharmaceutical drugs, alcohol, tobacco and volatile substances (hereinafter called drugs) has serious consequences for public health, safety and social welfare.
- 1.3 *Determined* to reduce the health, social and economic burden caused by drugs.

- 1.4 *Recognising* that the harm caused by drugs is not proportionately distributed across all groups in the population, and that, as a result of historical and socioeconomic factors, Indigenous communities and other disadvantaged groups suffer a greater burden of harm.
- 1.5 *Recognising* that scientific evidence has unequivocally established that drug use causes, and can contribute to, premature death, disease and disability, as well as accidents and other harms to the user, to other individuals, to family members and society as a whole.
- 1.6 *Recognising* the potential addictive nature of drugs and the definition of harmful use, intoxication and dependence as disorders within the International Classification of Diseases.
- 1.7 *Recognising* the concern people have about the harm done by drugs to individuals, families and societies.
- 1.8 *Concerned* about the disproportionate impacts of use experienced by some groups including Indigenous Australians and young people.
- 1.9 *Concerned* about the impact of advertising, promotion and sponsorship aimed at encouraging the use of drugs.
- 1.10 *Recognising* that public health, clinical and law enforcement approaches to drug use need to be ethical, informed by evidence, cost-effective and formulated without undue influence from commercial and political interests or other pressure groups.
- 1.11 *Recognising* the special contribution that non-governmental organisations and organisations, professional bodies, women's and youth, consumer, cultural and care groups, and academic institutions can have for drug policy and program efforts at all community levels.
- 1.12 *Recalled* Article 25 of the Universal Declaration of Human Rights which affirms that '*everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services*'.
- 1.13 *Recalled* the preamble to the Constitution of the World Health Organisation, which states that '*the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition*'.
- 1.14 *Recalled* Article 12 of the International Covenant on Economic, Social and Cultural Rights, which states that it is '*the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*'.
- 1.15 *Recalled* that the United Nations Convention on the Rights of the Child provides that Parties to that Convention recognise the right of the child to the enjoyment of the highest attainable standard of health.

- 1.16 *Recalled* the United Nations 1961 Single Convention on Narcotic Drugs, the 1972 Protocol Amending the Single Convention on Narcotic Drugs, the 1971 Convention on Psychotropic Substances and the 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, which aim to eliminate the root causes of the problems of narcotic and psychotropic drug use, including the demand for and illicit trade in such drugs.
- 1.17 *Recalled* the goals of the Ottawa Charter for Health Promotion which calls on countries to build healthy public policy, create supportive environments, strengthen community action, develop personal skills and reorient health services.
- 1.18 *Recalled* the mission of Australia's National Drug Strategy 2004–2009 to improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in Australian society.

Proposes the following, outlining the expectations of the community with regard to drugs:

The whole population

- 2.1 People should have a family, community and working life protected from accidents, violence and other negative consequences of drug use.
- 2.2 People should receive impartial education that is informed by evidence (starting early in life, and appropriate to their age and stage), on the consequences of drug use on their health, the family and society.

- 2.3 People who use drugs (for health or other reasons) should have access to accurate information on the risks associated with drug use, and be supported to prevent and reduce the harms arising from their drug use.
- 2.4 People who do not wish to use drugs should be safeguarded from pressures to use drugs and be supported in their non-drug using behaviour.

Children and young people

- 2.5 Children and young people should be born into and grow up in an environment protected to the greatest extent possible from the negative physical, behavioural and emotional consequences of drug use.
- 2.6 Children and young people should be able to grow up in an environment free, to the greatest extent possible, of promotion and marketing of drugs, including advertising and media sponsorship.

Parents and caregivers

- 2.7 Parents and caregivers should ensure that they do not expose children to the negative physical, behavioural and emotional consequences that might arise from their own drug use.
- 2.8 Parents and caregivers should have access to accurate information to assist in educating children about drug use, harms and treatment.

Drug users

- 2.9 People should not suffer unlawful discrimination based solely on their use of alcohol, tobacco or other drugs.
- 2.10 People who are dependent on drugs, as defined by international classifications of mental and behavioural disorders, should not be unlawfully discriminated against by virtue of their dependence.
- 2.11 People who use drugs should be able to receive information, treatment and care for their drug use (and for any concurrent disorders), which is accessible, affordable, and informed by evidence.
- 2.12 People with serious problems related to their use of alcohol and other drugs must be treated with dignity and respect and provided with opportunities and support that will enable them to get well and recover, and achieve their full human potential in leading a meaningful life in the communities of their choice.

Health care and welfare providers

- 2.13 Health care and welfare providers should be able to provide treatment and care that is informed by evidence to drug users without risk or fear of harm or discrimination.
- 2.14 Health care and welfare providers should offer or facilitate appropriate care, and a range of treatment and rehabilitation options for people who use drugs and are in need of such interventions.

Law enforcement and corrections personnel

- 2.15 Law enforcement and corrections personnel should be able to apply legislation and carry out duties relevant to drug use within their lawful authority, including the use of discretionary powers.
- 2.16 Law enforcement policy makers should ensure that the policies surrounding policing, the application of existing law, and the creation of new laws concerning the manufacture, trafficking and use of illicit drugs and the regulation of the manufacture, trade and use of licit drugs are informed by evidence.
- 2.17 Law enforcement and corrections personnel should have access to appropriate training that develops an awareness of drug issues, particularly the differential effects of patterns of drug use and drug use problems in relevant populations.

Education personnel

- 2.18 Education and training institutions for education personnel should ensure they include accurate information on drugs that includes the source of information.
- 2.19 Personnel working in schools and higher institutions should ensure they offer information on drugs that is impartial and informed by evidence to support all individuals to make healthy choices about drug use.

Governments and community organisations

- 2.20 Governments within Australia and other organisations should work collaboratively with communities and relevant non-governmental organisations to ensure that appropriate public education and communication are delivered to raise public awareness about the harms associated with drug use, and the effectiveness of treatment, care, and program and policy responses to drug-related harm.
- 2.21 Governments within Australia and other organisations, including relevant non-governmental organisations, should assist communities to create a living, recreational and working environment that enables all people to make safe and healthy lifestyle choices with regard to drug use, and which are free, to the extent possible, from the injurious consequences of drug use. Policy on drugs should be based on evidence and formulated without undue influence from any organisation including those involved in the production, distribution or sale of alcohol, tobacco or pharmaceutical drugs.

Policy makers and program providers

- 2.22 Policy makers should ensure that any policy that may affect drug users or their families takes account of the impact on the drug users, their families and the broader community; and such policy making should be transparent and publicly accountable.

- 2.23 Policy makers and their advisors should develop and implement non-discriminatory policies on drugs that are ethical, informed by evidence and which accurately reflect the harm and nature of the drugs being addressed.
- 2.24 Providers of prevention and health promotion programs designed to reduce the harm caused by drugs should ensure that their programs are ethical, informed by evidence, effective, safe, and culturally appropriate.
- 2.25 There is a need for collaboration and cooperation between and across government, non-government, private sectors and the community to reduce the uptake of drug use and drug-related harm. Such collaboration should include the education and training sectors, law enforcement, workplace relations, health care and welfare service providers, consumers and commercial industry (especially tobacco and alcohol industries).

Alcohol and tobacco producers, retailers and servers

- 2.26 Alcohol and tobacco producers, distributors, retailers and servers should not promote, market or sell alcohol and tobacco products directly to children and adolescents.
- 2.27 Alcohol and tobacco producers should contribute to community programs and initiatives to lessen the harms of drug use.
- 2.28 People in the hospitality and alcohol industry should work to reduce the harmful consequences of intoxication, harmful patterns of drinking and the risk to the community of crime, menace and other antisocial behaviour.

Appendix 1: Sample of recommendations submitted for review of the *Alcoholics and Drug-dependent Persons Act 1968 (Vic)*

As part of a review of the *Alcoholics and Drug-dependent Persons Act 1968 (Vic)*, the Alcohol Policy Unit of the Victorian Department of Human Services invited submissions from interested persons and organisations. As illustrated below, submissions varied widely. The main features of a selection of recommendations include:

- Victorian Alcohol and Drug Association (2005): Repeal the entire *Alcoholics and Drug-dependent Persons Act 1968 (Vic)* and explore the scope for using the *Mental Health Act 1986 (Vic)* and the *Guardianships and Administrative Act 1986 (Vic)* to provide AOD treatment to those with cognitive impairment.
- Law Institute of Victoria (2005): Retain short-term detention as per s.11, either in an amended *Alcoholics and Drug-dependent Persons Act 1968 (Vic)* with all non-related provisions of the Act removed, or enact new legislation. Detention should be limited to alcohol- and drug-dependent persons who pose an imminent risk of harm to themselves or others where treatment can reasonably be expected to reduce harm and is used as a last resort.¹⁴⁷
- Office of the Public Advocate (Tomas, 2005): Retain and strengthen s.11 to enable enforced detention and treatment in a drug and alcohol treatment facility, of drug- or alcohol-affected individuals, for up to 14 days. Include admission criteria, and accountability and appeal processes similar to those contained in the *Mental Health Act 1986 (Vic)*. Guardianship is not an appropriate mechanism for admission for assessment and/or treatment.

¹⁴⁷ This recommendation included using the criteria within the *Mental Health Act 1986 (Vic)* as a guide.

Appendix J: AOD treatment in custodial settings

In Australia, custodial settings offer another environment for compulsory treatment. Though the level of coercion is significantly less than applied through the diversionary and civil commitment procedures discussed in this paper, some degree of coercion is present. That treatment is offered within a custodial justice setting and is viewed

favourably in such matters as parole applications, which creates a coercive element to the treatment programs offered.

Provisions for treatment within custodial settings are found in a range of Australian statutes, including criminal, correctional and sentencing legislation. Table 7.1 lists the legislation in each State that relates to AOD treatment of prisoners.

Table 7.1: Legislation relating to rehabilitative treatment of offenders in custody

Jurisdiction	Legislation	Sections
Australian Capital Territory	<i>Rehabilitation of Offenders (Interim) Act 2001</i>	
New South Wales	<i>Crimes Legislation Amendment (Criminal Justice Interventions) Act 2002</i>	Part 9
	<i>Bail Act 1978</i>	s.36A
	<i>Crimes (Sentencing Procedure) Act 1999</i>	ss. 9, 10, 11, 12
Northern Territory	<i>Sentencing Act 1995</i>	Part 6
	<i>Prisons (Correctional Services) Act 1980</i>	Part XX
Queensland	<i>Corrective Services Act 2000</i>	s.190
South Australia	<i>Correctional Services Act 1982</i>	s.23(6)
Tasmania	<i>Sentencing Act 1997</i>	
Victoria	<i>Sentencing Act 1991</i>	ss. 38, 18S, 18ZG
Western Australia	<i>Prisons Act 1981</i>	s.95

There are presently no national guidelines for custodial treatment; rather, individual States and Territories have developed AOD treatment programs to meet the needs of their prison population, unguided by a common framework. Some States have been directed to do this by very specific guidelines outlined in the legislation (e.g. Queensland), while other State legislation makes only oblique references to guide the shape of rehabilitative programs (e.g. Victoria) (Howells et al., 2004).

AOD education programs currently available in Australian State and Territory prisons generally have a harm reduction focus and most are of less than 20 hours' duration. There are, however, models for longer treatments, such as the Victorian 13-week Intensive Drug Treatment Program and the 100-hour Moving on from Dependencies programs in Western Australia. Given the complex problems typically seen within prison populations, it has been suggested that programs of longer duration (i.e. more than 50 hours) are more effective (Howells et al., 2004) (see Table 7.2).

Transition programs, aiming to assist prisoners with re-integration into the community upon their release from prison, are described in section 3.1.8. Programs operate within prisons and through community-based treatment programs (Howells et al., 2004; Forensic Psychology Research Group, 2003). For example, Victorian prison parole boards may refer prisoners who are eligible for parole to the Community Offenders Advice and Treatment Service (COATS) for AOD assessment. COATS assesses prisoners, prepares AOD treatment plans and arranges treatment at

community-based AOD services. Attendance is then made a condition of the prisoner's release on parole (Victoria Department of Human Services, 2005a).

Residential AOD treatment programs in Australian prisons take two main forms:¹⁴⁸ therapeutic community programs and designated drug-free units. Therapeutic communities (described in Appendix D) are long-term, highly structured, intensive treatment interventions that generally utilise group discussions and systems of sanctions and rewards (Howells et al., 2004; Forensic Psychology Research Group, 2003).

Drug-free units also use systems of reward and punishment. They forbid any drug use and include counselling and support for abstinence. Drug-free units aim to reduce the demand for illicit substances in prison, provide a safe and supportive environment where offenders are free from the pressures to use drugs, and provide support to offenders to remain drug-free. Prisoners may be required to undergo regular drug testing and agree to a number of principles, conditions and regulations as well as maintain suitable levels of treatment (Office of the Correctional Services Commissioner, 2002; Western Australia Department of Justice, 2003). Prisons in New South Wales, Queensland, South Australia and Western Australia utilise drug-free units within custodial settings (see Table 7.3 below).

Non-residential AOD treatment programs operate in prisons in each State. Non-residential programs target a diverse range of groups, in terms of severity of substance use problems and stage of custodial sentence, and most commonly include a range

¹⁴⁸ Boot camps, or shock incarceration programs, are a third form of residential treatment program. These are short-term prison programs run like military training (Atkinson, 1995). They are common in the United States (especially for young male criminal offenders) but have not been adopted in Australia, except in a highly modified form as work camps and only to a limited extent. Boot and work camps are thereby excluded from this paper.

of counselling techniques such as ‘individual, group or family counselling, peer group support, vocational therapy and cognitive therapy’ (Forensic Psychology Research Group, 2003). Such programs range in duration from brief interventions to programs spanning the duration of an offender’s sentence. Elements that may be incorporated into such programs include motivational enhancement, education about the link between substance use and offending, relapse prevention, skill development, and transition to the community.

Opioid maintenance therapies are another form of non-residential treatment, of which methadone maintenance treatment (MMT) is the main type.¹⁴⁹ MMT is widely available in

Australia, found in prisons in every State and Territory (see Table 7.3 below), though not in every prison. It is least common in prisons in Queensland, where just 45 prisoners (1% of the prison population) received methadone treatment in 2003–04. Contrast this with New South Wales and South Australia where 10 per cent and 12 per cent of the total prison population respectively received MMT (Cresswell, 2006).

A summary of the types of AOD treatments available in Australian prisons as at July 2004, adapted from Black et al. (2004), is contained in Table 7.3.

Table 7.2: AOD education programs in Australian prisons¹⁵⁰

Jurisdiction	Program title	Duration	Specific target ¹⁵¹
Australian Capital Territory	Drug Awareness Program	12 hours	
	Coping Skills Program	30 hours	
New South Wales	Alcohol and Other Drugs: Education	12 hours	
	Alcohol and Other Drugs: Relapse Prevention	12 hours	
	SMART Recovery Program		
Northern Territory	Illicit Drug Treatment Program	16 hours	
	Cannabis Treatment Program	16 hours	
	Alcohol Treatment Program	20 hours	

¹⁴⁹ MMT involves the daily administration of the oral opioid agonist methadone as a treatment for opioid dependence. See Appendix D.

¹⁵⁰ Table taken from Howells et al. (2004) with additions.

Jurisdiction	Program title	Duration	Specific target ¹⁵¹
Queensland	Ending Offending	12 hours	Indigenous offenders
	Substance Abuse Managing and Preventing Relapse	20 hours	
	Prison Opioid Treatment Program		
	Illicit drug use by offenders action plan		
	Queensland Correctional Facilities Education Project		
	Post-Prison Community-Based Release Orders (including treatment conditions)		
	Pre-Release Orientation to Treatment and Motivation program	54 hours plus 54 hours homework	
	Turning Point		
	Getting SMART	12 sessions	Graduates of Getting SMART and Pathways
Pathways: High-intensity substance abuse program			
	SMART Recovery Program		
South Australia	Alcohol and Other Drugs (Parts A & B)	12 hours	
	Ending Offending	12 hours	Indigenous offenders
Tasmania	Substance Use is Not the Only Choice	46 hours	
Victoria	Alcohol and Driving Education	12 hours	
	Benzodiazepine Education Program	12 hours	
	Cannabis Education Program	12 hours	
	CLD Drug Education Program	12 hours	Indochinese
	Prison-Based Drug and Alcohol Program – Intensive	130+ hours	Women’s adaptation available
	Relapse Prevention Program	12 hours	

Jurisdiction	Program title	Duration	Specific target ¹⁵¹
	Alchemy: Alcohol Education and Reduction	20 hours	
	Understanding Substance Abuse and Dependence	40 hours	
	13-Week Intensive Drug Treatment Program	125 hours	
	Alcohol and Other Drugs	12 hours	
	Opioid Substitution Therapy Program		
	New Horizons		
Western Australia ¹⁵²	Women's Substance Use Program	35 hours	Female offenders
	Female Relapse Prevention Program	25 hours	Female offenders
	Moving on from Dependencies (Men)	100+ hours	
	Moving on from Dependencies (Women)	100 hours	Female offenders
	Pathways	99.5 hours	
	Choices	43 hours	
	Substance Abuse Relapse Prevention	25 hours	
	Managing Anger and Substance Use Program	50 hours	Men with anger & AOD issues
	Indigenous Men Managing Anger & Substance Use	50 hours	Indigenous men in remote areas with anger & AOD issues
	Individual counselling	8 hours	
	Drug Awareness Workshop	5 hours	
	Brief Intervention Services	4–8 hours	Remand & short sentence prisoners

¹⁵¹ Where no specific target is named, the program is designed for the general prison population.

¹⁵² Refer to Offender Services Program Guide, July 2005 – June 2006 (Offender Services Branch, Prisons Division, Western Australia Department of Corrective Services) for details of each program.

Table 7.3: AOD treatment types available in Australian prisons

Jurisdiction	Education	Counselling	Opioid maintenance therapy	Detoxification	Drug-free units
Austn Capital Territory	✓	✓	✓	✓	
New South Wales	✓	✓	✓	✓	✓ (pilot)
Northern Territory	✓	✓	✓	✓	
Queensland	✓	✓	✓	✓	✓ (pilot)
South Australia	✓	✓	✓	✓	✓
Tasmania	✓	✓	✓	✓	
Victoria	✓	✓	✓	✓	
Western Australia	✓	✓	✓	✓	✓

Formal evaluations of custodial-based AOD programs are relatively rare and there is little information available on which to assess claims of effectiveness. Most programs do not involve the routine use of psychometric measures and do not record levels of substance use. The inclusion of a diverse mix of participants with varying levels of commitment to addressing their drug-using and offending behaviour further confounds systematic evaluation (Howells et al., 2004).

Evaluations of drug-free units have been reported in just two of the Australian States in which they are operating – New South Wales and South Australia – and offer little to no evidence of effectiveness. Evaluation of the drug-free wing in Parklea (NSW) reported that continued use of amphetamines, heroin and cocaine was lower among unit participants (57%) compared with prisoners in the regular prison, 67 per cent of whom continued to use. However, significance levels for this study were not reported and clearly the unit was not entirely drug-free (Kevin, 2002).

An evaluation was also conducted of the South Australian Drug-Free Therapeutic Unit, which operated between 1994 and 2001. Urinalysis testing showed statistically significant reductions in offenders' use of cannabis, opiates and benzodiazepines (Incorvaia & Kirby, 1997). However, the unit's drug-free status was again questionable. Staffing difficulties resulted in closure of the unit in 2001, and the drug-free units currently operating in the Cadell Training Centre in South Australia have not yet been evaluated (Black et al., 2004).

There is some evidence that AOD treatment for women in Queensland prisons is inadequate. In a survey of 100 female prisoners, 84 per cent reported that they were not receiving any help for their abuse of drugs and alcohol in prison (Kilroy, 2000, cited in Black et al., 2004).

One key informant reported that compulsory treatment in prisons is ineffective:

*Very high rates of fatal overdose upon release from prison point to the failure of compulsory treatment.*¹⁵³

Methadone maintenance therapy (MMT) has been found in general to reduce heroin use, mortality rates and HIV infection rates (Warren & Viney, 2004) and has also been associated with reductions in drug-related and property-related criminal behaviours (Marsch, 1998). In Australia, researchers at the National Drug and Alcohol Research Centre found that 77 per cent of prisoners who received methadone treatment for at least eight months remained out of prison 12 months after release, compared with just 3 per cent of prisoners who did not have access to methadone while in prison (Dolan et al., 2005).

An economic evaluation of the New South Wales prison methadone program, incorporating 21 prison MMT programs, concluded that the program was cost-effective (i.e. the annual cost of MMT is offset) if approximately 20 days of re-incarceration were avoided (Warren & Viney, 2004).

Howells et al. (2004) report that the international evidence most strongly favours therapeutic community programs for reducing drug use among prison populations, with the evidence for drug-free residential units being mixed. Research suggests that people who suffer the most severe consequences of the harms associated with their drug use, including criminal activity and social disadvantage such as homelessness, tend to find therapeutic communities an effective form of treatment (Alcohol and other Drugs Council of Australia, 2003a).

Australian custodial treatment programs have been criticised for largely failing to specifically address the link between substance use and offending, and for rarely including through- or after-care as a component of programs. These criticisms require further examination.

¹⁵³ K110.