

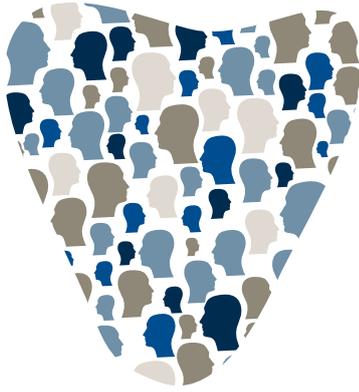


sentencing
ADVISORY
COUNCIL

MANDATORY TREATMENT FOR ALCOHOL AND DRUG AFFECTED OFFENDERS:

RESEARCH PAPER No.2

September 2017



About this Research Paper

The Tasmanian Government has asked the Sentencing Advisory Council for advice on the implementation of mandatory treatment for offenders with substance abuse problems.

This Research Paper considers mandatory treatment for offenders with substance abuse problems in four situations: in prison, as part of a drug treatment order, as part of a parole order and as part of a community-based sanction. It considers the justifications for creating a mandatory treatment regime and the legal mechanisms that may be used to achieve that outcome.

Information on the Sentencing Advisory Council

The Sentencing Advisory Council was established in June 2010 by the Attorney-General and Minister for Justice, the Hon Lara Giddings MP. The Council was established, in part, as an advisory body to the Attorney-General. Its other functions are to bridge the gap between the community, the courts and the Government by informing, educating and advising on sentencing issues in Tasmania. At the time that this paper was concluded, the Council members were Emeritus Professor Arie Freiberg AM (Chair), Dr Jeremy Prichard, Mr Scott Tilyard, Mr Peter Dixon, Ms Kim Baumeler, Mr Graham Hill, Professor Rob White, Associate Professor Terese Henning, Ms Kate Cuthbertson and Ms Linda Mason.

Acknowledgements

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1.

Introduction

1.1 BACKGROUND TO THIS PAPER AND TERMS OF REFERENCE

In 2016, the Attorney-General, Dr Vanessa Goodwin MLC, requested that the Sentencing Advisory Council provide advice on the issue of mandatory treatment. Initially, the request was directed to the mandatory treatment of sex offenders serving sentences of imprisonment. This was done in Stage 1 of the project which was published in September 2016.¹ The Attorney-General also requested that the Council consider mandatory treatment for offenders with alcohol and drug issues. This is Stage 2 of the project. Accordingly, as requested, this Research Paper considers mandatory treatment in prison and in the community for offenders with drug and alcohol issues. It considers the justifications for creating a mandatory treatment regime and the legal mechanisms that may be used to achieve that outcome.

At the outset, it is noted that there is a lack of clarity about the meaning of 'mandatory treatment' in the context of the treatment of offenders with drug and alcohol abuse issues. For example, in some contexts, mandatory treatment has been used to describe the legal mechanisms where offenders are directed into treatment by the criminal justice system, whether or not an offender's consent is required.² Treatment where an offender is legally coerced to participate has also been referred to as involuntary treatment.³ Treatment where an offender has a choice to participate or face other consequences in the criminal justice system has also been described as coerced or quasi-compulsory treatment rather than mandatory treatment.⁴ Another definition of compulsory treatment draws from the criminal law to describe situations where: (1) an offender is sentenced to care or treatment instead of prison irrespective of consent; (2) an offender is sentenced to prison and care/treatment irrespective of consent; and (3) an offender is sentenced to care or treatment with initial consent but is able to be kept in that care irrespective of any later expressed will.⁵ Mandatory treatment can also refer to treatment where an offender has consent in terms of whether he or she agrees to the making of a sentencing order with a treatment condition but then adherence to the conditions, including treatment, is compulsory.

This paper discusses coerced treatment (where there is legal coercion to participate in treatment but an offender has a choice as to whether to take part) and mandatory treatment (where there is legal coercion and the offender is not given a choice as to whether to take part). Either form of treatment may occur in prison or in a community setting. However, as discussed at [3.1], even if an offender is directed to attend drug or alcohol treatment without their consent (that is, that treatment is mandatory), an offender cannot be forced to attend, and even if the offender physically attends, this does not guarantee actual participation or co-operation with treatment.

Further, it is noted that there are other types of coercion that may put pressure on an offender to take part in treatment (beyond legal coercion). These include pressure from friends and family, employers, medical professionals

1 See Sentencing Advisory Council, Tasmania (TSAC), *Mandatory Treatment for Sex Offenders* (Research Paper 1, 2017).

2 See for example, Crime and Misconduct Commission (Queensland), *Mandatory Treatment and Perceptions of Treatment Effectiveness: A Queensland Study of Non-Custodial Offenders with Drug and/or Alcohol Abuse Problems* (Research and Issues Paper No 7, 2008) 3.

3 DLA Piper Australia, *Review of the Severe Substance Dependence Treatment Act 2014 (Vic)* (Vol 2: Literature Review).

4 See for example Michael Schaub et al, 'Predictors of Retention in the "Voluntary" and "Quasi-Compulsory" Treatment of Substance Dependence in Europe' (2011) 17 *European Addiction Research* 97, 98.

5 Magnus Israelsson and Arne Gerdner, 'Compulsory Commitment to Care of Substance Misusers – A Worldwide Comparative Analysis of the Legislation' (2010) 3 *Open Addiction Journal* 117, 122.

and other service providers.⁶ In the context of the criminal justice system, coercion into treatment may take place at different stages of the process: pre-arrest (before a charge is laid), pre-trial (after a charge is laid but before the hearing), pre-sentence (after a finding of guilt but before sentence), post-conviction (as part of sentence) or pre-release (prior to release from prison).⁷ As indicated, this Research Paper focuses on the issues surrounding the creation of legal mechanisms for the implementation of mandatory treatment in a prison context in Tasmania (that is, post-conviction and/or pre-release), as well as for sentenced offenders in the community (post-conviction). It examines:

- treatment provided in custody;
- treatment that is undertaken as a condition of release from prison on parole;
- treatment that is undertaken as part of a drug treatment order; and
- treatment pursuant to a community order.

The treatment of offenders with drug and alcohol issues is directed to offender rehabilitation and aims to improve community safety by reducing reoffending. An enormous body of literature exists in relation to drugs, alcohol, crime and treatment.⁸ Research has shown that there is a strong association between substance use and crime with this being an important risk factor for reoffending. However, while there is substantial evidence of an association between substance use and offending, the relationship between crime and substance use (including illicit drugs and alcohol) is complex. There is evidence that drug treatment can be effective as a crime control measure,⁹ and inherent in the reasoning behind the implementation of mandatory treatment is the assumption that compulsory treatment will more effectively prevent reoffending when compared to voluntary treatment or no treatment. Another important consideration is the capacity to provide adequate treatment services, whether in prison or in the community, to ensure that the offender is not being 'set up to fail'.¹⁰

In the Council's consideration of drug and alcohol treatment, the Council is addressing illicit drug use, alcohol use and the non-therapeutic use of licit pharmaceuticals (for example, buprenorphine).

In the preparation of this paper, the Council has also sought feedback from key stakeholders and responses were received from the following:

- Ben Bartl, Policy Officer, Community Legal Centres Tasmania (CLC Tas) (Submission 1).
- Jessie Raj, Women's Legal Service Tasmania (WLST) (Submission 2).
- The Hon Alan Blow OAM, Chief Justice of the Supreme Court (Submission 3).
- Frank Brinken, Prisoners Legal Service Inc (PLS) (Submission 4).
- Sarah Charlton, Chief Executive Officer, Holyoake (Submission 5).
- Alcohol, Tobacco and other Drugs Council Tasmania Inc (ATDC) (Submission 6).
- Daryl G Coates SC, Director of Public Prosecutions (DPP) (Submission 7).
- Chris Fox, Manager, Community Mental Health Services and Alcohol and Drug Services (ADS) (Submission 8).
- Tristan Bell, Senior Practice and Policy Officer, Department of Justice (Submission 9).
- Chris Jones, Chief Executive Officer, Anglicare; Supplementary Information provided by Margie Law (Submission 10).

The Council expresses its appreciation and has taken the feedback received into account.

6 E Pritchard, J Mugavin and A Swan, *Compulsory Treatment in Australia* (ANCD Research Paper No 14, 2007) ix, referring to Wild 2006.

7 Ibid 20, 31 referring to Spooner et al 2001.

8 Ibid ix.

9 Imogen Halstead and Suzanne Poynton, 'The NSW Intensive Drug and Alcohol Treatment Program (IDATP) and Recidivism: An Early Look at Outcomes for Referrals' (Contemporary Issues in Crime and Justice No 192, Australian Institute of Criminology, 2016) 2.

10 Arie Freiberg, *Pathways to Justice: Sentencing Review 2002* (2002) 44.

I.2 SCOPE OF PAPER

Chapter 2 provides information about the nexus between substance use and offending. It considers research that has examined the treatment of alcohol and drug users in the criminal justice system.

Chapter 3 sets out the framework for rehabilitation programs for drug and alcohol users in the criminal justice system (from voluntary to mandatory approaches). It provides an overview of the rehabilitation programs that are available for drug and alcohol treatment of offenders in Tasmania. It also examines the current legislative framework that allows a court to impose treatment conditions on an offender and other mechanisms which may operate to coerce an offender to participate in a treatment program.

Chapter 4 considers the mechanisms that could be used to expand the requirements for mandatory treatment for offenders with substance abuse issues in Tasmania and examines the strengths and weaknesses of these approaches.

This paper only considers the issue of mandatory treatment in the context of drug and alcohol affected offenders who serve their sentence at Risdon Prison and does not consider the programs that may be offered at Ashley Detention Centre. It also considers the community-based treatment options for offenders sentenced under the *Sentencing Act 1997* (Tas) but does not address the issue of treatment for offenders sentenced under the *Youth Justice Act 1997* (Tas). The appropriate treatment of young offenders raises complex and separate issues from the delivery of rehabilitation programs to adults and is beyond the scope of this paper.

Further, the paper does not focus on the provision of involuntary treatment beyond the scope of the criminal justice system under *Mental Health Act 2013* (Tas) or the *Alcohol and Drug Dependency Act 1968* (Tas).¹¹ This paper is also not intended to provide a review of the effectiveness of the current treatment programs that exist in Tasmania.

¹¹ The *Alcohol and Drug Dependency Act 1968* (Tas) provides for civil commitment and compulsory treatment of patients for six months after which this period can be renewed. An admission application may be made in respect of a patient on the grounds — (a) that the patient is suffering from alcohol dependency or drug dependency to a degree that warrants their detention in a treatment centre for medical treatment; and (b) that it is necessary in the interests of their health or safety or for the protection of other persons that they be so detained, s 24(2). This Act previously contained provisions that allowed a court to make a treatment order in sentencing an offender, if the offence was punishable by imprisonment and it was the court's opinion that the offence was committed (a) while that person was in a state or condition of drunkenness or was under the influence of alcohol or any drug; or (b) as a consequence of his or her suffering from alcohol dependency or drug dependency. These provisions were repealed by the *Sentencing Act 1997* (Tas) which sought to consolidate sentencing powers in Tasmania.

2.

The use of alcohol and drugs and their nexus with offending

2.1 THE USE OF ALCOHOL AND DRUGS IN AUSTRALIA

Alcohol consumption is widespread in Australia and a substantial proportion of Australians drink alcohol at harmful levels. The 2013 *National Drug Household Survey* found that four fifths of Australians aged 14 years and older reported consuming alcohol in the past year.¹² The recent *National Wastewater Drug Monitoring* project involved testing wastewater for several illicit and licit drugs at a number of sites across Australia, including seven sites in Tasmania (three capital city sites and four regional sites).¹³ It measured drug use by approximately 58% of the Australian population.¹⁴ The report observed that 'alcohol and tobacco were consistently the highest consumed drugs in all states and territories' and the 'national average consumption of alcohol ... per 1000 people per day is 1200 standard drinks'.¹⁵ Tasmania's estimated alcohol consumption was above the national average at both the regional and capital sites.¹⁶ In relation to risky drinking, Australian research has found that 17.1% of people exceeded the lifetime risk guidelines of two standard drinks per day and 25.5% had consumed alcohol at a level that placed them at a risk at least once a month.¹⁷ Other survey research has found that 'more than one third (37%) of Australian drinkers consume alcohol with the intention of getting drunk'¹⁸ and almost half (46%) of those surveyed were classified as risky drinkers (that is, they consumed five or more standard drinks on a single occasion during the previous three months).¹⁹

The use of illicit drugs and the non-therapeutic use of licit pharmaceuticals in Australia is less prevalent than alcohol use. The 2016 *National Drug Household Survey* found that 42.6% of people reported illicit use of any drug over their lifetime and that 15.6% of people reported illicit use of any drug in the 12 months before the survey.²⁰ The most commonly used drug was cannabis (10.4% used recently and 35% over the lifetime) followed by pain-killers/analgesics and opioids (3.5%) and ecstasy (2.2%) as the second and third most common drugs for recent use and ecstasy (11.2%) and pain-killers/analgesics and opioids (9.7%) as the second and third most common drugs for lifetime use.²¹ In 2016, 6.3% of people had used methyl/amphetamines in their lifetime and 1.4% had used it in the last 12 months.²² Other research released in 2016 indicated that there had been an increase in the number of regular and dependent methylamphetamine users with population rates being 2.09% for regular users and 1.24% for dependent use.²³ Increased use of methylamphetamine (relative to other illicit drug use) was reported in the 2017 *National Wastewater Drug Monitoring Program*, which found that methylamphetamine was the highest consumed

12 Australian Institute of Health and Welfare, *National Drug Strategy Household Survey Detailed Report 2013* (2014) 30.

13 Ibid 19.

14 Ibid 8.

15 Australian Criminal Intelligence Commission, *National Wastewater Drug Monitoring Program 2017*, Report (2017) 38.

16 Ibid 34.

17 Australian Institute of Health and Welfare, *National Drug Strategy Household Survey Key Findings 2016* (2017) Table 16.

18 Foundation for Alcohol Research and Education, *Annual Alcohol Poll 2016* (2016) 19.

19 VicHealth, *Australians Attitudes Towards their Health, Consuming Alcohol and Taking a Break from Alcohol – Survey Highlights*, 2.

20 Australian Institute of Health and Welfare, above n 17, Tables 24, 25.

21 Ibid Table 24.

22 Ibid Tables 24, 25.

23 Louisa Degenhardt et al, 'Estimating the Number of Regular and Dependent Methamphetamine Users in Australia, 2002–2014' (2016) 204 *Medical Journal of Australia* 153.

illicit drug tested across all regions in Australia.²⁴ The average national consumption for methylamphetamine was 35 doses per 1000 people per day.²⁵ It found that capital city sites in Tasmania and the Australian Capital Territory showed the lowest consumption levels nationwide while high levels were found at several regional sites including in Tasmania.²⁶ However, overall, the Tasmanian estimated consumption of methylamphetamine was below the national average in both regional and capital sites.²⁷

2.2 THE DRUG–CRIME NEXUS

Australian research suggests that many offenders have a history of substance abuse and many commit crime while under the influence of alcohol and/or drugs.

Substance use is clearly a risk factor for criminal behaviour,²⁸ with research showing that ‘substance misuse is more prevalent among offenders than in the general community’.²⁹ More frequent drug use is associated with higher rates of offending.³⁰ In a national study of adult prisoners, 62% of male inmates and 67% of female inmates reported being ‘intoxicated’ — that is, because of consuming any substance — at the time of the most serious offence for which they had been incarcerated.³¹ The rate appears to be lower, yet still notable, among people who have been arrested. In an analysis of self-reported data from Australian arrestees (n = 1884) approximately 40% of participants indicated that they were intoxicated at the time of offending.³² When arrestees were asked more broadly whether they *attributed* their offence to drugs or alcohol or both, the figure rose to 45%. Across the entire group of arrestees, 30% attributed their offence to alcohol compared with 19% for any illicit drug. Further, in relation to those who attributed their offending to illicit drug use, 40% of arrestees attributed their offending to their state of intoxication and only 25% attributed their offending to economic factors relating to their drug use.³³

These figures bear similarities to findings from national studies of people who regularly inject drugs. In 2013, 36% of injecting drug users reported committing some sort of crime in the month preceding their interview, whether it was drug dealing (23%), a property offence (18%), fraud (2%) or a crime of violence (3%). Two in every three participants also reported being intoxicated at the time of the offence(s). The most commonly identified substances linked to the different categories of offending behaviour were: cannabis (about 30% for drug dealing and fraud); benzodiazepines for property offences (29%); and alcohol and heroin for violence (both 32%).³⁴ Other research has found that two out of every three offenders detained by police tested positive to at least one drug, not including alcohol (66%).³⁵ Compared with their counterparts from other parts of Australia, Tasmanians who regularly inject drugs appear to be more inclined to report criminal activity in the month preceding their interview. In fact, in 2013 and 2012 the Tasmanian cohort had the highest level of self-reported criminal activity: 47% and 56%³⁶ respectively.

In the Tasmanian context, Holyoake, a non-profit counselling service, reported that it ‘has long observed the connection between substance abuse and criminal activity’ and noted that the association ‘has become more predictable in recent years since the emergence of crystal methamphetamine (ice) and over 90% of incarcerated clients attending Holyoake programs now have an association with ice’.³⁷

24 Australian Criminal Intelligence Commission, above n 15, 3.

25 Ibid 38.

26 Ibid 4.

27 Ibid 40.

28 Daniel Nagin, David Farrington and Terrie Moffitt, ‘Life-course Trajectories of Different Types of Offenders’ (1995) 33 *Criminology* 111.

29 Jason Payne and Antonette Gaffney, ‘How Much Crime is Drug and Alcohol Related? Self-reported Attributions of Police Detainees’ (Trends and Issues in Crime and Criminal Justice No 439, 2012) 1.

30 Deborah Bradford and Jason Payne, ‘Illicit Drug Use and Property Offending Among Police Detainees’ (Contemporary Issues in Crime and Justice No 157, 2012) 2, 7.

31 Toni Makkai and Jason Payne, ‘Drugs and Crime: A Study of Incarcerated Male Offenders’ (Research and Public Policy Series No 52, Australian Institute of Criminology, 2003); Holly Johnson, ‘Drugs and Crime: A Study of Incarcerated Female Offenders’ (Research and Public Policy Series No 63, Australian Institute of Criminology, 2004).

32 Payne and Gaffney, above n 29.

33 Ibid 4.

34 Jenny Stafford and Lucinda Burns, ‘Australia Drug Trends 2013: Findings from the Illicit Drug Reporting System (IDRS)’ (Australian Drug Trends Series No 109, National Drug and Alcohol Research Centre, 2014).

35 Antonette Gaffney et al, ‘Drug Use Monitoring in Australia: 2008 Annual Report on Drug Use Among Police Detainees’ (Monitoring Report No 9, Australian Institute of Criminology, 2010).

36 Jenny Stafford and Lucinda Burns, ‘Australia Drug Trends 2012: Findings from the Illicit Drugs Reporting System (IDRS)’ (Australian Drug Trends Series No 91, National Drug and Alcohol Research Centre, 2013).

37 Submission 5.

In relation to male offenders, Makkai and Payne examined the criminal careers of male offenders and classified offenders into seven typologies of offending or crime types:³⁸

- regular property offenders (27%). In relation to these offenders, more than 93% of all regular property offenders had tried one or more of the four main drug categories — cannabis, amphetamines, heroin and cocaine. It was reported that 88% had used at least one of these drugs in the six months prior to the arrest for which they were in prison and more than 80% were defined as current regular users of at least one drug;³⁹
- regular multiple offenders (15%). In relation to these offenders, 98% had tried one or more of the four main drug categories. It was reported that 90% had used at least one of these drugs in the six months prior to the arrest for which they were in prison and 88% were defined as current regular users of at least one drug;⁴⁰
- regular violent offenders (8%). In relation to these offenders, more than 70% of all regular violent offenders had tried one or more of the four main drug categories. It was reported that 56% had used at least one of these drugs in the six months prior to the arrest for which they were in prison and 49% were defined as current regular users of at least one drug;⁴¹
- regular fraud offenders (8%). In relation to these offenders, 93% of all regular fraud offenders had tried one or more of the four main drug categories. It was reported that 84% had used at least one of these drugs in the six months prior to the arrest for which they were in prison and 79% were defined as current regular users of at least one drug;⁴²
- drug sellers (7%). In relation to these offenders, 99% of offenders had tried one or more of the four main drug categories. It was reported that 90% had used at least one of these drugs in the six months prior to the arrest for which they were in prison and 87% were defined as current regular users of at least one drug;⁴³
- drug buyers (7%). In relation to these offenders, 100% of offenders had tried one or more of the four main drug categories. It was reported that 91% had used at least one of these drugs in the six months prior to the arrest for which they were in prison and 88% were defined as current regular users of at least one drug;⁴⁴ and
- homicide offenders (5%). In relation to these offenders, 74% of all homicide offenders had tried one or more of the four main drug categories. It was reported that 53% had used at least one of these drugs in the six months prior to the arrest for which they were in prison and 37% were defined as current regular users of at least one drug.⁴⁵

The remaining offenders were grouped into a non-regular offender group (24%). In relation to these offenders, 50% of offenders had tried one or more of the four main drug categories. It was reported that 26% had used at least one of these drugs in the six months prior to the arrest for which they were in prison and 14% were defined as current regular users of at least one drug.⁴⁶

Loxley and Adams have considered the unique characteristics of female offenders, including the use of alcohol and illicit drugs. They found that:

Compared to male detainees, the females were less likely to have used alcohol heavily in the previous year or to be dependent on alcohol. They had higher rates of illicit drug use (except for cannabis and ecstasy); were more likely to have injected them; and had higher rates of dependency on illicit drugs. ...

Female detainees were more likely than male ones to attribute their crime to illicit drug use. ... In general it seems that the association between drug use and criminal activity is stronger in women than in men. The use of illicit drugs was associated, particularly in female detainees with property offending. Alcohol use is more likely to be associated with violent crime than other crimes, and regular and dependent alcohol use increased women's likelihood of being involved in violent offending, although not to the same extent as it did men's.⁴⁷

38 Makkai and Payne, above n 31, xv.

39 Ibid 37.

40 Ibid 69.

41 Ibid 56.

42 Ibid 85.

43 Ibid 94.

44 Ibid 104.

45 Ibid 112.

46 Ibid 123.

47 Wendy Loxley and Kerryn Adams, *Women, Drug Use and Crime: Findings from the Drug Use Monitoring in Australia Program* (AIC Reports Research and Public Policy Series 99, 2009) iii.

In its submission, the WLST also highlighted the differences that exist between male and female offenders in relation to drug use. The WLST wrote that 'in general, it appears that the nexus between drug use and criminal activity is stronger in women than in men. Drug use appears to be more central to women's involvement in crime than it is to men's' and, further, that it can 'be argued that the severity of women's drug use is more closely related to their criminality than it is for men'.⁴⁸ Accordingly, the WLST's position was that these differences should be recognised so that 'any treatment for alcohol and drug affected offenders mandatory, or otherwise, needs to cater to women's specific needs'.⁴⁹ Although the discussion of the content of any programs is beyond the scope this paper, the WLST stressed the need for programs to 'focus on female-specific topics such as sexual abuse and body image, residential facilities for women with dependant family, and tailored care for pregnant mothers'.⁵⁰ The importance of programs addressing treatment needs of women with dependent children, as well as programs that are targeted specifically to women and their personal histories and drug use patterns was highlighted.⁵¹

While there is substantial evidence of an association between substance use and offending, the relationship between crime and substance use (including illicit drugs and alcohol) is complex, particularly when examined over the life course of offenders. The causal relationships are unclear, as it is not known whether drug use leads to crime, crime leads to the use of drugs, drug use and crime arise from a common cause (such as a 'common sociological or psychological cause, such as delinquency or age'), or whether there is no causal association.⁵² Further, not all illicit drugs users commit other crimes and not all people who consume alcohol commit crime.⁵³ Socio-economic factors such as poor education, unemployment and homelessness are more important than drug use 'in predicting the frequency of offending'.⁵⁴ This was stressed by the ATDC and Holyoake.⁵⁵

In focusing on an offender's substance use as a factor in offending, it is important to recognise that 'crime is the product of multiple factors, both personal and environmental'.⁵⁶ The ATDC highlighted this complexity, indicating that it was important 'to note and recognise the complexity of offenders when determining what treatment and/or programs should be introduced, expanded or [invested] in'.⁵⁷ In understanding the complexity of people with alcohol and other drug (AOD) issues who have come into contact with the criminal justice system, the ATDC indicated that they 'usually present with complex issues that require access to an array of services including: mental health, income support [and] housing among others. For this group, AOD treatment must be anchored in "whole of person" approaches'.⁵⁸ In its view, in considering the causal link between offending and drug use, it was also important to consider the factors that initiated drug use or offending in the first place such as childhood trauma, lack of education, homelessness or poor family support and address the root issues of the behaviour. The ATDC also made reference to the consequences of criminal justice sanctions on the health of people with AOD issues,

the largest of which, is the stigmatisation and resulting discrimination afforded to these people who use drugs. It is important to note that the 'health' of the person who uses drugs extends beyond the physical effects of drug use in mental health and behavioural aspects.⁵⁹

As discussed at [2.3], there are benefits in terms of reduced recidivism and reduced drug use from well designed and well implemented treatment in the criminal justice system. However, as indicated above, it is important to recognise the limits of treatment. In this context, it is important to stress that while there is value in providing treatment (where appropriate), the significance of treatment facilitated by legal coercion should not be overstated in terms of its ability to reduce overall drug use and offending in the community. Nevertheless, there are other benefits to providing treatment to offenders with drug and alcohol issues. The ATDC and the ADS highlighted the significance of health improvements for offenders that derive from effective treatment. The ADS wrote that:

48 Submission 2.

49 Submission 2.

50 Submission 2.

51 Submission 2.

52 Susan Goldsmid and Matthew Wills, 'Methamphetamine Use and Acquisitive Crime: Evidence of a Relationship' (Trends and Issues in Crime and Criminal Justice No 516, 2016) 2.

53 Ibid 2–3. See Arie Freiberg et al, *Queensland Drug and Specialist Courts Review* (Final Report, 2016) 88–9 for a more detailed discussion of the drug-crime nexus.

54 Alex Stevens, 'Are Drugs to Blame?' (2015) 102 *Criminal Justice Matters* 33, 33.

55 Submissions 5 and 6.

56 Freiberg et al, above n 53, 63.

57 Submission 6.

58 Submission 6.

59 Submission 6.

[t]he treatment of offenders with drug and alcohol issues should be directed to offender rehabilitation for the purposes not only of improving community safety by reducing reoffending but also improving health outcomes as a consequence of that treatment intervention.⁶⁰

Holyoake also identified improved health and overall quality of life for offenders as a goal of treatment, in addition to the reduction of involvement with the criminal justice system.⁶¹ Improved health and social outcomes underpin the National Drug Strategy (NDS), which aims 'to build safe and healthy communities by minimising alcohol, tobacco and other drug-related health, social and economic harms among individuals, families and communities'.⁶² The Council recognises the significance of the health and social benefits achieved by effective treatment for the offender, as well as benefits for the offender's family and community.⁶³

2.3 SUBSTANCE ABUSE AND RECIDIVISM

Although measuring recidivism is complex, both in terms of how recidivism is defined and the method used to calculate it,⁶⁴ many offenders do reoffend. The Australian Institute of Criminology has reported that 'about 60% of those in custody in Australia have been in prison before'⁶⁵ and in Tasmania, 39.8% of prisoners released from prison in 2013–14 were returned to prison within two years and 49.8% were returned to corrective services (which includes a prison sentence or a community sentence).⁶⁶ In 2016, 61% of Tasmanian prisoners had previously been imprisoned.⁶⁷ In relation to non-custodial orders, 19.2% of prisoners discharged from community-based orders in Tasmania in 2013–14 received a new community-based sanction within two years and 24.1% were returned to corrective services (which includes a prison sentence or a community sentence).⁶⁸ Factors linked to recidivism include poor education, employment history, mental illness and bad health as well as drug and alcohol misuse.⁶⁹ Holyoake noted that, 'offenders targeted by coerced AOD treatment programs frequently also experience a range of other social problems associated with housing, mental health, literacy, employment, limited social skills and family relationships.' Relying on research conducted by the National Institute of Drug Abuse, Holyoake wrote that '[t]hese other factors impact on the risk of drug relapse and recidivism and must also be taken into account within treatment programs'.⁷⁰

Nevertheless, substance misuse 'is an important risk factor for recidivism and return to custody'. Holyoake considered that addressing 'an individual's drug issues will impact, or has the potential to impact on their level of recidivism'.⁷¹ Alcohol and illicit drug use 'are significant independent predictors of self-reported criminal activity and reincarceration of parolees'.⁷² Accordingly, there are important social benefits from effectively addressing drug use issues as it has the potential to reduce recidivism and, from a public health perspective, there are opportunities to address a wider range of health risks linked to illicit drug use such as hepatitis C, mental health problems and overdose.⁷³ There are also potential benefits to the individual offender.

60 Submission 8.

61 Submission 5.

62 Ministerial Council on Drug Strategy, Australian Government, *National Drug Strategy 2010 – 2015* (2011) ii. In the draft 2016 – 2025 National Drug Strategy, this aim has been amended to include a reference to 'safe, healthy and resilient communities': Intergovernmental Committee on Drugs, *National Drug Strategy 2016 – 2025 Draft* (2015) 3 (emphasis added).

63 See discussion in Freiberg et al, above n 53, 25.

64 See discussion in Jason Payne, *Recidivism in Australia: Findings and Future Research* (Research and Public Policy Series No 80, Australian Institute of Criminology, 2007); Clare Ringland, 'Measuring Recidivism: Police versus Court Data' (2013) 175 *Contemporary Issues in Crime and Justice*; Sentencing Advisory Council, Victoria (VSAC), *Reoffending Following Sentencing in Victoria: A Statistical Overview* (2015); Robin Fitzgerald, Adrian Cherney and Lachlan Heybroek, *Recidivism Among Prisoners: Who Comes back?* (Trends and Issues in Crime and Criminal Justice No 530, Australian Institute of Criminology, 2016); Taylor Ruggero, Jamie Dougherty and John Klofas, *Measuring Recidivism: Definitions, Errors and Data Sources* (Working Paper 2015-03, Centre for Public Safety Initiatives, 2015).

65 Australian Institute of Criminology, *Recidivism*, 2011, <http://www.aic.gov.au/crime_community/communitycrime/recidivism.html>; Payne, above n 64, 62.

66 Productivity Commission, *Report on Government Services Sector Overview C Justice* (Final Report, 2017) Table C.4.

67 Australian Bureau of Statistics (ABS), *Prisoners in Australia 2016* (2016) Table I.3.

68 Productivity Commission, above n 66, Table C.6.

69 Australian Institute of Criminology, above n 65; Payne, above n 64, 97.

70 Submission 5.

71 Submission 5.

72 Halstead and Poynton, above n 9, referring to Catherine Ferguson, *Parole in Western Australia: An Analysis of Parole Cancellations of Female Offenders* (Trends and Issues in Crime and Criminal Justice No 501, 2015); Stuart Kinner, *The Post-release Experience of Prisoners in Queensland* (Trends and Issues in Crime and Criminal Justice No. 325, 2006); D MacKenzie et al, 'The Impact of Probation on the Criminal Activities of Offenders' (1999) 36 *Journal of Research in Crime and Delinquency*, 423-453.

73 Kinner, above n 72, 2.

Although precise estimates are difficult to obtain, during incarceration prisoners do engage in substance use — both illicit substance use and the extra medical use of prescription substances.⁷⁴ However, it is noted that the rates of drug use vary between prisons and fluctuates over time.⁷⁵ A 2015 report on the health of Australia's prisoner's included data from 437 prison discharges from all states and territories in Australia except New South Wales. It found that 10% of discharges had used drugs in prison, including 6% of discharges injecting drugs in prison,⁷⁶ and 3% of discharges using alcohol in prison.⁷⁷ Similarly, a study that examined the results of urine tests in Tasmanian prisons found that of 714 tests administered 15% tested positive for cannabis, 0% tested positive for amphetamine and heroin and 14% tested positive for other drugs.⁷⁸ Drug use in prison works against treatment and rehabilitative programs operating in prison and research suggests that continued drug use in prison or the intention to use drugs on release are strong predictors of reoffending.⁷⁹ In addition to undermining the effectiveness of treatment, substance use in prison has health risks for prisoners (for example, the transmission of blood-borne viruses such as hepatitis C and HIV,⁸⁰ mental health problems and the risk of overdose on release⁸¹), impacts on the safety and security of the prison environment (for example, increased violence, intimidation and corruption)⁸² and the wider community (risk of recidivism).⁸³ Corrective services have sought to address the prison–drug market through the implementation of supply reduction, demand reduction and harm reduction strategies.⁸⁴ However, the reality is that it is difficult to keep drugs out of prisons. Clearly, the provision of treatment is an important demand reduction strategy.⁸⁵

2.4 TREATING DRUG AND ALCOHOL USERS IN THE CRIMINAL JUSTICE SYSTEM

There is considerable research that has examined effective treatment and intervention options and this section provides a brief overview of the principles that have been identified as representing best practice in corrections.

Three key principles have been accepted as best practice in reducing reoffending. These are:

- (1) use identified and validated actuarial risk assessment tools;
- (2) employ cognitive behavioural techniques and services as foundation of treatment and intervention;
- (3) match offenders to appropriate service levels and intervention types based on prognostic risk and criminogenic needs.⁸⁶

Treatment has been identified as the primary response to drug dependency with imprisonment without treatment being said to have 'minimal, if any, effect in terms of deterring drug use'.⁸⁷ While effective treatment has a community benefit in reducing reoffending, it also has a substantial benefit to the quality of life of the individual offender (for example, health and social outcomes).

74 Emma van Dyken, *Using Wastewater Analysis to Measure the Prevalence of Prison Drug Use and the Effectiveness of Prison Drug Use Supply Reduction Strategies* (PhD Thesis, University of Tasmania, 2015) 2.1.2.

75 Information provided by Jeremy Prichard.

76 Australian Institute of Health and Welfare, *The Health of Australia's Prisoners 2015* (2015) 102.

77 Ibid 110.

78 Kate Dolan and Ana Rodas, 'Detection of Drugs in Australian Prisons: Supply Reduction Strategies (2014) 10 *International Journal of Prisoner Health* 111, 115. It is unclear what time period this finding relates to as the authors note that they attempted to obtain data for 2009 but that this was not feasible across all jurisdictions: at 116.

79 Freiberg et al, above n 53, 88; Kinner, above n 72, 4–5.

80 Australian National Council on Drugs, *National Corrections Drug Strategy* (2008) 2.

81 Australian Institute of Health and Welfare, above n 76, 167–8.

82 Tim McSweeney, Paul Turnbull and Mike Hough, *Tackling Drug Markets and Distribution Networks in the UK* (UK Drug Policy Commission, 2008) 9; Clarissa Penfold, Paul Turnbull and Russell Webster, *Tackling Prison Drug Markets: An Exploratory Qualitative Study* (Home Office Online Report 39/05, 2005) 26–7 <http://www.antonioacasella.eu/archila/Tackling_39_05.pdf>; Maria Kevin, *Addressing Prisoner Drug Use: Prevalence, Nature and Context* (Research Publication No 47, NSW Department of Corrective Services, 2015) 1.

83 Payne and Gaffney, above n 29.

84 Supply reduction includes strategies such as metal detectors and searches including drug dog searches, urinalysis and drug seizures in prison, see Ana Roda, Adam Bode and Kate Dolan, *Supply, Demand and Harm Reduction Strategies in Australian Prisons: An Update* (ANCD Research Paper, 2011) 71. Harm reduction policies include harm reduction education programs, blood-borne virus testing, condom/dental dam provision and disinfectant provision: at 73.

85 Ibid xii–xiii.

86 Jason Payne and Anthony Morgan, *Drug and Specialist Courts Review Appendix E: Building Effective Interventions for Drug Users in the Criminal Justice System* (2016) 4; David Wilson, 'Correctional Programs' in David Weisburd, David Farrington and Charlotte Gill (eds), *What Works in Crime Prevention and Rehabilitation: Lessons from Systematic Reviews* (Springer, 2016) 193.

87 Jeffrey Kushner, Roger Peters and Caroline Copper, *A Technical Assistance Guide for Drug Court Judges on Drug Court Treatment Services* (Bureau of Justice Assistance Drug Court Technical Assistance Project, 2014) 4.

Research has also shown that:

- recovery is a long-term process, will likely entail relapses, and frequently requires multiple episodes of treatment;
- no single treatment modality is appropriate for everyone and so individualised treatment plans that can be modified as needed are important;
- expectations for drug treatment participants in terms of program compliance and progression should differ, depending upon their individual situation(s) and stage of program participation;
- not all participants will progress at the same pace and the drug court structure must therefore provide the flexibility to address the individual needs of each participant;
- court-based interventions need to provide a continuum of treatment that assures patients access to needed levels and intensities of services, as and when they need them; and
- effective treatment must address the multiple needs of the individual, both substance addiction specifically and ancillary services, with particular focus on 'criminogenic factors'.⁸⁸

Many of these factors align with the submission received from the ATDC. The ATDC stressed the need to anchor treatment in 'whole of person' approaches and for treatment to accommodate and address the complexity of an individual's presentation. The ATDC wrote that 'whether mandated, coerced or voluntary, treatment plans or programs need to recognise [the trauma] of offenders — for treatment to be effective, and get to the root of the issues, offenders will require a more intense level of treatment, including 1:1 counselling as well as group programs'. Anglicare also agreed that recovery is a long-term process that may entail relapse and multiple episodes of treatment. Accordingly, it considered that it was 'essential that for mandated treatment to be effective it needs to be long-term and include assisting the person to establish "natural" social supports'.⁸⁹

The National Institute of Drug Abuse has identified 13 principles for effective treatment in criminal justice populations:

- (1) Drug addiction is a brain disease that affects behaviour.
- (2) Recovery from drug addiction requires effective treatment, followed by management of the problem over time.
- (3) Treatment must last long enough to produce stable behavioural changes.
- (4) Assessment is the first step in treatment.
- (5) Tailoring services to fit the needs of the individual is an important part of effective drug abuse treatment.
- (6) Drug use during treatment should be carefully monitored.
- (7) Treatment should target factors that are associated with criminal behaviour.
- (8) Criminal justice supervision should incorporate treatment planning for drug abusing offenders and treatment providers should be aware of correctional supervision requirements.
- (9) Continuity of care is essential for drug abusers re-entering the community.
- (10) A balance of rewards and sanctions encourages pro-social behaviour and treatment participation.
- (11) Offenders with co-occurring drug abuse and mental health problems often require an integrated treatment approach.
- (12) Medications are an important part of treatment for many drug abusing offenders.
- (13) Treatment planning for drug abusing offenders who are living in or re-entering the community should include strategies to prevent and treat serious, chronic medical conditions, such as HIV/AIDS, hepatitis B and C, and tuberculosis.⁹⁰

88 Ibid 5.

89 Submission 10.

90 National Institute for Drug Abuse, *Principles of Drug Abuse Treatment for Criminal Justice Populations – A Research Based Guide* (2014) <<https://www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations/principles>>. These principles were relied upon in the research examining the re-establishment of a drug court in Queensland: Freiberg et al, above n 53, 128–9. It is noted that the ADS expressed concern that the Council had relied on the US National Institute of Drug Abuse principles without reference to the National Drug Strategy given that there are 'substantial differences in resources, health and social welfare system and policy responses in the two countries'. The ADS indicated that it did 'not disagree with all principles outlined by the National Institute of Drug Abuse, but notes that some are in contrast to current treatment philosophy in Australia and that which is considered contemporary best practice in alcohol, tobacco and other drug treatment', (Submission 8).

These principles can provide guidance in the Australian context, as Freiberg et al write, 'given the ubiquity of concern about the management of alcohol and other drug related offending'.⁹¹ In Australia, the framework for AOD treatment is underpinned by the NDS, which has an overarching approach of harm minimisation using the three pillars of demand reduction, supply reduction and harm reduction.⁹² The NDS recognises that more attention is required to address drug use among prison populations. This increased attention is through supply reduction, education and treatment and reducing harms as well as to help prevent drug use from continuing or recurring when people leave prison.⁹³ Best practice approaches for people in contact with the criminal justice system are set out in the draft 2016–2025 strategy as follows:

- Implement smoke-free policies in correctional facilities.
- Improve the capability, capacity and confidence of the workforce to work with people who have a range of complex needs.
- Access to education, health promotion, treatment and support services while in prison and during their transition back into the community.
- Provision of a range of treatments, including detoxification and withdrawal management, pharmacotherapy, drug free units or therapeutic communities.
- Testing, education and treatment for blood borne viruses.
- Restorative justice conferencing.
- Strengthen existing harm reduction efforts in prison settings, such as opioid substitution therapy, and to support inmates to adopt safe behaviours and assist inmates connect with health and social services post-release.
- After-care and support post-release.
- Drug detection units and searching of offenders, staff, visitors and vehicles.⁹⁴

There is also considerable research that underpins the treatment and intervention framework known as 'Risk-Need-Responsivity' (RNR). RNR principles are internationally recognised and underpin many prison-based offender rehabilitation programs for adult offenders.⁹⁵ In this context, risk refers to the probability of reoffending.⁹⁶ This approach is risk management focused and the principles can be summarised as follows:

The Risk principle suggests that higher risk offenders stand to benefit more from rehabilitation programs than low risk offenders; the Needs principle suggests that programs should target individual 'criminogenic' needs, or those dynamic risk factors that are directly related to offending behaviour, and the Responsibility principle refers to those internal and external factors that may impede an individual's response to interventions such as weak motivation or program content and delivery.⁹⁷

In its submission, the ADS indicated that offenders at lower risk of recidivism may benefit from alcohol, tobacco and other drugs (ATOD) intervention and that criminogenic risk alone should not determine a person's access to ATOD treatment.⁹⁸ The Council's observations in relation to low-risk offenders should not be taken to mean treatment may not benefit low-risk offenders, rather they highlight the research that makes it clear that 'the intensity of drug treatment, the provision of allied treatment and the intensity of supervision by the criminal justice system should be guided by the principles of risk, needs and responsivity'.⁹⁹ Although applying the RNR framework in practice is likely to be challenging, it is important that treatment is appropriately directed as the evidence is clear that there are risks

91 Freiberg et al, above n 53, 128.

92 Ministerial Council on Drug Strategy, above n 62, 1; Intergovernmental Committee on Drugs, above n 62, 3.

93 Ministerial Council on Drug Strategy, above n 62, 7.

94 Intergovernmental Committee on Drugs, above n 62, 28–9.

95 Karen Heseltine, Andrew Day and Rick Sarre, 'Prison-based Correctional Offender Rehabilitation Programs: The 2009 National Picture in Australia' (AIC Reports: Research and Public Policy Series 112, 2011) 34.

96 Christopher Lowenkamp and Edward Latessa, 'Understanding the Risk Principle: How and Why Correctional Interventions Can Harm Low-Risk Offenders' (Topics in Community Corrections, 2004) 3.

97 Kevin Howells et al, *Correctional Offender Treatment Programs: The National Picture in Australia* (2004), 71 <<http://www.criminologyresearchcouncil.gov.au/reports/200203-04.html>>.

98 Submission 8.

99 Freiberg et al, above n 53, 35.

of exacerbating drug use and increasing offending when low-risk offenders are over-treated or over-supervised.¹⁰⁰ Several reasons have been suggested for the harm caused to low-risk offenders by intense correctional interventions: (1) it exposes low-risk offenders to high-risk offenders; (2) placing lower-risk offenders in highly structured and restrictive programs will disrupt the factors that make them low-risk (such as employment, family, pro-social peers and attitudes); and (3) lower-risk low-functioning offenders may be manipulated by more sophisticated, higher-risk, predatory offenders.¹⁰¹

While recognising the importance of these principles and agreeing that any alcohol and drug treatment program implemented in Tasmania should be evidence-based and reflective of best practice for successful treatment, this paper does not further address the extensive professional psychological literature on the specifics of treatment programs.

2.4.1 EFFECTIVENESS OF DRUG AND ALCOHOL REHABILITATION PROGRAMS

There is extensive literature that has evaluated the effectiveness of drug and alcohol rehabilitation programs that operate within the criminal justice system, including drug courts as well as prison-based substance abuse programs.¹⁰² Evidence indicates that community-based drug abuse treatment can reduce drug use and offending, with research indicating that drug courts are effective in reducing recidivism for adult offenders.¹⁰³ In terms of prison-based programs, 'the strongest positive evidence is for the effectiveness of therapeutic communities' with some group counselling programs also being potentially beneficial.¹⁰⁴ Therapeutic communities in the prison context are where a group is separated from the general prison population. They are described as follows:

[It] represents an intensive form of treatment, often lasting 6–12 months or longer. The treatment model is based on the idea that an individual with a substance abuse program needs to address broad psychological programs beyond its drug dependence. A therapeutic community is a phased program and participants become increasingly involved in helping run the program as they progress through stages.¹⁰⁵

Therapeutic communities have been found to reduce reoffending upon release and also to reduce drug use.¹⁰⁶ Community-based therapeutic communities have been effective in reducing criminal behaviour.¹⁰⁷

Coercion and treatment efficacy

What is the relationship between coercion and treatment efficacy? While there may be a perception that legally coerced treatment is less likely to be effective than voluntary treatment in reducing recidivism, this is not borne out in the literature. Recognising that 'engaging coerced clients in treatment is a task that requires great therapeutic skill',¹⁰⁸ coercion does not mean that treatment will be ineffective. Offenders who are legally coerced into treatment do not have worse outcomes than those who are voluntarily treated. This reflects the complexity of the relationship between coercion and motivation and that there are multiple sources that may apply pressure to a person to take part in treatment for substance abuse. These sources include family, friends, welfare agencies, employers and

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- 100 Lowenkamp and Latessa, above n 96, 3; Joan McCord, 'Cures That Harm: Unanticipated Outcomes of Crime Prevention Programs' (2003) 587 *Annals of the American Academy of Political and Social Science* 16; Christopher Lowenkamp, Edward Latessa and Alexander Holsinger, 'The Risk Principle in Action: What Have We Learned from 13,676 Offenders and 97 Correctional Programs?' (2006) 51 *Crime and Delinquency* 1.
- 101 Lowenkamp and Latessa, above n 96, 7–8.
- 102 For a recent summary see, Amanda Perry, 'Sentencing and Deterrence' in David Weisburd, David Farrington and Charlotte Gill (eds), *What Works in Crime Prevention and Rehabilitation: Lessons from Systematic Reviews* (Springer, 2016) 161, 181–3 (drug courts) and Wilson, above n 86, 204–7 (prison programs). See also Freiberg et al, above n 53, 140–4; Payne and Morgan, above n 86, 29–48.
- 103 Perry, above n 102, 183, 187; Redonna Chandler, Bennett Fletcher and Nora Volkow, 'Treating Drug Abuse and Addiction in the Criminal Justice System: Improving Public Health and Safety' (2009) 301 *JAMA* 183, 184.
- 104 Wilson, above n 86, 205, 207.
- 105 Ibid 205.
- 106 Ojmarrh Mitchell, David Wilson and Doris MacKenzie, 'Does Incarceration-based Drug Treatment Reduce Recidivism? A Meta-Analytic Synthesis of the Research' (2007) 3 *Journal of Experimental Criminology* 353, 353; Ojmarrh Mitchell, David Wilson and Doris MacKenzie, *The Effectiveness of Incarceration-Based Drug Treatment on Criminal Behaviour: A Systematic Review* (Campbell Systematic Reviews, 2012) 7.
- 107 Katy Holloway and Trevor Bennett, 'Drug Interventions' in David Weisburd, David Farrington and Charlotte Gill (eds) *What Works in Crime Prevention and Rehabilitation: Lessons from Systematic Reviews* (Springer, 2016) 219, 234. Research conducted in relation to the effectiveness of therapeutic communities outside the criminal justice system found that substance use was reduced during the stay but it was unclear whether relapse was prevented once the person had left, see Marion Malivert, et al, 'Effectiveness of Therapeutic Communities: A Systematic Review' (2012) 18 *European Addiction Research* 1.
- 108 Andrew Day, Kylie Tucker and Kevin Howells, 'Coerced Offender Rehabilitation – A Defensible Practice' (2004) 10 *Psychology, Crime and Law* 259, 267.

health professionals, as well as legal pressure.¹⁰⁹ In a study that compared substance-dependent offenders receiving treatment instead of imprisonment (quasi-compulsory) with voluntary treatment groups, Schaub and his colleagues found that coerced drug treatment was as effective as voluntary treatment provided through the same services in reducing substance use and crime.¹¹⁰ Stevens summarises the available research as suggesting that quasi-compulsory treatment 'can be as effective as treatment that is entered voluntarily, but is not generally more or less effective than such voluntary treatment'.¹¹¹

In summary, legal coercion can be beneficial as it can provide a motivation for an offender to take part in treatment that he or she would not otherwise engage in — 'the coercive influence exerted by the criminal justice system can indeed act as an effective catalyst for engagement with treatment services'.¹¹² However, the challenge is to engage and retain these participants. It appears the key is the ability of the criminal justice system to encourage an offender to take part in treatment while at the same time having appropriate programs and skilled practitioners to ensure that the offender remains engaged and motivated to change. As Stevens suggests, one of the reasons why quasi-compulsory treatment 'seems to have similarly positive results to voluntary treatment is because, when ethically carried out, it is not necessarily damaging to the patient's motivation to change'.¹¹³

However, the potential utility of legal coercion needs to be distinguished from the effectiveness of compulsory or mandatory treatment. Hall and Lucke write that 'evidence for the effectiveness of compulsory prison-based drug treatment is weak. Historical experience is, at best, mixed, and outcomes are poor in the absence of post-release supervision'.¹¹⁴ Stevens notes that:

[t]here is ... little, if any, evidence to demonstrate that compulsory treatment ... is effective in meeting the aims of drug treatment. Indeed, there are studies that have demonstrated the failure of compulsory treatment to meet these aims in various countries, including the USA, Sweden, and the Netherlands.¹¹⁵

In an analysis of the Dutch system,¹¹⁶ Stevens noted that the 'result of the evaluation ... showed that it produced results that were no better than less coercive forms of treatment, and [that it] was ineffective for those who felt compelled and therefore did not participate in treatment'.¹¹⁷ In a 2016 review of the effectiveness of compulsory drug treatment, Werb et al concluded that '[e]vidence does not, on the whole, suggest improved outcomes related to compulsory treatment approaches, with some studies suggesting potential harms'.¹¹⁸

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- 109 Poppy Rourke, John Howard and Kristy Martire, 'Legal Mandates and Perceived Coercion in Residential Alcohol and Other Drug Treatment' (2015) 22 *Psychiatry, Psychology and Law* 756, 756–8.
- 110 Michael Schaub et al, 'Comparing Outcomes of "Voluntary" and "Quasi-Compulsory" Treatment of Substance Dependence in Europe' (2010) 16 *European Addiction Research* 53.
- 111 Alex Stevens, 'The Ethics and Effectiveness of Coerced Treatment of People Who Use Drugs' (2012) 2 *Human Rights and Drugs* 7, 14.
- 112 Alex Stevens et al, 'The Relationship Between Legal Status, Perceived Pressure and Motivation in Treatment for Drug Dependence: Results from a European Study of Quasi-Compulsory Treatment' (2006) 12 *European Addiction Research* 197, 203.
- 113 Stevens, above n 111, 14.
- 114 Wayne Hall and Jayne Lucke, 'Legally Coerced Treatment for Drug Using Offenders: Ethical and Policy Issues' (Contemporary Issues in Crime and Justice No 144, Bureau of Crime Statistics and Research, 2010) 8.
- 115 Stevens, above n 111, 11. The aims of treatment of drug dependence include the reduction or elimination of illicit drug use, reduction of the health damages associated with drug use and reduction of the harms to society.
- 116 This is a system of compulsory placement in a treatment institution, rather than compulsory treatment itself.
- 117 Stevens, above n 111, fn 23.
- 118 Dan Werb et al, 'The Effectiveness of Compulsory Drug Treatment: A Systematic Review' (2016) 28 *International Journal of Drug Policy* 1, 1.

3. *Rehabilitation and mandatory treatment for drug and alcohol users in the criminal justice system*

In Tasmania and other jurisdictions (in Australia and internationally), there has been a move towards a focus on offender rehabilitation as a means of reducing reoffending and improving community safety.

This chapter sets out the framework for rehabilitation programs for drug and alcohol users in the criminal justice system (from voluntary to mandatory approaches). It provides an overview of the rehabilitation programs that are available for drug and alcohol treatment of offenders in Tasmania, which includes the following options:

- treatment in custody;
- treatment as a condition of release from prison on parole;
- treatment as part of a drug treatment order which involves a prison sentence held in abeyance; and
- treatment pursuant to a community order.

3.1 CUSTODIAL REHABILITATION PROGRAMS

Custodial drug and alcohol rehabilitation programs for offenders are provided in all Australian jurisdictions as well as comparable overseas jurisdictions (New Zealand, Canada and England and Wales).¹¹⁹ There are also prison-based programs in many states in the United States and other countries.¹²⁰

In relation to custody-based treatment programs before release, participation in such treatment programs is generally subject to some degree of coercion.¹²¹ Coercion to participate in a prison-based rehabilitation programs can be understood as involving several different options associated with increased legal pressure placed on an offender ranging from consensual 'voluntary' participation, where failure to participate is relevant to release on parole, through to mandatory treatment where a prisoner is compelled to attend treatment by a court order or legislative direction. There are limits to the degree of legal coercion in relation to the requirement to attend psychological or rehabilitative treatment. Even if an offender is directed to attend without their consent, this would only entail an increased level of pressure but it would not guarantee participation or co-operation:

In psychological rehabilitation programmes ... the offender cannot be physically compelled to attend a treatment session, or even if he or she does attend, to participate fully. Directly coerced psychological or rehabilitative treatment in this absolute sense is virtually impossible.¹²²

119 See Heseltine, Day and Sarre, above n 95, 28–9; Correctional Services Canada, *National Substance Abuse Program* <<http://www.csc-scc.gc.ca/correctional-process/002001-2009-eng.shtml>>; UK, *Offender Behaviour Programmes* <<https://www.justice.gov.uk/offenders/before-after-release/obp>> (UK); Information provided by Julie Miller, Department of Corrections, New Zealand, letter 18 October 2016 (NZ).

120 See Steven Belenko, Matthew Hiller and Leah Hamilton, 'Treating Substance Use Disorders in the Criminal Justice System' (2013) *Current Psychiatry Report* 1.

121 It is acknowledged that social pressure (from friends or family) may influence an offender's decision to take part in treatment, see Day, Tucker and Howells, above n 108, 260.

122 *Ibid* 260.

If the treatment entails rehabilitation rather than medication, it must be recognised that it is impossible to force an individual to fully engage in psychotherapeutic treatment.¹²³ Further, 'offenders can only be engaged to change; they cannot be forced to change (with or without a compulsory treatment law).'¹²⁴

Consideration also needs to be given to how the negative consequences that attach to a failure to attend a mandatory treatment program could differ in a practical sense from the legal pressures that are placed on an offender to voluntarily attend a rehabilitation program. In the criminal justice context, coerced treatment creates significant ethical concerns, creates tensions between the legal system and treatment providers and raises practical questions about the effectiveness of compulsory treatment.¹²⁵

Compulsory treatment is viewed as either using the judicial role appropriately with sanctions and rewards to retain participants and increase treatment efficacy or as forcing treatment upon involuntary participants, overriding due process, and providing unsolicited and ineffective treatment.¹²⁶

These issues are considered further at [4.1] below.

3.1.1 VOLUNTARY PARTICIPATION WITH CONSEQUENCES FOR FAILURE TO PARTICIPATE

In Australia, participation in all but one of the custody-based alcohol and drug rehabilitation programs for adult offenders is voluntary in the sense that an offender must consent to participate in the program and may decline to do so.¹²⁷ However, there are negative consequences for an offender arising from the operation of the parole system for a failure to participate, which provides a powerful incentive for participation in relevant treatment in prison. This is the current situation in Tasmania.

In Tasmania, while it is not mandatory to participate in any of the programs offered at Risdon Prison, an offender's participation in appropriate rehabilitation programs is relevant to the Parole Board's decision to release an offender on parole. Unlike recent changes that have been made to the *Corrections Act 1997* (Tas), that specifically direct the Parole Board to have regard to an offender's participation in a sex offender treatment program as a relevant factor for the grant of parole,¹²⁸ the statutory criteria for release on parole do not list refusal to participate in treatment as a relevant factor for other offenders. However, the current legislation still provides a framework of legal coercion that encourages an offender to take part in relevant treatment while in prison. The *Corrections Act 1997* (Tas) directs the Parole Board to have regard to the likelihood of an offender reoffending and the rehabilitation of the prisoner.¹²⁹ Participation in treatment would be relevant to this assessment. Further, the Board is also directed to consider any reports tendered to the Board.¹³⁰

The *Sentencing Act 1997* (Tas) does not confer the power to a court to order an offender to participate in a program whilst in prison and there is no power at common law for a sentencing judge to enforce a recommendation that an offender receive treatment while in prison.¹³¹ Previously, under the *Alcohol and Drug Dependency Act 1968* (Tas), there was provision for a person to be transferred from custody under sentence to a treatment centre at the direction of the Attorney-General, if the Attorney-General was satisfied on the written report of a medical practitioner that the person was suffering from alcohol or drug dependency.¹³² However, this provision was repealed with the introduction of the *Sentencing Act 1997* (Tas) and this power no longer exists.

As with Tasmania, in South Australia, none of the programs offered by the Department of Corrective Services is mandatory but the Parole Board often refuses the application of prisoners who have not engaged in programs

123 Astrid Birgden, 'A Compulsory Drug Treatment Program for Offenders in Australia: Therapeutic Jurisprudence Implications' (2008) 30 *Thomas Jefferson Law Review* 367, 378; Alex Stevens, 'Editorial: On Coercion' (2005) *International Journal of Drug Policy* 207, 208.

124 Astrid Birgden and Luke Grant, 'Establishing a Compulsory Drug Treatment Prison: Therapeutic Policy, Principles, and Practices in Addressing Offender Rights and Rehabilitation' (2010) 33 *International Journal of Law and Psychiatry* 341, 348.

125 Birgden, above n 123, 378.

126 Ibid.

127 The exception is New South Wales, as discussed at [3.1.3].

128 See TSAC, above n 1.

129 *Corrections Act 1997* (Tas) ss 72(4)(a), (c).

130 Ibid s 72(4)(k).

131 Richard Fox, 'The Compulsion of Voluntary Treatment in Sentencing' (1992) 16 *Criminal Law Journal* 37, 37.

132 *Alcohol and Drug Dependency Act 1968* (Tas) s 37(1)(a) as repealed by *Sentencing Act 1997* (Tas) Sched 1.

for which they have been found suitable.¹³³ From the perspective of the Department of Corrective Services, the advantages of the participation in a program from the point of view of prisoners is that they: (1) receive rehabilitation in order to reduce the risk of reoffending and improve future life opportunities; and (2) allow progression through their sentence plan, which includes access to additional rehabilitation, lower security ratings and associated environments and community reintegration options including parole.¹³⁴

Voluntary participation in alcohol and drug treatment with consequences for failure to participate is also the situation in Victoria, where participation in alcohol and drug treatment may be required for parole eligibility.¹³⁵ The Parole Manual states that the extent to which substance abuse is related to the person's offending and the extent to which the prisoner has engaged in treatment is relevant to release on parole.¹³⁶ The Parole Board also takes into account the offender's participation in the program. If an offender is a serious violent or sexual offender, they will generally not be released on parole without completing the programs that they have been assessed as requiring. In addition, '[g]eneral offenders with a moderate or high-risk of reoffending may also not have their parole granted without completing the required treatment programs'.¹³⁷ This includes an assessment of an offender's engagement in the program and if the offender's participation was 'poor, disengaged or present[ed] behaviour requiring significantly more treatment to reduce the risk of reoffending', then the offender may not be granted parole.¹³⁸ If an offender assessed as requiring treatment has not been able to do the required program in prison before their parole eligibility date, the Board would only considering releasing the offender 'if there were significant factors to mitigate the risk to the community'.¹³⁹

This also reflects the position in the Northern Territory, where the Parole Manual specifies that the rehabilitation courses undertaken by an offender are relevant to an offender's release on parole:

Unless there are exceptional circumstances, prisoners participating in a rehabilitation program to address offending behaviour should not be released on parole until the program is completed. Although specific programs may have been recommended by the sentencing Judge/Magistrate, some prisoners may not be assessed and waitlisted in time to complete the required programs prior to their parole eligibility date. On some occasions, such prisoners may be considered suitable to access the necessary interventions in the community if released to parole.¹⁴⁰

In Queensland, there is a system of court ordered parole as well as parole granted by the parole board.¹⁴¹ If parole is a matter for the Parole Board, the Parole Board is directed by Ministerial Guideline to take account of the recommended rehabilitation programs for the prisoner and the offender's progress in addressing those recommendations.¹⁴² Similarly, an offender's participation and performance in programs are relevant to release on parole in Western Australia¹⁴³ and New South Wales,¹⁴⁴ and an offender's participation in activities (which includes treatment activities and programs) is relevant in the Australian Capital Territory.¹⁴⁵

Accordingly, in Australia, while participation in rehabilitation programs is generally not mandatory or compulsory, refusal to participate may have adverse consequences for an offender (by reasons of mechanisms such as parole) and accordingly, treatment may be understood to be coerced or 'quasi-mandatory'.¹⁴⁶

133 Information provided by Gene Mercer, email 20 September 2016. It was noted that very few prisoner refuse to engage in rehabilitation programs.

134 Ibid.

135 Victorian Ombudsman, *Investigation into the Rehabilitation and Reintegration of Prisoners in Victoria* (2015) 59.

136 Adult Parole Board of Victoria, *Parole Manual* (5th ed, 2015) 18.

137 Ibid.

138 Ibid.

139 Ibid 14.

140 Parole Board of the Northern Territory, *Policy and Procedures Manual*, 35.

141 See Walter Sofronoff, *Queensland Parole System Review*, Final Report (2016).

142 Ministerial Guideline to the Queensland Parole Board, *Parole Orders* (2015) 3.

143 *Sentences Administration Act 2003* (WA) ss 5A(f), (g).

144 *Crimes (Administration of Sentences) Act 1999* (NSW) ss 135(2)(h), 135A.

145 *Crimes (Sentence Administration) Act 2005* (ACT) s 120(h).

146 See Birgden, above n 123; Stevens, above n 123; Day, Tucker and Howells, above n 108.

3.1.2 VOLUNTARY PARTICIPATION BUT PARTICIPATION MANDATED AS A REQUIREMENT FOR PAROLE

An increased level of coercion would be to legislatively provide that, while an offender needs to consent to participate in treatment, an offender who is assessed as having alcohol and/or drug issues and in need of treatment is not eligible for release on parole unless the offender has satisfactorily taken part in a suitable rehabilitation program. Although participation in programs is relevant to release on parole and may be required by the parole board (as discussed above), in Australia, legislation does not prescribe that release on parole is contingent on having completed a program. This occurs in some overseas jurisdictions in relation to sex offender treatment programs.¹⁴⁷ However, the Council has not been able to identify jurisdictions that use this approach in relation to alcohol and drug treatment. Instead, the Council has found literature that has highlighted that only a minority of offenders who could benefit from treatment receive such treatment in prison.¹⁴⁸

3.1.3 MANDATORY PARTICIPATION

An additional level of coercion would be to require mandatory rehabilitation for drug and alcohol use for suitable offenders sentenced to a term of imprisonment. Outside the strict criteria for coerced psychiatric treatment under the *Mental Health Act 2013* (Tas), where prisoners with acute mental health illnesses who require specialised mental health inpatient treatment can be transferred to the Secure Mental Health Unit as a forensic patient,¹⁴⁹ there are no provisions for mandatory treatment to be administered to prisoners in Tasmania and an offender's consent would be required for medical or psychological treatment.

Mandatory prison-based treatment is rare internationally, and, as noted, most other existing adult drug and alcohol treatment programs in Australia, England and Wales, Canada and New Zealand are all voluntary albeit with negative consequences attached to failure to attend.¹⁵⁰ The exception is in New South Wales, where a court can compel repeat drug-related offenders to receive drug treatment in prison as part of a sentence. The New South Wales approach was based on a program developed in the Netherlands.¹⁵¹ This applies in relation to those drug offenders who have a Compulsory Drug Treatment Program order made, which is a specialist drug treatment order targeted at repeat drug-related offenders and does not apply to all drug offenders.¹⁵² Under the *Drug Court Act 1998* (NSW) s 5A, a person is eligible if:

- convicted of an offence other than murder, manslaughter, attempted murder, sexual assault of adults or children or any sexual offence involving a child, an offence involving the violent use of a firearm, certain offences involving commercial quantities or large commercial quantities of prohibited plants or drugs;
- sentenced to imprisonment for an offence to be served by full-time detention and the non-parole period was at least 18 months and the total sentence was not more than six years;
- the person has a long-term dependency on the use of drugs; and
- the facts of the offence, together with the person's history indicate that offence is related to the person's long-term drug dependency and associated lifestyle.

147 TSAC, above n 1, 4.

148 Chandler, Flectner and Volkow, above n 103, 183; David Olson and Arthur Lurigio, 'The Long-Term Effects of Prison-Based Drug Treatment and Aftercare Services on Recidivism' (2014) 53 *Journal of Offender Rehabilitation* 600, 601. See further [4.1].

149 See *Corrections Act 1997* (Tas) s 36A; *Mental Health Act 2013* (Tas) s 87. See also Department of Health and Human Services, *Wilfred Lopes Centre*, <http://www.dhhs.tas.gov.au/mentalhealth/mhs_tas/gvt_mhs/forensic_mental_health_service/wilfred_lopes_centre>. There is also a limited power for a prisoner to be force fed in circumstances where the failure to eat food is endangering the life or health of the prisoner, *Corrections Regulations 2008* (Tas) reg 9(1).

150 A review of the New South Wales Compulsory Drug Treatment Program reported that there were two known prison-based legally coerced drug treatment programs and these operated in the Netherlands and in Hong Kong: see Joula Dekker, Kate O'Brien and Nadine Smith, *An Evaluation of the Compulsory Drug Treatment Program (CDTP)* (NSW Bureau of Crime Statistics and Research, 2010) 6. A 2016 study by Werb et al, above n 118, referred to a mandatory prison-based addiction treatment program that operated in Taiwan. It also referred to compulsory inpatient treatment or drug detention in China, the United States, Sweden and Thailand. A study by Israelsson and Gerdner reported that 45 out of 90 countries had compulsory commitment to care under the criminal law with this being more prevalent in South America and Africa and less often in Oceania and Europe: see Israelsson and Gerdner, above n 5, 124. This study reported the legal situation up to 1999.

151 Dekker, O'Brien and Smith, above n 150, 6. It is noted that the Dutch program has been changed so that it has been integrated into another program that targets a wider variety of systematic offences by including people who are not drug-dependent, females and offenders with psychiatric problems: at 7.

152 The Compulsory Drug Treatment Order is different from the Drug Court Program, which is a semi-coercive program that does not involve treatment in custody. However, the Drug Court Program may require a participant to enter a residential rehabilitation centre.

In addition, the person must be male, aged 18 or older and the court can only make an order in relation to a person if they usually reside in a limited number of local government areas.¹⁵³ A person is not eligible if the person suffers from a mental condition, illness or disorder that is serious or leads to the person being violent and the mental condition could prevent or restrict the person's active participation in a drug treatment program.¹⁵⁴

Under the *Drug Court Act 1998* (NSW), a court has an obligation to refer an offender who may be eligible to the Drug Court for a determination of whether the person should be made subject to a compulsory drug treatment order.¹⁵⁵ Once an offender is found to be eligible, they are assessed for suitability. This assessment is conducted by a multidisciplinary team and includes information regarding the offender's drug treatment history, history of violent offences in the community and violent acts in person, the likelihood of committing a domestic violence offence in the final stage of the program, their level of motivation and attitude toward compulsory drug treatment and whether the defendant may harm the program or any other person's participation in the program.¹⁵⁶

If an order is made, the order is said to be compulsory because neither the offender nor the Crown can appeal against the making of the order.¹⁵⁷ The personal treatment plan is developed by a multidisciplinary team in collaboration with the offender. It imposes conditions for treatment and rehabilitation, sets out the rewards for meeting the conditions and identifies areas of dynamic risk and wellbeing needs.¹⁵⁸ An offender must comply with the compulsory drug treatment personal plan.¹⁵⁹ This is necessary to progress from one stage to the next. There are also sanctions for non-compliance, which include more intensive supervision, increased case management, regression to a prior stage or revocation of the order and removal from the program.¹⁶⁰

Treatment is provided in the Compulsory Drug Treatment Correctional Centre, which is a small, purpose built, stand-alone prison, subject to judicial oversight from the Drug Court. There are three phases to the program:

- **Stage 1** – closed detention where the offender is kept in full-time custody at the Compulsory Drug Treatment Correctional Centre for a minimum of six months;
- **Stage 2** – semi-open detention where the offender is kept in the Compulsory Drug Treatment Correctional Centre and may be allowed to attend employment, training or social programs in the community for a minimum of six months; and
- **Stage 3** – community custody, where the offender resides in the community under intensive supervision. The Drug Court determines release on parole.

This means that an offender could be living in the community after 12 months rather than the alternative of serving the 18 months or longer non-parole period in prison. In this way, the program has been designed so that the 'benefits of treatment outweigh the costs of non-participation'.¹⁶¹ The 'powerful incentive of accelerated community reintegration under supervision prior to the expiry of the non-parole period' also counters the potential anti-therapeutic effect of the mandatory nature of the order.¹⁶² In fact, research suggests that despite its mandatory nature, 'few participants see themselves as being compelled to participate'.¹⁶³ An evaluation conducted by the NSW Bureau of Crime Statistics and Research found that '80 of the 95 participants (84%) perceived their admission to the Program as *voluntary* and any negative affective reactions decreased significantly between sentencing and the baseline interview and then maintained itself throughout the Program'.¹⁶⁴

153 *Drug Court Regulations 2015* (NSW) cl 5. These areas are: Ashfield, City of Auburn, Bankstown City, Blacktown City, Botany Bay City, Burwood, Camden, Campbelltown City, Canada Bay, Canterbury City, Fairfield City, Hawkesbury City, Holroyd City, Hornsby, Hunter's Hill, Hurstville City, City of Kogarah, Ku-ring-gai, Lane Cove, Leichhardt, Liverpool City, Manly, Murrumbidgee, Mosman, North Sydney, Parramatta City, Penrith City, Pittwater, Randwick City, Rockdale City, Ryde City, Strathfield, Sutherland Shire, City of Sydney, The Hills Shire, Warringah, Waverley, Willoughby City, Woollahra.

154 *Drug Court Act 1998* (NSW) s 5A(3).

155 Section 18B.

156 Dekker, O'Brien and Smith, above n 150, 3.

157 *Drug Court Act 1998* (NSW) s 18D(4).

158 Dekker, O'Brien and Smith, above n 150, 3.

159 *Crimes (Administration of Sentences) Act 1999* (NSW) s 106C.

160 Dekker, O'Brien and Smith, above n 150, 3.

161 Birgden, above n 123.

162 Birgden and Grant, above n 124, 344.

163 Hall and Lucke, above n 114, 8 citing Dekker, O'Brien and Smith, above n 150.

164 Birgden and Grant, above n 124, 344. This reflects the reality that coercion has both an objective quality (the pressure that is applied) as well as a subjective quality (the perception of the person who is subject to the pressure), see Bruce Winick, 'A Therapeutic Jurisprudence Approach to Dealing with Coercion in the Mental Health System' (2008) 15 *Psychiatry, Psychology and Law* 25, 28.

Although the order is mandatory, an offender may choose not to comply with the order and this may result in the offender being ordered to regress to a previous stage in the Compulsory Drug Treatment Correctional Centre or having the order revoked.¹⁶⁵ If the order is revoked, the consequence for the offender 'simply means that they return to the conditions of ordinary imprisonment'.¹⁶⁶ In reality, then, the offender has a choice (albeit constrained) about whether to take part in treatment because the compulsory nature of the order only means that the offender will be housed in the Compulsory Drug Treatment Correctional Centre. As discussed above, while an offender can be actively encouraged to participate in treatment, he or she cannot be compelled against their will to actually take part or to satisfactorily take part in treatment.

3.1.4 CUSTODIAL PROGRAMS IN TASMANIA

In Tasmania, there are several rehabilitation programs delivered by the Intervention Programs Unit (IPU) to inmates of the Tasmanian Prison Service based on their criminogenic need, or, in other words, 'behaviours that contribute to their offending behaviour'.¹⁶⁷

The IPU has two alcohol/drug counsellors who provide individual trauma informed in-depth counselling and brief interventions. There are also 11 program facilitators who deliver programs to prisons in group settings. The following programs offered by the IPU unit are relevant to offenders whose use of alcohol and/or drugs contributed to their offending behaviour:

- **EQUIPS program.** This has a 20-session foundation program with offenders being referred on to the offence specific programs depending on need, including EQUIPS Addiction. EQUIPS Foundation runs over 10–12 weeks and is usually completed prior to Equips Addiction. EQUIPS Addiction also runs over 10–12 weeks and is targeted to address addictive behaviour. In 2016, this program replaced 'Getting SMART', which was a low to medium intensity drug and alcohol program.
- **Pathways program.**¹⁶⁸ This is high intensity program that is delivered in three phases over 120 hours, completed as a closed group. The phases are: (1) *Challenge to Change* (20 sessions) which is aimed at increasing motivation for change and providing information on the benefits to change, the role of thought and behaviour in change and the connections between substance abuse and criminal conduct; (2) *Commitment to Change* (22 sessions) which strengthens basic skills for change and helps participants to learn strategies to change thoughts and behaviour that contribute to substance abuse and criminal conduct; (3) *Ownership of Change* (8 sessions) which encourages healthy living and lifestyle balance.

There are a number of ways in which an inmate can be referred to a program. Tier 1, 2 or 3 assessments including the Level of Service/Case Management Inventory (LS/CMI) and Therapeutic Service Unit based assessments result may result in referrals to the IPU.¹⁶⁹ Custodial officers may refer inmates and inmates are able to request a program.¹⁷⁰

165 The grounds for revoking the order were:
 (a) if (i) the offender has failed to comply with a condition of the offender's compulsory drug treatment personal plan; and (ii) that failure is of a serious nature; and (iii) in the opinion of the Drug Court, the offender: (A) is unlikely to make any further progress in the offender's compulsory drug treatment program, or (B) poses an unacceptable risk to the community of reoffending, or (C) poses a significant risk of harming others or himself or herself; or
 (b) if the non-parole period for the offender's sentence has expired or is about to expire and the offender is serving his or her sentence in closed detention (Stage 1) or semi-open detention (Stage 2); or
 (c) if the offender ceases to be an eligible convicted offender; or
 (d) if, in the opinion of the Drug Court (having regard to advice provided by the Director and the offender's progress in the compulsory drug treatment program), the offender is unlikely to make any further progress in the offender's compulsory drug treatment program; or
 (e) for any other reason the Drug Court sees fit, (*Crimes (Administration of Sentences) Act 1999* (NSW) s 106Q(1)).

166 Hall and Lucke, above n 114, 8.

167 Department of Justice, *Intervention Programs Unit* (nd).

168 It is noted that this program was developed by Kenneth Wanberg and Harvey Milkman, *Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change* (Sage Publications, 2nd ed, 2006).

169 A Tier 1 assessment is preliminary assessment and is intended to occur no later than 48 hours after admission into prison. A Tier 2 assessment is a more detailed assessment that involves assessing an offender's interest in participating in a program. As of 2017, there is a move to have this assessment done at the Hobart Reception Prison. A Tier 3 assessment is a more detailed assessment that involves administering the LS/CMI to determine criminogenic need as the basis of developing a sentence plan. This is done for offenders sentenced to more than six months' imprisonment.

170 Department of Justice, *Intervention Programs Unit* (nd).

All inmates are eligible for introductory programs. This includes offenders on remand. However, sentenced inmates are given preference. Eligibility requirements for high intensity programs mean that inmates who are unconvicted or are appealing their convictions are not eligible.

Programs are generally delivered in a group setting. However, individual program support may be provided where an inmate is housed in areas that do not cater for group-based activities or where there are significant developmental/behavioural issues.

Programs are mainly focused on the Risdon Prison Complex (Medium Security) and the Mary Hutchinson Women's Prison on the basis of available resources and 'the need to target to the greatest need'.¹⁷¹ Group programs are not run in Maximum Security; however, these offenders may be offered individual counselling.¹⁷²

There is also drug and alcohol treatment provided by external service providers such as Holyoake, which provides additional group-based treatment to prisons in the minimum security prison and the Salvation Army's X-Cell program, which provides individual alcohol and drug treatment throughout the prison.¹⁷³ Holyoake indicated that, in its experience, in addition to program model and staff skills, one of the key factors contributing to positive client outcomes in the Holyoake prison program is that offenders are consciously treated with respect.¹⁷⁴

In addition, the Pathways program is run in the Apsley Alcohol and Drug Treatment Unit. This unit was opened in 2015. It is a ten-bed facility located within maximum security. It provides accommodation for the specialist Alcohol, Tobacco and other Drugs Intervention Unit, which offers a minimum of a 12-week full time program that includes the Pathways Program and other activities, education and external service speakers. It is aimed at offenders who are highly motivated to give up drugs, who have tried other programs in the past and who have struggled with drug abuse for a long time.¹⁷⁵ An offender is eligible if they:

- want to stop using drugs;
- have been sentenced and are serving at least six months' imprisonment;
- are not under appeal;
- have recent stable behaviour but can be any prison classification;
- not using illicit drug replacement medicine;
- agree to the ADTU rules;
- commit to staying in the unit for a minimum of 12 weeks;
- have final approval from a selection panel who consider matters such as medical issues, behaviour and safety concerns.

In the last two years, there have been 113 offenders who have been assessed as being in need of drug and/or alcohol treatment.¹⁷⁶ Of these offenders assessed as in need of treatment, 70 have commenced treatment. This includes EQUIPS Addition, Alcohol and other Drug Counselling, participation in the Apsley Unit and the Holyoake program (Gottawanna). As at 22 March 2017, 49 prisoners had completed treatment and 20 were currently undertaking treatment. There are 43 offenders who have been assessed as in need of treatment who are currently on the waiting list for programs. There are 19 prisoners currently on the waiting list for the Alcohol and Drug Treatment Unit who have not been assessed by an AOD Counsellor and five prisoners who are currently on the waiting list who have been assessed by an AOD Counsellor. Overall, in this period, 359 prisoners have participated in drug and alcohol treatment: 70 were referred by Planning and Reintegration and Therapeutic Services, four referred by health or through disciplinary action, 97 self-referred and 188 were signed up by program facilitators.¹⁷⁷ Currently, demand for treatment programs is outstripping the ability of Corrective Services to deliver programs.¹⁷⁸

171 Ibid.

172 Information provided by Erin Hunn, 28 March 2017.

173 Department of Justice, *Annual Report 2015–16* (2016) 30.

174 Submission 5.

175 Tasmania Prison Service, Alcohol Drug Treatment Unit, Brochure.

176 The average daily prison population for the period 2014–15 was 468 and for 2015–16 it was 524.

177 Information provided by Erin Hunn, 28 March 2017.

178 Ibid.

It is noted that the Parole Board has observed that rehabilitation program placement availability has been an issue for applicants for parole, particularly for those subject to shorter sentences of imprisonment.¹⁷⁹ The Parole Board expressed its hope that the new In-house Drug Treatment program would assist with this issue.¹⁸⁰ This highlights the important issue of capacity and resourcing given that if the system cannot provide sufficient programs for those who want to participate, it would be problematic to add to the demand by requiring participation from those who have chosen not to take part in treatment.

3.2 REHABILITATION AS A PAROLE CONDITION

In Australia, legislation provides parole authorities with a broad discretion in relation to the conditions that may attach to a parole order, which means there is provision for a treatment condition to be attached to parole.¹⁸¹ An offender must comply with the parole conditions and, if a parole order is breached, there is discretion for the Parole Board to cancel the parole order and return the offender to prison. This means that the benefit for the offender in complying with the treatment condition is that the offender is able to remain in the community to serve the remainder of the period of the sentence of imprisonment under supervision rather than in prison.

Participating in rehabilitation can be required as a condition of an offender's release on parole in Tasmania. Under the *Corrections Act 1997* (Tas) s 72(5), the Parole Board has a wide discretion to impose conditions on an offender on release and a parole order can be subject to such terms and conditions as the Parole Board considers necessary. The Parole Board has indicated that there are standard conditions (as well as special conditions that may be attached to a parole order) including the requirement to '[a]ttend as directed by the Probation Officer any rehabilitation program nominated by the Probation Officer and not, without the permission of the Probation Officer, be discharged from or do anything to bring about a discharge from that program'.¹⁸² The Parole Board may also impose conditions in relation to the use of drugs and alcohol, testing for substance use, banning an offender from licenced premises and providing for a curfew. All offenders will be subject to a condition that prohibits the use of illicit drugs and an offender may receive an alcohol ban and a ban on attending licenced premises if the use of alcohol formed part of the offending behaviour.¹⁸³ An alcohol ban may be a blanket ban (that is, no alcohol) or it may require an offender not to excessively use alcohol or not go to licenced premises.¹⁸⁴ In addition to requiring that the Probation Officer may direct an offender into assessment treatment, the Parole Board may impose a treatment condition as part of the conditions of parole.¹⁸⁵ An offender must submit to the parole conditions and a failure to comply with the conditions imposed may result in the revocation of parole and an offender's return to prison.

Prisoners are made aware of the relevance of attempts to address the underlying causes of offending as a factor that is relevant to release on parole. The Parole Board offers a parole awareness program to inmates, and as part of this program, offenders are advised about the factors taken into account by the Board in making decisions about parole. In relation to alcohol and drug use, prisoners are directed to consider if their offending was associated with alcohol and drugs and if the prisoner had done anything in prison to address those issues. This has resulted in greater awareness for prisoners about the need to participate in programs.¹⁸⁶ However, an issue that has been identified is the availability of treatment services in the community for prisoners released on parole, including difficulties in accessing residential treatment services directly on release from prison.¹⁸⁷

179 Parole Board of Tasmania, *Annual Report 2014–15* (2015) 5.

180 *Ibid.*

181 *Corrections Act 1986* (Vic) 74(4)(b); *Corrections Regulations 2009* (Vic) reg 83B(b); *Crimes (Administration of Sentences) Act 1999* (NSW) s 128; *Corrective Services Act 2006* (Qld) s 200(2); *Correctional Services Act 1982* (SA) s 68(1aa)(b); *Sentence Administration Act 2003* (WA) s 30(g); *Crimes (Sentence Administration) Act 2005* (ACT) s 136(a)(ii); *Parole Act* (NT) s 5(5)(b); *Corrections Act 1997* (Tas) 72(5).

182 Parole Board, *Annual Report 2014–15* (2015) 25.

183 Information provided by Liz Hawkes, 29 March 2017.

184 *Ibid.*

185 *Ibid.*

186 *Ibid.*

187 *Ibid.*

3.3 DRUG TREATMENT ORDERS

In many jurisdictions, including Tasmania, a key response to the issue of drug-related crimes has been the establishment of drug courts reflecting a therapeutic or problem-oriented approach to offending.¹⁸⁸ This approach differs from the traditional criminal justice system response as it is aimed at addressing the issues that underpin an individual's offending and improving the wellbeing of the offender. The problem-oriented approach recognises the multi-dimensional nature of offending, for example, by accepting that substance abuse is not only a justice problem but also a health problem. Its focus is on identifying what works in reducing and eliminating offending behaviour, while at the same time ensuring offenders take responsibility for their own behaviour.

In relation to drug courts/treatment orders, an offender's consent to take part in treatment is generally required, and in this sense participation is voluntary. However, there are legal pressures that operate on an offender that may influence his or her decision to consent to the order (and the associated treatment) given that the offender receives a sentence of imprisonment that is unactivated or held in abeyance on the proviso that the offender comply with the order. In other words, there is a choice between taking part in treatment in the community or serving a sentence of imprisonment. Once an offender has originally consented to the order, the offender is compelled to comply with the treatment conditions and is in breach of the order if he or she fails to do so.

In Tasmania, a court can impose treatment requirements for adult offenders by the use of drug treatment order (DTO) under the *Sentencing Act 1997* (Tas) Part 3A. This order is available to offenders sentenced in the Supreme Court and the Magistrates Court and is aimed at addressing the cycle of drugs and crime for offenders with substance abuse issues.¹⁸⁹ There are four explicit purposes of a DTO: (1) to provide an alternative sanction to imprisonment;¹⁹⁰ (2) through treatment, to facilitate the offender's rehabilitation and reintegration into the community; (3) to reduce the incentive for the offender to resort to criminal activity; and (4) to reduce risks to the offender's health and well-being.¹⁹¹

As with other drug court models, a DTO is not mandatory because it requires the consent of the offender to the making of the order and to compliance with the order. However, treatment is legally coerced because the offender is sentenced to a term of imprisonment that is not activated on condition that the offender complies with the DTO. The court has broad powers on breach of a DTO, including requiring that the offender serve all or a portion of the unactivated sentence.¹⁹² This means that once an offender has agreed to the making of a DTO, the offender must comply with the requirements of the order and there are consequences (including the possibility of being required to serve the sentence of imprisonment) for non-compliance.

A DTO has two components: (1) a custodial part; and (2) a treatment and supervision part. The court imposes on the offender the sentence of imprisonment it would have imposed were it not making the order, but the offender is not required to serve the custodial component of the order unless it is activated by contravention of the order.¹⁹³ A maximum period for a custodial sentence attached to a DTO is not prescribed in the *Sentencing Act 1997* (Tas).¹⁹⁴ Similarly, there is no set period provided for the length of the treatment and supervision component of the order.¹⁹⁵ The *Sentencing Act 1997* (Tas) s 27R(2) provides that if the order is not cancelled within a two-year period, then the court must review the treatment and supervision part of the order to determine whether, notwithstanding any

188 In Australia, there are drug courts in New South Wales, Victoria, South Australia and Western Australia. Drug courts also exist in New Zealand, Canada and the United Kingdom. In the United States, in 2015, it was estimated that there were over 3000 drug courts, see National Institute of Justice, *Drug Courts*, <<https://www.nij.gov/topics/courts/drug-courts/Pages/welcome.aspx>>. Sentences that allow a court to order an offender to enter treatment instead of imprisonment also exist in Austria, Germany and Switzerland: see Alex Stevens et al, above n 112, 198.

189 *Sentencing Act 1997* (Tas) s 7(ab) inserted by the *Sentencing Amendment Act 2016* (Tas). This sentencing option was introduced in the Magistrates Court in 2007 and has recently been extended to the offenders sentenced in the Supreme Court.

190 It is noted that this is not reflected in the operation of the DTO as the custodial part of the DTO requires a sentence of imprisonment to be imposed. Accordingly, a DTO is not a true alternative sanction to imprisonment but is another way of serving a prison sentence.

191 *Sentencing Act 1997* (Tas) s 27C.

192 *Ibid* s 27M(1).

193 *Ibid* s 27F.

194 TSAC, *Phasing Out of Suspended Sentences* (Final Report No 6, 2016) 47. This contrasts with the DTO in Victoria, where the custodial part of the sentence is no longer than two years, *Sentencing Act 1991* (Vic) s 18ZD. The review of drug courts in Queensland recommended that the court be allowed to impose a sentence of up to four years' imprisonment: Freiberg et al, above n 53, Recommendation 21.1.

195 This also contrasts with the DTO in Victoria where the DTO operates for two years unless it is cancelled earlier (*Sentencing Act 1991* (Vic) s 18XC(2)(b)) and the model for a drug court proposed in Queensland, where the treatment and supervision part operates for two years: Freiberg et al, above n 53, Recommendation 21.1.

other provision of the Part, it should continue.¹⁹⁶ The *Sentencing Act 1997* (Tas) s 27R(4) also provides that on the completion of the review, the court must cancel the treatment and supervision part of the order and either make an order activating some or all of the custodial part of the order or cancel the order and resentence the offender (other than by making a CMD order).¹⁹⁷ There has been uncertainty about the interaction of these provisions and no universally accepted interpretation in the Magistrates Court. Most magistrates interpreted the provisions to mean that, if an offender has not graduated, they must cancel the order at the second anniversary review. However, a small number of magistrates interpreted the provisions to mean that there is power to continue the order beyond the two-year review and have adopted the approach that the review has not been finalised until the expiration of any extension of the order.¹⁹⁸

Following the DTO being made available as a sentencing option in the Supreme Court, there has been consideration of the interaction of these provisions as well as the length of imprisonment that may be imposed as part of a DTO. In *Tasmania v Joseph*,¹⁹⁹ Brett J observed that:

in an unusually worded provision, it would seem that having conducted the review, the only option available to either the Supreme Court or Magistrates Court is to cancel the treatment and supervision part of the order and exercise the courts' power under s 27Q(2). This effectively requires the court to either activate some or all of the custodial part of the order, or resentence the offender in a manner other than the imposition of a sentence of imprisonment. The intention would seem to be to bring the order to an end.²⁰⁰

This interpretation accords with the approach of the majority of magistrates and limits the treatment and supervision component of the order to two years. Further, in view of the provisions in relation to the cancellation reward operating within the two-year period,²⁰¹ his Honour considered that 'it would, in most circumstances, be inappropriate to make a drug treatment order if the custodial component will exceed two years'.²⁰²

There are core and program conditions that attach to a DTO. There are a number of core conditions that relate to an offender not committing imprisonable offences as well as the supervision and reporting requirements of an offender. In addition, a core condition exists in relation to the requirement that the offender undergo treatment for the offender's illicit drug use problem as is specified in the order or from time to time as specified by the court.²⁰³ In addition, the court must add at least one of the following program conditions to the treatment and supervision part of the order:

- submit to drug testing, as specified in the order;
- submit to detoxification or other treatment, whether or not residential in nature, as specified in the order;
- attend vocational, educational, employment, rehabilitation or other programs specified in the order;
- submit to medical, psychiatric or psychological treatment specified in the order;
- must not associate with persons or classes of persons specified in the order;
- must reside at such place, and for such period, as is specified in the order;
- must do or not do anything else that the court considers necessary or appropriate concerning the offender's illicit drug use or the personal factors that the court considers contributed to the offender's criminal behaviour.

196 *Sentencing Act 1997* (Tas) s 27R.

197 *Ibid* ss 27Q(2), 27R(4).

198 TSAC, above n 194, 47 referring to email from Tristan Bell, Team Leader (South) — Court Mandated Diversion to Rebecca Bradfield, 19 May 2015.

199 [2017] TASSC 23.

200 *Ibid* [32].

201 This relates to the provisions of s 27L that allow a court to cancel a drug treatment order as a reward if the offender has been fully or substantially compliant with the conditions of the order; the continuation of the order is no longer necessary to meet the purposes for which it has been made, and the period of imprisonment that the offender would have had to serve if the order had been fully activated at the time of sentencing has expired. As Brett J observed, 'a cancellation reward is, therefore only available within a period of two years after the making of the order, and, by definition, can only apply if the period of imprisonment imposed, pursuant to the custodial part of the order, has expired': *ibid* [34].

202 *Ibid*.

203 There are additional conditions if the offence is a domestic violence offence, requiring that the offender: must not commit another family violence offence; must comply with any family violence order, interim family violence order or police family violence order; must attend and undergo assessment for, and treatment under, rehabilitation programs as directed by court diversion officers; if directed to undergo any rehabilitation programs, must attend and satisfactorily complete those programs and comply with the reasonable directions of the persons employed or engaged to conduct them: *Sentencing Act 1997* (Tas) s 27G(1).

The court must not attach more program conditions than it considers necessary to achieve the purposes of the order.

There is a range of service providers that may be involved in an offender's treatment and rehabilitation (depending on what is most suitable to address the criminogenic and other needs of the offender). These include the State Alcohol and Drug Service, Housing Tasmania, mental health services, an offender's general practitioner, and providers of counselling, and residential rehabilitation services.

The program had been capped at 80 participants but this was increased to 120 in the current budget.²⁰⁴ The number of offenders fluctuates — as of 17 July 2017, there were 64 offenders participating in the CMD Program and an additional 21 offenders at the assessment stage.²⁰⁵ The offenders ranged in age from 20 to 51 with a median age of 33. Participants on the order were predominately male offenders (86%). There are a range of illicit drugs used by offenders with the principal drug of concern typically being methamphetamine/amphetamine followed by cannabis, opiates and benzodiazepines. There are a significant portion of the participants who are polydrug users, with the majority using cannabis as well as their drug of choice and others using a number of other drugs.²⁰⁶ In the period January 2014 to September 2016, there were 315 assessment reports completed and of these assessments, 185 were assessed as eligible and suitable.²⁰⁷ In total, in 2014–15, 39 offenders were sentenced in the Magistrates Court to a DTO and in 2015–16, there were 66 offenders sentenced.²⁰⁸

3.4 COMMUNITY-BASED TREATMENT

Other Australian jurisdictions and comparable overseas jurisdictions (New Zealand, Canada and England and Wales) also provide community-based drug and alcohol treatment for offenders who are subject to a community-based order.²⁰⁹

3.4.5 VOLUNTARY PARTICIPATION WITH CONSEQUENCES FOR FAILURE TO PARTICIPATE

In some jurisdictions, consent is required to the making of community-based orders that contain treatment conditions. For example, in Victoria, an offender must consent to the initial making of a community correction order, which may contain a treatment and rehabilitation condition.²¹⁰ If an offender does not consent to the initial order or conditions, then the court may impose different conditions or a different order, possibly imprisonment. Further, if the offender breaches the order, the court has the option of cancelling the order and re-sentencing the offender, which may be sentencing the offender to imprisonment.²¹¹ In addition, if the offender contravenes the community correction order, he or she commits an offence punishable by a term of not more than three months' imprisonment.²¹²

204 Guy Barnett, Acting Minister for Corrections, 'Increased Cap for Court Mandated Diversion Program' (Media Release, 7 June 2017).

205 Sharlene Smith, Email to Rebecca Bradfield 18 July 2017.

206 Email from Tristan Bell to Rebecca Bradfield, 29 September 2016.

207 Ibid.

208 Department of Justice, above n 173, 36.

209 See NSW Government, Justice Corrective Services, *Compendium of Offender Behaviour Change Programs in New South Wales* (2016) (NSW); Department of Correctional Services South Australia, *Offender Rehabilitation Programs: Fact Sheet* (SA); Government of Western Australia, Department of Community Corrections, *Rehabilitation Programs* (WA); Corrections Victoria, *Corrections Alcohol and Drug Strategy 2015: Overview* (2015) 12 (Vic); Northern Territory Government, *Community Based Order* <<https://nt.gov.au/law/prisons/community-based-order>> (NT); Information provided by Julie Miller, Department of Corrections, New Zealand, letter 18 October 2016 (NZ); Correctional Services Canada, *Offender Rehabilitation* <<http://www.csc-scc.gc.ca/correctional-process/002001-2000-eng.shtml>>; Justice UK, *Offender Behaviour Programmes* <<https://www.justice.gov.uk/offenders/before-after-release/obp>> (UK).

210 *Sentencing Act 1991* (Vic) ss 37(c), 48D. Under s 37, an offender is required to consent to the CCO generally and under s 48D, the court may attach a treatment condition.

211 *Sentencing Act 1991* (Vic) s 48M.

212 Ibid s 83AD. See TSAC, above n 194, Ch 7 and Appendix B for a summary of conditions that can attach to intermediate sentencing orders and consequences for breach.

3.4.6 MANDATORY TREATMENT

In other jurisdictions, including Tasmania, there are mechanisms by which treatment in the community can be mandated through the use of community-based sentencing orders.

In Tasmania, a court may make a probation order that contains a condition that the offender undergo assessment and treatment for alcohol or drug dependency as directed by a probation officer and/or that the offender must submit to testing for alcohol or drug use as directed by a probation officer.²¹³ Probation can be imposed as an independent stand-alone sentencing order.²¹⁴ Probation can also be used in conjunction with a suspended sentence, either as a condition of a fully or partly suspended sentence²¹⁵ or as a combined sentencing order.²¹⁶ A probation order containing a special condition in relation to assessment and treatment can also be combined with a sentence of full-time imprisonment,²¹⁷ which means that the offender is released to a probation order after the offender has completed the required period in prison.

Probation orders are couched in mandatory terms as there is no express requirement for an offender to consent to the making of the order (as exists in some jurisdictions).²¹⁸ However, an offender's (un)willingness to comply with the requirement for treatment may mean that the order is cancelled or varied or may amount to a breach of the order.²¹⁹ Despite the absence of a specific legislative direction that the offender consent to the order, an offender cannot be compelled to engage in psychological treatment (as discussed above) and an offender may choose not to participate even though this may amount to a breach of the order with the consequence that the offender may be re-sentenced.

In the period 2013–14, the Supreme Court imposed probation orders containing special conditions in relation to assessment and treatment for drug and alcohol dependency in 98 of the 593 cases (16.5%) sentenced under the *Sentencing Act 1997* (Tas).²²⁰ It is noted that in two of these cases, the judge also made an order that the offender comply with the requirements of a DTO made in the Magistrates Court and in an additional case, the judge made an order that the offender comply with the requirements of the DTO (without any additional conditions in relation to drug and alcohol assessment and treatment). Further, in an additional six cases, the judge structured the sentence imposed in the Supreme Court around the requirements of an existing or potential DTO made in the Magistrates Court.

Table 3-1 shows that probation orders containing assessment and treatment conditions were most commonly used in relation to suspended sentences and only rarely did a judge impose a stand-alone probation order that contained a drug and alcohol assessment and treatment condition.

Table 3-1: Use of drug and alcohol assessment and treatment conditions in probation orders by type of order, Supreme Court, Tasmania 2013–14

Sentencing order	No	%
Probation combined with imprisonment	16	16.3
Probation combined with PSS	35	35.7
Probation combined with FSS	41	41.8
Probation	6	6
Total	98	100

Sum does not total due to rounding.

213 *Sentencing Act 1997* (Tas) ss 37(2)(b)–(c).

214 *Ibid* s 7(d).

215 *Ibid* s 24(2)(b).

216 *Ibid* s 8(1).

217 *Ibid* s 8(1)(b).

218 See for example, *Sentencing Act 1991* (Vic).

219 *Sentencing Act 1997* (Tas) s 41(6)(b).

220 This period was examined to provide a sample of sentences imposed in the Supreme Court. It is noted that in Victoria, a treatment and assessment condition was used for 87.9% of community corrections orders imposed in the higher courts between May 2015 and December 2015. In 2015, a treatment and assessment condition was imposed for 74.3% of community correction orders in the Magistrates Court: VSAC, *Community Correction Orders: Third Monitoring Report (Post-Guideline Judgment)*, (2016) 17, 21. It is not known what proportion of the treatment and assessment conditions related to drug and alcohol use.

Table 3-2 indicates the broad range of crime types where the Supreme Court imposed a probation order with a drug and alcohol assessment and treatment condition.

Table 3-2: Use of probation orders with drug and alcohol assessment and treatment conditions by crime type, Supreme Court 2013–14

Crime type	No	%
Burglary	9	9.2
Property damage (incl arson and unlawfully setting fire to property)	20	20.4
Drug offences	15	15.3
Non-sexual offences against the person	23	23.5
Offences involving fraud or dishonesty	3	3.1
Robbery	23	23.5
Sexual offences	3	3.1
Other	2	2.4

Sum does not total due to rounding.

Another model of mandatory community-based treatment is the requirement that a court must sentence an offender to treatment and the offender's acceptance of the order is not relevant to the making of the order.²²¹ This approach is not commonly adopted.

3.4.7 COMMUNITY-BASED PROGRAMS IN TASMANIA

There are a number of programs that have been run by Community Corrections that address drug and alcohol misuse.²²² Community Corrections previously ran a Getting SMART program that had a drug and alcohol focus. Getting SMART was a cognitive behavioural approach to behavioural change and was designed to help individuals gain independence from addictive behaviours (substances or activities). The program offered specific Cognitive Behaviour Therapy (CBT) tools and techniques for each of the program modules. The four modules of the program concentrated on stages of the change process were as follows:

- Module 1: Enhancing and Maintaining Motivation to Abstain
- Module 2: Coping with Urges
- Module 3: Problem Solving
- Module 4: Lifestyle Balance

The program was designed to target offenders with high level addictive behaviours, specifically in relation to alcohol, illicit drugs (or misuse of prescription drugs) and gambling. Community Corrections targets offenders with AOD abuse issues. Eligibility for the program centred on the Alcohol Use Disorders Identification Test (AUDIT) and Drug Abuse Screen Tool (DAST). A score of 16 or above on the AUDIT, and six or above on the DAST, rendered an offender eligible for the program. Their use of alcohol and/or other drugs also needed to have some impact on their offending behaviour.

221 This exists in Kansas, in the United States, where a judge must sentence non-violent offenders convicted of a first or second offence of drug possession to up to 18 months' community supervision and treatment, if the offender is assessed as high-risk according to a drug abuse assessment and moderate risk or high-risk according to criminal risk-needs assessment: Kansas Statute Article 68, 21-6824. This is discussed in Andres Rengifo and Don Stemen, 'The Impact of Drug Treatment on Recidivism: Do Mandatory Programs Make a Difference? Evidence from Kansas's Senate Bill 123' (2009) 59 *Crime and Delinquency* 930; Patrick Springer, 'Probationary Drug Treatment in Kansas' (2014) 62 *Kansas Law Review* 1365. While an offender can be mandated into treatment, an offender cannot be forced to comply and there are sanctions for non-compliance. If an offender does not comply with the treatment conditions, there are non-prison sanctions including up to 60 days in a county jail, fines, community service, intensified treatment, house arrest and electronic monitoring. Further, the order can be terminated and the underlying sentence imposed.

222 The following information about the programs delivered by Community Corrections was provided by Emily Chase, email 29 March 2017.

The Getting SMART program was not delivered regularly by Community Corrections due to resourcing issues and in 2016 it was abandoned due to the introduction of the EQUIPS suite of programs, including the Addiction Program. In 2015, 14 offenders commenced the program, and nine completed (across two programs). There were difficulties in obtaining referrals for the Getting Smart program, and, as it was not delivered regularly, Probation Officers would often refer offenders to external services, such as the Alcohol and Drug Service, Holyoake or the Salvation Army, to address addictive behaviours. There was never a waitlist as such for Getting SMART as program staff would ask for referrals when they were in a position to deliver the program.

Getting SMART has been phased out and a new suite of programs introduced including the EQUIPS program that has a drug and alcohol component (EQUIPS Addiction). EQUIPS was introduced in Community Corrections in 2016, with program facilitators receiving the necessary training. Program delivery commenced in 2017. EQUIPS Addiction is very similar to Getting SMART in terms of content. The two main changes to the program have been the removal of a significant homework component to address literacy issues and the introduction of tailored self-management plans at the end of each module of the program. The majority of the content is otherwise identical to Getting SMART. EQUIPS Addiction uses the same eligibility criteria as existed for Getting SMART and will target offenders whose offending is linked to their substance abuse issue.

Currently, Community Corrections has two Addiction Programs being delivered in the South. The first program commenced with 11 participants and it was expected that six offenders would graduate from the program (on 2 April 2017) after several participants had been removed: two for non-attendance, one for conflict with another participant (he has been returned to the waitlist) and two due to significant health issues (these participants will be reassessed once their health issues are resolved). The program that commenced on 30 March 2017 had 13 participants. This brought the current waitlist in the South to five offenders. The North commenced an Addiction Program on 5 April 2017 with 14 participants. This left four offenders on the waitlist in the North. The North West commenced an Addiction Program on 8 April 2017 with 12 participants. This left eight on the waitlist in the North West.

The family violence program delivered by Community Corrections also has a drugs and alcohol component. It includes two sessions on substance use. This includes linking substance use to abusive practices and exploring the role of substance use in the participants' specific family violence offending. It comes from a harm minimisation perspective and looks at safety planning around substance use, particularly in relation to contact with partner/victim while using substances (that is, where they choose to use), and how much they choose to use. It also looks briefly at how to stand up to peer pressure around substance use. Offenders may also be referred to individual work with their supervising Probation Officer around decision making and alcohol use. Offenders with significant untreated alcohol or drug abuse issues that may prevent them from fully engaging in the relevant program, can be referred for treatment with an external service prior to engagement in the program.

As indicated, there is no requirement for an offender to consent to take part in the treatment programs offered by Community Corrections. Offenders are usually assessed by a probation officer (usually pre-sentence for a pre-sentence report) and then, if the court imposes a probation order or community service order, the offender is under the supervision of community corrections and is placed on a waiting list for the relevant program. Suitable offenders may also be identified as part of the parole process and are required to participate in treatment as part of the conditions attached to parole. It is also possible to direct an offender to participate in treatment post-sentence if his or her substance abuse was not identified at an earlier stage in the process. Offenders can be directed to engage in treatment regardless of whether they agree to take part. However, when an offender does not want to engage at all, they are very unlikely to successfully complete any treatment program.

Different external services providers have different entry requirements, but, generally, with residential rehabilitation the offender needs to demonstrate a commitment to the program. This means that if the offender was directed into treatment and did not agree to this at all, it is unlikely the service would accept the referral. There are also differences in the treatment provided by external services.

In terms of enforcement of the conditions of an order (either a court order or a parole order), it is easier to enforce engagement with internal programs, such as EQUIPS Addiction. This is because external services will not often chase up non-attendance, and if the offender is not engaging they are more likely to terminate treatment until the offender is ready to engage. Internal programs will reinforce compliance with supervision order conditions as well as program delivery.

There are limitations on the ability of offenders to take part in programs for offenders who receive a short community-based order or only have a relatively short period of parole supervision. The programs offered by Community Corrections are delivered over 10 weeks, and the order needs to allow enough time to wait for a program to become available, as well as 10 weeks to participate in the program. Accordingly, it is recommended that offenders have orders of no less than 12 months in order to be suitable for a program. However, Community Corrections could, if needed, work with a reduced timeframe of no less than eight months. Otherwise, there is a chance the offender could miss the program prior to the expiry of their order. For example, if an offender commenced a six-month order just after a program commenced, they would have to wait for that program to finish (10 weeks) and then the 2–3 week break between programs, and would only be eligible for the next program if the waitlist was not longer than 14 (the absolute maximum number per group). This would make it difficult for the offender to finish the program and there would be no scope for reinforcing the program content through supervision with the Probation Officer once the program was complete.

The Sober Driver Program is another program run by Community Corrections for repeat drink drivers. This is a post-conviction education program, which magistrates may direct offenders to participate in as part of the sentences they impose. There is no explicit statutory basis for the sober driver program. Instead, the program can be imposed as a condition of a suspended sentence or as part of a probation order or a community service order.²²³ Based on the information provided by the Department of Justice, it is an educational and skill based group program that targets adult offenders who are convicted of two or more drink driving offences within a five-year period.²²⁴ The program was developed in NSW and is delivered over a nine-week period, consisting of one two-hour session per week. It is conducted by two trained facilitators and addresses issues associated with drink-driving, including the consequences of drink-driving, the effects of alcohol on driving, managing drinking situations, alternatives to drink-driving and relapse prevention and stress management. A condensed version of the program has also been delivered.²²⁵ The purpose of the program is to assist repeat offenders to separate drinking from driving.²²⁶

The Sober Driver Program requires a minimum of six participants to run, although there have been two programs conducted with five participants.²²⁷ The maximum number of participants is 18. In order to participate, an offender must be both eligible (adult offenders with two or more drink-driving offences in the last five years with sufficient time on their order to complete the program (three months or 22 hours)) and suitable. Suitability is assessed on the basis of factors that will affect participation (a responsiveness assessment procedure) which include employment, available transport to attend sessions, mental health issues and literacy.²²⁸

Community Corrections receives a high number of offender referrals from the Magistrates Court, and there is a high demand for the Sober Driver Program. In 2014 and 2015, 1240 offenders were assessed as being eligible for the Sober Driver Program pre-sentence and 773 were found to be suitable for the program. From its inception until 2014–15, 711 offenders have successfully completed the Sober Driver Program with completion rates increasing from 57% in 2008–9 to 84% in 2014–15.²²⁹

223 *Sentencing Act 1997 (Tas)* ss 24(2), 28(g), 37(2)(a).

224 Department of Justice, Tasmania, *Annual Report 2014–15*, 63–4.

225 *Ibid* 64.

226 Evalynn Mazurski, Daya Withaneachi and Scott Kelly, *The NSW Sober Driver Program: Recidivism Rates and Program and Parameters* (2012).

227 Julie-Anne Toohey, 'Sobering Thoughts: An Examination of Tasmania's Sober Driver Program' (University of Tasmania, Field Project, 2012) 33 <http://papers.ssm.com/sol3/papers.cfm?abstract_id=2080695>.

228 *Ibid*.

229 Tasmania Law Reform Institute (TLRI), *Responding to the Problem of Recidivist Drink Drivers*, Issues Paper No 23 (2017).

4. Expansion of requirements for mandatory treatment for drug and alcohol rehabilitation

This chapter considers the mechanisms that could be used to expand the requirements in custodial and community settings for mandatory treatment for offenders with substance abuse issues in Tasmania. It considers the strengths and weaknesses of these approaches.

4.1 CUSTODIAL TREATMENT

If the government wished to make drug and alcohol treatment mandatory for offenders in prison (rather than voluntary as is the current situation), it would be possible to introduce a **Compulsory Drug Treatment Program Order** (CDTP) (based on the New South Wales approach).

The NSW model is discussed at [3.1.3] and key features of this model include that:

- (1) it operates from a small, purpose built stand-alone prison;
- (2) the management approaches and the use of rewards are designed to maintain a drug-free prison environment (non-contact visits in Stage I, searches, high frequency drug testing and a weekly barbeque if the unit has remained drug and alcohol free);²³⁰
- (3) it only applies to a targeted category of repeat drug offenders;
- (4) it is carefully designed so as not to be anti-therapeutic including the use of a significant incentive for compliance in the form of earlier eligibility for release on parole;
- (5) there is judicial monitoring of offenders in partnership with correctional authorities as well as health and other service providers;²³¹
- (6) there are respectful relationships with staff with staff being 'encouraging and engaging, rather than coercive and punishing ... with the focus on prevention and pro-social modelling rather than detection of rule violations'.²³²

It is important to note that while offenders sentenced to the CDTP order are required to spend their sentence in a dedicated drug treatment prison, the order cannot compel an offender to participate in the program and the offender may have the order revoked and be returned to mainstream prison. In the period 1 August 2006 to 31 July 2009, there were 109 offenders who entered the CDTP and 26 participants were removed from the program (23.9%).²³³ The need to reduce the perception of coercion is also a crucial feature informing the design of the program, so that it 'seek[s] to minimise perceived coercion and maximise both the actuality and perception of voluntariness'.²³⁴ The program is structured to ensure that it is more beneficial for an offender to comply with the order than to not comply and so the motivational strategy counteracts the compulsory nature of the order.²³⁵ As indicated at [3.1.3], this approach has been successful as the majority of participants in the program perceive their admission as voluntary.

230 Birgden and Grant, above n 124, 347. It is noted that as of October 2012, over 35 000 tests had been conducted with only 1.56% returning positive results for illicit drug use: Corrective Services NSW, *Review of the Compulsory Drug Treatment Program and the Compulsory Drug Treatment Correctional Centre pursuant to the Crimes (Administration of Sentences) Act 1999* (2013) 8.

231 Birgden, above n 123.

232 Birgden and Grant, above n 124, 347.

233 Dekker, O'Brien and Smith, above n 150, 21.

234 Winick, above n 164, 29.

235 Birgden, above n 123, 380.

Support for the introduction of a mandatory treatment order (based on the NSW model) is provided by the evaluation of the CDTP, which found that there were significant improvements in offender mental and physical health²³⁶ and that the majority of participants considered that the program would be helpful to them.²³⁷

The introduction of a mandatory treatment order could also be supported on the basis that it allows a sentencing court to direct an offender into treatment who may not be willing to voluntarily commence treatment or remain in treatment. As discussed, the program targets 'people with long-term drug dependence who have committed multiple criminal offences to support their dependence over a long period'.²³⁸ It is aimed at breaking the 'drug-crime' cycle for offenders who have either failed to enter or complete other voluntary or court-based treatment programs.²³⁹ The need for additional coercive legal powers for this groups of offenders was recognised by Judge Dive, Senior Judge of the Drug Court of NSW, who expressed the view that the program should be compulsory because offenders may 'make a poor decision and decline a referral without fully appreciating the benefits the CDTP can provide'.²⁴⁰

However, it has been suggested that the mandatory nature of the NSW program is unnecessary. Hall and Lucke argue that it not necessary for the drug treatment program to be mandatory on the basis that:

First, it is doubtful that the program is compulsory in any meaningful sense. Certainly, few participants see themselves as being compelled to participate. ... By its program entry criteria, its clientele have failed to be deterred from using drugs by spending long periods in prison. A failure to comply with the demands of the CDTCC program simply means that they return to the conditions of ordinary imprisonment. Second, a substantial proportion of participants want to be in the program because it allows the early supervised release from prison of participants who complete the program. Third, the veneer of compulsion adds to the expense of the program by requiring a court hearing and judicial oversight of the assessment and treatment process. It may be simpler and less expensive to offer the treatment program as a voluntary program for recidivist offenders.²⁴¹

An additional ground for making the program voluntary is on the basis that this would recognise the autonomy and dignity of offenders.²⁴² On this basis, Birgden suggested the offender be given a choice before receiving an order but once sentenced to detention at the Compulsory Drug Treatment Correctional Centre (CDTCC) participation in the program of drug treatment and rehabilitation could be made compulsory.²⁴³ This is consistent with the approach adopted in the Tasmanian DTO.

Further, mandatory treatment following the NSW approach would be a costly intervention: the compulsory drug treatment program was initially resourced with funding of \$6 million from 2005 to 2007,²⁴⁴ and the facility was established with a capital cost of \$3.5 million.²⁴⁵ It is housed in a minimum security facility that provides accommodation for 70 participants²⁴⁶ and in four years had not been at 100% capacity.²⁴⁷ Further, the fact that the eligibility criteria are 'aimed to treat recidivist drug dependent offenders who received a long enough sentence to allow for intensive rehabilitation while excluding offenders who had a history of serious drug or violent offences' has the effect that few offenders qualify.²⁴⁸ Accordingly, it has been argued that it is a very expensive approach that 'will only have a minimal impact on overall recidivism and crime in the community even if it has a substantial impact on participants' drug use and recidivism'.²⁴⁹

236 Dekker, O'Brien and Smith, above n 150, viii.

237 Ibid ix.

238 Ibid 1.

239 Birgden, above n 123, 368 quoting the second reading speech.

240 Corrective Services NSW, above n 230, 18.

241 Hall and Lucke, above n 114, 8.

242 Corrective Services NSW, above n 230, 13 reporting Birgden's views.

243 Ibid.

244 Corrective Services NSW, above n 230, 6.

245 Ibid.

246 Ibid.

247 Ibid 54.

248 Hall and Lucke, above n 114.

249 Ibid 7.

The effectiveness of the CTDP in terms of reducing reoffending and reducing long-term drug use has not been considered in published evaluations.²⁵⁰ More generally, research conducted in relation to the effectiveness of treatment tends to support the utility of legal coercion but does not provide an evidence base for compulsory treatment. Accordingly, Werb et al have stated that '[i]n light of the lack of evidence suggesting that compulsory drug treatment is effective, policymakers should seek to implement evidence-based, voluntary treatment modalities in order to reduce the harms of drug use'.²⁵¹ The weakness of the research evidence to support compulsory treatment was also highlighted by Holyoake and the ADS.²⁵² Balanced against this are ethical and human rights concerns about the use of mandatory treatment for offenders with drug and alcohol problems. As Stevens notes, the 'element of constrained choice in quasi-compulsory treatment for drug using offenders is an important difference from compulsory treatment for drug users. The former can be consistent with human rights, whereas compulsory treatment is more likely to breach them'.²⁵³ Similarly, Payne and Morgan have written that, '[i]t is neither ethical nor just to limit the availability of non-treatment pathways in the criminal justice system'.²⁵⁴ This view was reiterated by Holyoake: 'To offer an offender the choice between the normal pathway through the criminal system, or a treatment alternative is generally considered ethical, according to Pritchard et al'.²⁵⁵ In these circumstances, it is doubtful whether there is any benefit in terms of recidivism or reduced drug use in mandating treatment when compared to concerns about the ethics of requiring an offender to submit to mandatory treatment.

In its submission, the WLST gave consideration to the creation of a CDTP, similar to the New South Wales approach. It noted that the NSW model is male-only and does not have a female equivalent. While the WLST conceded that female offenders with long-term drug dependency in Tasmania may benefit from such a compulsory drug treatment program, it considered that there was also 'an argument for the current community-based DTO being more female-friendly, in that it allows women to avoid a custodial term and therefore maintain family ties, care for dependent children and face less social stigma'. On balance, the WLST's position was that a specialist women-only CDTP was not needed in Tasmania and that there was uncertainty about the utility of a CDTP scheme, regardless of the offender's gender. Instead, it was the WLST's view 'that the existing drug treatment framework, mandatory or otherwise, be improved to cater for the specific needs of female offenders that are alcohol and drug affected'.²⁵⁶

The ATDC acknowledged that while there would be some benefits to implementing the CDTP model, it considered that investment would be better spent expanding existing programs within the prison, community corrections and community service organisations. It identified the following concerns in relation to the introduction (or consideration) of a compulsory drug treatment correctional model:

- potentially too restrictive in terms of eligibility criteria which would restrict the client group;
- aimed at long term/serious drug offenders which overlooks the principles of, and policies around putting resources into early intervention and prevention strategies;
- too expensive to establish for the number of people who would benefit;
- potential stigma/discrimination attached to offenders placed in the program.

If a new program was introduced, the ATDC suggested that a pilot program may be an option to evaluate the effectiveness and the outcomes achieved before significant financial investment is made.²⁵⁷

250 Corrective Services NSW, above n 230, 63. It is noted that an Australian Research Council funded evaluation of treatment effectiveness is being finalised as well as a 10-year evaluation report conducted by Corrections Research and Evaluation of Statistics and CDTCC interagency partners: Justice Corrective Services, *Compendium of Offender Behaviour Change Programs in New South Wales (2016)* 34. This research may provide greater clarity in relation to the effectiveness of the mandatory treatment model in terms of reductions in recidivism.

251 Corrective Services NSW, above n 230, 8.

252 Submissions 5 and 8.

253 Stevens, above n 123, 1.

254 Payne and Morgan, above n 86, 50.

255 Submission 5 citing Pritchard, Mugavin and Swan, above n 6.

256 Submission 2.

257 Submission 6.

The ADS also raised concerns about resourcing and effectiveness, expressing concern about 'any change to legislation and/or existing operational programs without the required preparatory work, for example, considering the evidence base related to its objectives and the clinical skills and resources that would be required'.²⁵⁸ It highlighted the need for adequate and appropriate supports services to be in place prior to any legislative change. Holyoake raised concerns about the cost of developing a separate facility and the ongoing costs of developing a model similar to the New South Wales CDTP. Holyoake considered that this cost needed to be weighed against the impact on recidivism and the reduction of crime in the community. It noted that the NSW programs had not reached capacity in the first four years of operation (due in part to strict eligibility criteria) and that the eligibility criteria 'must be sufficient to ensure 100% occupancy, and commensurate budgetary adherence'. Holyoake also commented on the need for adequate resourcing for the programs offered in the prison. Its view was that a 'key consideration regarding the proposed model must be the provision of adequate funding to enable the delivery of such services, a commitment not yet demonstrated by either government'. It stated that:

The expansion of coercive drug and alcohol treatment programs in Tasmania will require a genuine commitment by the government to provide additional funding to community based addiction specialists such as Holyoake, who have the knowledge and skills to deliver high quality programs which have been proven to work.²⁵⁹

In addition to the resource and capacity implications for the treatment sector, there will also be costs for the criminal justice system. This was highlighted by the DPP, whose view was that the CDTP would be a costly intervention that:

would create further pressure on judicial, prosecutorial and defence counsel resources, and may make sentencing procedures more complicated, lengthy and reliant on reports from relevant programs which would in turn require more funding to be able to service these requests.²⁶⁰

CLC Tas stated that it did not support mandatory alcohol and drug treatment in prison or in the community.²⁶¹ Similarly, the Prisoners Legal Service made it clear that it did not support mandatory treatment for offenders with alcohol and drug issues. However, it outlined the following requirements if the government introduced mandatory treatment:

We support the building of a custom designed stand-alone treatment centre in line with the current program that operates in NSW.

The program must encourage compliance rather than discourage non-compliance through punishment.

The program must be linked to a program aimed at offering support and assistance upon completion of the in prison component of the course.

The drug treatment program should be available to all offenders, regardless of offending if it can be shown that their drug usage was a substantial cause of their offending.

People serving a sentence should be able to request entry into the program while in prison and not be limited to entry only at the time of sentencing.

It should be available to people who are interested in addressing their drug usage, not only long term repeat offenders but also first time offenders, to prevent the cycle of repeated imprisonment before it begins.

This cannot be done within the normal prison environment and should be done in a stand-alone facility.²⁶²

Clearly a stand-alone model akin to the NSW approach will be accompanied by considerable demand on the capacity and resources of the justice and health sectors. It will also need to be well-designed to ensure that it is therapeutic (rather than anti-therapeutic) in its effect. This reflects the view of Anglicare, which indicated that it was supportive of mandatory treatment 'as long as it is established within a restorative justice and therapeutic jurisprudence framework that uses a stepped care approach and utilises a wide suite of options including assisting people to develop and strengthen natural supports'.²⁶³ Anglicare also raised concern about the application of mandatory treatment to people who have used violence against another person. Its view was that 'where offending has involved both substance use and violence against another person, mandatory treatment for substance use ought to be considered within the broader context of the appropriate criminal justice response to a crime of violence'.²⁶⁴

258 Submission 8.
259 Submission 5.
260 Submission 7.
261 Submission 1.
262 Submission 4.
263 Submission 10.
264 Ibid.

Further, it noted that 'offending that involves violence needs to be considered differently from offending that does not involve violence' and that it was necessary to address both the violence and the AOD issues in sentencing and treatment.²⁶⁵

The government could also (or alternatively) make provision for any offender to be mandated by the sentencing judge to undergo rehabilitation in prison using the existing treatment services. This avoids the expense of establishing a separate, specialist prison. This was Holyoake's preferred approach to mandatory treatment. Holyoake wrote that 'a new bright shiny prison will be of no use if the therapeutic programs are not evidence based, best practice, delivered by experts and proven to work'. However, Holyoake considered that there were several questions that needed to be answered before mandatory treatment should be adopted including:

- the need to uphold human rights and to ensure offenders are treated with respect and dignity;
- the need for a legally sound definition of mandatory treatment;
- the need for compulsory treatment to be beneficial to the offender and not have the potential to cause harm;
- the need to support a restorative approach rather than a punitive one;
- the need to have a model that is able to address other issues impacting of the offender's likelihood of reoffending, such as housing, mental health, literacy, employment, social skills and family relationships;
- the need for flexible criteria to ensure the program is at capacity;
- a costing for the model and a commitment to fund it; and
- the need to evaluate the program.²⁶⁶

These concerns cannot be addressed merely by legislating to provide a sentencing judge with the power to mandate treatment.

Further, it could be argued that a general requirement for mandatory treatment is contrary to research evidence in relation to the need for treatment to be matched to an offender's risk and criminogenic needs and the absence of research that supports the effectiveness of mandatory treatment.²⁶⁷ In addition, it is likely to be an inefficient allocation of resources. It has been observed that:

Perhaps our most salient observation is that expectations of treatment — whether "coerced" or not — should be realistic; these options are not a panacea for tackling the wider problems of drug misuse and drug-related crime. ... Our reading of the research evidence is that desistance from both substance misuse and offending behaviours are increasingly conceptualised as protracted processes rather than discrete events, with drug treatment forming a crucial but minor aspect in the larger process of recovery ... The point to stress here is that desistance from drug use and offending behaviours will not necessarily be triggered by corraling an ever increasing number of drug-using offenders into treatment.²⁶⁸

Significant legal coercion to undertake rehabilitation in prison already exists given that participation in treatment is relevant to an offender's release on parole, and indications are that demand for the current programs exceeds the capacity to provide them. In this context, Holyoake questions whether it 'is necessary to create a compulsory prison-based drug treatment model, when there exists a highly successful voluntary program which is both unfunded and unable to meet the increased demand'.²⁶⁹

In the Australian context, Casey and Day have observed that the provision of effective treatment services is constrained by 'the financial burden of providing treatment to the large number of offenders who present with substance use problems'.²⁷⁰ Research in other jurisdictions has highlighted that only a minority of offenders who could benefit from treatment receive it in prison.²⁷¹ In Victoria, there are reports of 'high demand and long waiting

265 Ibid. Angicare indicated that 'offending involving violence against another person needs to be considered within existing provisions of the criminal justice system. Therapeutic jurisprudence principles may be applied in consideration of whether restorative justice approaches would also be appropriate'.

266 Submission 5.

267 See [2.3.1].

268 Tim McSweeney, Alex Stevens, Neil Hunt and Paul Turnbull, 'Twisting Arms of a Helping Hand? Assessing the Impact of "Coerced" and Comparable "Voluntary" Drug Treatment Options' (2007) 47 *British Journal of Criminology* 470, 485–6.

269 Submission 5.

270 Sharon Casey and Andrew Day, 'Prison Substance Misuse Programs and Offender Rehabilitation (2014) 21 *Psychiatry, Psychology and Law* 360, 360.

271 Chandler, Fletcher and Volkow, above n 103, 183; Olson and Lurigio, above n 148, 601.

lists for AOD programs'.²⁷² Similarly, in Queensland, it has been reported that there is 'a notable disparity between the level of rehabilitation for substance misuse that is needed and what is delivered, both in custody and in the community'²⁷³ and in a review of parole in NSW, it was reported that '[m]any stakeholders reported that offenders' [experienced] difficulties in accessing programs while they are in custody'.²⁷⁴ In view of the issues with delivering voluntary programs, there is a foreseeable risk that mandating treatment would mean that the capacity of the Tasmanian Prison Service to provide treatment is likely to be compromised.

The questionable need for mandatory treatment in prison when demands for voluntary places could not be met was raised in a number of submissions and the view was expressed that additional funding should be directed to expand voluntary treatment. CLC Tas believed that 'with demand for treatment programs greater than the level of supply, mandatory treatment is an inefficient allocation of resources'. CLC Tas suggested that given demand for treatment in prison exceeded available places, it is:

strongly recommend[ed] that appropriate levels of treatment be provided at Risdon Prison that will meet demand. That is, any prisoner who demonstrates a history of problematic drug use and is committed to treatment receives the treatment they need.²⁷⁵

Holyoake raised the issue of the inadequacy of funding under current arrangements stating that it had provided a highly successful prison program, which has recently been expanded to include community correction clients. It pointed to waiting lists for its voluntary programs arising from funding issues. It stated that 'despite the huge success and popularity of the Holyoake program, it receives no funding from the Tasmanian government, and was unsuccessful in a recent application to Primary Health for Federal ice funding'.²⁷⁶ Likewise, while the ATDC agreed that legal coercion to attend treatment can be beneficial to get an offender into treatment, it considered that it was 'very important to recognise that the benefits of mandated treatment should not be overstated in terms of its ability to reduce offending or lead to improved health outcomes for offenders'. It considered that parole was already a significant motivator for offenders to take place in treatment and courses in prison and that there was a need to have appropriate supports for offenders and adequate resources.²⁷⁷

In introducing any new powers to mandate treatment, the ATDC stressed that the 'capacity of the current AOD treatment workforce to respond to increased demands must be considered'. The ATDC commented on the overwhelming demand for AOD treatment among offenders in the Tasmanian prison services and questioned, in light of this current demand, the utility of mandating new clients who have chosen not to participate. The ATDC considered that there was a need to address existing resourcing issues to improve treatment services that are currently provided. In particular, it observed:

- The Tasmanian Prison Service currently only runs AOD programs in the medium security area of prison;
- The small number of AOD counsellors at Risdon Prison;
- The pharmacotherapy program has had approximately 20 places available to inmates with strict eligibility criteria in place. Anecdotal evidence suggests that 120 plus inmates should be on pharmacotherapy and the expansion of the program would allow better data on the levels of opioid dependence and a reduction in illicit drug trade in the prison.

In addition, the ATDC commented that there was a need to adequately resource the 'ongoing development of the skills and capacity of workers to be effective in treatment roles'.²⁷⁸

As discussed at [2.1], it is not possible to compel a person to participate in psychological treatment and this remains the case whether treatment is mandatory or voluntary. Holyoake stressed the importance of offender motivation and the need for an individual to be supported to change noting that '[m]otivation plays a critical role in recognising the need for change, seeking treatment, and achieving successful, sustained change for all substance users'.²⁷⁹ It advised that:

272 Victorian Ombudsman, above n 135, 59.

273 Walter Sofronoff, above n 141, 152.

274 NSW Law Reform Commission, *Parole*, Final Report No 142 (2015) 70.

275 Submission 1.

276 Submission 5.

277 Submission 6.

278 Submission 6.

279 Submission 5.

Behavioural change is a process that unfolds over time. It's not a one-size fits all process. It is vital to gaining an understanding of where a person sits in the stages of change to determine which therapeutic interventions will be most effective. If individuals are not prepared to change their behaviour, they won't. Alcohol and other Drug ... programs need to support people to move through the stages of change, allowing them to set realistic goals that are not doomed to fail.²⁸⁰

Holyoake stated that it was 'a long held belief by Holyoake that it is impossible to force a person to engage in therapeutic interventions if they chose not. Pressure to do so can lead to anger, increased drug use, increased domestic violence and other negative behaviours. It can also lead to feelings of failure and shame'.²⁸¹

Further, even if mandatory treatment for drug and alcohol affected offenders is introduced in Tasmania, it is only possible to impose a finite number of consequences (for example, denial of parole, remissions for prison based offenders) on an offender who does not comply. This is true regardless of whether treatment is expressed to be voluntary but coerced (the current position) or expressed as a mandatory requirement. As noted by the DPP, parole operates as an incentive for offenders to engage with programs in prison, even if it is not enforceable by the sentencing judge.²⁸² In addition, a judge may combine a sentence of imprisonment with a probation order to ensure that an offender engages with treatment services on release.²⁸³ The DPP's opinion was that:

our legislative framework provides sufficient avenues to enable the courts to impose sentences with a focus on rehabilitation by either providing a pathway to engage in community programs; to motivate offenders to participate with a view to maximising opportunity for a grant of an order for parole.²⁸⁴

CLC Tas also considered that 'there is sufficient legal coercion placed on offenders to engage with alcohol and other drug treatment without the need for the treatment to be mandatory'.²⁸⁵

A further concern is that mandating treatment for offenders in prison may actually decrease effective participation in the program and so be counterproductive. Research on coerced participation in rehabilitation programs has found that treatment tends to be accepted as 'fair' by offenders 'when it is made clear that it is their decision to accept or refuse treatment' and accordingly, it has been argued that '[r]educing the reality and the perception of excessive and "unfair" coercion should be an important objective in rehabilitation, both for ethical and practical reasons'.²⁸⁶ If compelled, offenders may take part in the treatment but fail to engage and merely 'go through the motions' or alternatively commence the treatment program but not make satisfactory progress and be exited from the program. Further, these offenders, given their failure to satisfactorily participate in treatment, may not be released on parole and will be unconditionally released (untreated) at the end of their sentence. An additional concern raised by Holyoake was the potentially disruptive effect of offenders who are coerced to attend treatment. Holyoake questioned whether 'mandatory treatment orders [would] ... set offenders up to fail, whilst potentially wasting funding that could be more effectively utilised to treat voluntary clients'.²⁸⁷

In this regard, it may be more beneficial to utilise additional therapeutic methods of encouraging participation (such as pre-treatment or motivational programs) as a means of motivating offenders to participate in treatment, instead of making treatment mandatory in prison. It has been argued that:

Coercion is not a substitute for high-quality treatment of adequate length. Simply expanding the numbers of people who are coerced towards treatment may not lead to a higher number of people who are motivated and are actually retained in treatment. It may have the perverse effect of wasting resources through assessing, processing and then punishing people who are ordered into treatment, but fail to engage with it.²⁸⁸

280 Ibid.

281 Ibid.

282 Submission 7.

283 Ibid.

284 Ibid.

285 Submission 1.

286 Day, Tucker and Howells, above n 108, 267 referring to J Rigg, 'Measures of Perceived Coercion in Prison Treatment Settings' (2002) 25 *International Journal of Law and Psychiatry* 473, 483.

287 Submission 5.

288 Stevens et al, above n 112, 207.

Research suggests that preparatory programs and communicating an offender's options may be more effective than focusing on the negative consequences that follow from non-participation and imposing severe sanctions as a means of coercion.²⁸⁹ As the ATDC cautioned, 'coercive or mandatory treatment may get the offenders into programs, but does not guarantee they will engage or benefit'.²⁹⁰ The DPP noted that 'the success of the programs and prisoners' willingness to engage in them is dependent on effective education programs being available within the prison whereby offenders are able to see benefits of participation and thus choose to actively engage with them'.²⁹¹ The Prisoners Legal Service's view was that 'instead [of mandatory treatment,] treatment should be made an attractive option to people who are being sentenced or currently servicing a sentence and thus increase voluntary participation in such programs'.²⁹²

There is also a need to consider issues in relation to offenders who receive short prison sentences. In 2016, 20.5% of prisoners were serving sentences of less than six months (83 out of 404)²⁹³ and in the period 2011 to 30 July 2014, 90.3% of sentences imposed in the Magistrates Court and 25% of sentences imposed in the Supreme Court were for less than nine months.²⁹⁴ Short sentences of imprisonment have been criticised on the basis that they expose offenders to the deleterious effects of imprisonment without any benefits such as participation in therapeutic programs.²⁹⁵ Shorter sentences have been associated with a higher risk of reoffending,²⁹⁶ and this might reflect the reality that offenders with shorter sentences receive less assistance both while imprisoned and upon release.²⁹⁷ While efforts have been made in Tasmania to address the treatment needs of offenders with short sentences by allowing offenders on remand to take part in treatment and to have flexibility in program delivery, the reality is that some offenders will not have sufficient time in prison to undertake a rehabilitation program or a rehabilitation program of a sufficient length to facilitate longer term treatment success.²⁹⁸ Further, offenders with short sentences will not be motivated to participate by parole considerations and are automatically released at the end of their sentence.²⁹⁹ Offenders who are not released to parole are also released at the end of their sentence without supervision into the community. These difficulties were identified by the DPP who noted that a sentencing judge could impose a probation order upon release from imprisonment that would require an offender to engage with treatment services.³⁰⁰

Recovery is a long-term process and there is a need for continuity of care for drug users re-entering the community.³⁰¹ In Tasmania, the importance of ensuring transitional support for those leaving prison by establishing through-care has been recognised as a key factor in meeting the reintegration needs of prisoners.³⁰² However, there remains limited provision for continuity of drug and alcohol treatment from prison to the community with linkages only available for the Holyoake program provided in minimum security as well as some linkage with services offered by the Salvation Army.³⁰³ Greater through-care could be used to address the treatment needs of short term prisoners, as well as providing support to longer term prisoners as they transition into the community. As Makkai has observed, '[e]ffective crime strategies will ultimately fail if they do not include pre- and post-release intervention programs designed to reduce the likelihood of re-offending among prisoners'.³⁰⁴

289 Day, Tucker and Howells, above n 108, 267.

290 Submission 6.

291 Submission 7.

292 Submission 4.

293 ABS, above n 67, Table 26.

294 TSAC, *Phasing out of Suspended Sentences: Background Paper* (2015) 29, 43.

295 TLRI, *Sentencing*, Final Report No 11 (2008) [3.2.7].

296 Fitzgerald, Cherney and Heybroek, above n 64, 8.

297 Maria Borzycki and Eileen Baldry, *Promoting Integration: The Provision of Prisoner Release Services* (Trends and Issues in Crime and Criminal Justice no 262, Australian Institute of Criminology, 2003); Fitzgerald, Cherney and Heybroek, above n 64, 8.

298 The length of treatment has been recognised as an important factor in longer-term treatment success: see Pritchard, Mugavin and Swan, above n 6, 65; Steven Jones, *Exploring Dimensions of Coercion across Treatment Programmes for Heroin Users: A Mixed Method Study* (PhD Thesis, Edge Hill University, 2016) 22.

299 In Tasmania, the current minimum term for offenders serving fixed terms sentences is a non-parole period of six months, or one half of the sentence, whichever is greater, unless there are exceptional circumstances: *Sentencing Act 1997* (Tas) s 17(3); *Corrections Act 1997* (Tas) ss 68, 70.

300 Submission 7.

301 See [2.3].

302 Department of Justice, *Breaking the Cycle – A Safer Community: Strategies for Improving Throughcare for Offenders* (2016) 19.

303 Information provided by Erin Hunn, 28 March 2017.

304 Forward to Kinner, above n 72, 1.

The need for through-care was highlighted in many of the submissions received. For example, the Prisoners Legal Service, indicated that there:

must be greater post release support and assistance aimed at reducing the temptation of returning to old habits. Any program aimed at reducing recidivism must approach the issue of addiction in a holistic manner and ensure that adequate access to housing, medical treatment and financial support are a central concern rather than the punishment or control of people who are returning to the community.

Instead of mandatory treatment, the Prisoners Legal Service's view was that voluntary treatment needed to be easy to access and sufficiently funded.³⁰⁵ Similarly, the ATDC highlighted the need for treatment to encompass after-care and a wrap-around framework that addressed the complex nature of offender needs. The ATDC made reference to the absence of a smooth transition from correctional programs to community service organisations meaning that 'there is real interruption to the continuity of treatment for offenders as they progress through the system'. It reported that following release from prison or upon finalising a drug treatment order, it is difficult for offenders to enter community-based AOD treatment programs.³⁰⁶ The ADS also agreed with the importance of transitional or through-care and the need to 'pay more attention to providing more substantive health, social and other support for people exiting our prisons systems in Australia, if we want to see better health and social outcomes among these populations in to the future'.³⁰⁷ Holyoake also commented on the need to address an offender's environment on release from prison.³⁰⁸ Anglicare suggested that case managers needed to work with a person to address supports in their home environment and, accordingly, encouraged the court system to incorporate post-treatment after-care as part of the mandatory treatment process.³⁰⁹

In terms of delivery of service, the ATDC indicated that ATDC Member organisations could 'play a role in the 'after care' when offenders are released from prison, or when they are no longer subject to orders through community corrections'. It suggested that these organisations 'are geared to deal with complex presentations and have a rich track record of providing successful AOD treatment'. A key point in the ATDC's submission was that community sector organisations have distinct advantages when providing AOD treatment as they are 'more connected to the communities that they serve, usually provide a "less siloed" type of service delivery and have more flexibility to be innovative'. The ATDC was supportive of 'any sentencing reforms that lead to increased resources for assessment, treatment, and relapse prevention' with community sector organisations being able to provide interventions from education and brief interventions to long term residential and clinical treatment.³¹⁰ The ADS also expressed a willingness to be an active participant in any future discussions regarding ATOD treatment for consumers.³¹¹

4.2 TREATMENT AS A CONDITION OF PAROLE

As discussed at [3.2], considerable legal powers already exist in Tasmania to direct an offender to take part in the treatment in the community as a condition of a parole order. Offenders released on parole can be directed to take part in treatment and there does not appear to be any need for legislative reform. The DPP noted the powers of the Parole Board to require an offender to participate in therapeutic programs upon release. The Prisoners Legal Service indicated that parole 'should be used as a tool to allow for treatment in the community'.

305 Submission 4.
306 Submission 6.
307 Submission 8.
308 Submission 5.
309 Submission 10.
310 Submission 6.
311 Submission 8.

4.3 TREATMENT AS A CONDITION OF A DRUG TREATMENT ORDER

As discussed at [3.3], another sentencing order that is available to respond to the rehabilitative needs of drug affected offenders is the DTO. As noted, while this is not a mandatory order (as an offender's consent is required to the making of the order), there is significant legal pressure applied to the offender to agree to the making of the order (given that the choice is prison or participation in the DTO). In addition, the order is mandatory in the sense that the offender must adhere to the conditions of the order, including treatment requirements, once the order is made. The Prisoners Legal Service observed that the DTO already created a situation where people were essentially compelled to take part in treatment and therefore any new system aimed at compulsion is unlikely to have a positive effect on meaningful participation.³¹²

In its consideration of the treatment needs of alcohol and drug affected offenders, the Council has identified an area of need in relation to the sentencing orders that provide for community-based treatment in respect of problematic alcohol use. TSAC has previously recommended that the DTO should be expanded to accommodate offenders with a history of alcohol abuse, where that substance abuse has contributed to the offender's criminal behaviour.³¹³ This was supported by the ADS. CLC Tas also considered that the eligibility criteria required amendment to allow the order to be used for alcohol or pharmaceutical drug misuse.³¹⁴ Concerns about the availability of sentencing orders that provide for community-based treatment for alcohol use have also been identified in the Tasmania Law Reform Institute (TLRI) project that examines the adequacy of current sentencing responses for repeat drink drivers and seeks stakeholder feedback in relation to the introduction of a Driving While Intoxicated List.³¹⁵ The Council has also recommended that the order be expanded to apply to all offences (other than sexual offences). This would mean that the order would be available where the harm caused was not minor.³¹⁶ This would still be subject to the requirement that the order was appropriate in the circumstances of the case.³¹⁷ CLC Tas also considered that the DTO should be available where the harm was not minor.³¹⁸ So far, these recommendations have not been implemented.

Following advice from TSAC, the government has expanded the operation of the DTO to the Supreme Court, however, following the decision in *Tasmania v Joseph*,³¹⁹ the view of the DPP is that the operation of the DTO may be limited in that jurisdiction.³²⁰ As indicated above at [3.3], Brett J stated that in most circumstances it would be inappropriate to impose a DTO if the custodial component will exceed two years. His Honour also considered the requirement for the court to be satisfied that a DTO was appropriate in all the circumstances.³²¹ This will require that the court 'be satisfied that the order will properly respond to the various aims of sentencing appropriate to the case. The result, in some cases, may be that, having regard to the seriousness of the crime, the court cannot be satisfied that a drug treatment order is appropriate'.³²² This will involve an assessment of whether the objective seriousness of the crime and the consequent need for denunciation and general deterrence outweigh the desirability of rehabilitation.³²³ While this decision appears to have limited the application of the DTO in the Supreme Court, it would still appear that a majority of offenders will still be eligible for the order (at least based on sentence length). TSAC's analysis of the use of imprisonment in the Supreme Court for the period 1 January 2011 – 30 July 2014 found that, of the 441 sentences of imprisonment imposed, 63.6% of offenders received a term of imprisonment of less than two years and 37.2% of offenders received a sentence of two years or longer.³²⁴

312 Submission 4.

313 TSAC, above n 194, Recommendation 6.

314 Submission 1.

315 TLRI, above n 229.

316 TSAC, above n 194, Recommendation 9.

317 *Sentencing Act 1997* (Tas) s 27B(3)(a).

318 Submission 1.

319 [2017] TASSC 23.

320 Submission 7.

321 *Sentencing Act 1997* (Tas) s 27B(3)(a).

322 *Tasmania v Joseph* [2017] TASSC 23, [31].

323 *Ibid* [35]. His Honour recognised that 'the choice to impose a sentence of imprisonment and to make a drug treatment order does not mean that the need for and prospects of rehabilitation of the defendant are not important considerations in the determination of sentence. The correctional system is quite capable of responding to any commitment by the defendant towards rehabilitation by supplying appropriate programs whilst in prison and, further, rehabilitative options in the community can be advanced through parole. A sentence which takes account of rehabilitation by making appropriate provisions for parole provides the appropriate sentencing mix in this case': at [35].

324 TSAC, above n 294, 29. It is noted that while 13.4% of offenders received a sentence of between two and less than three years, it is not known what proportion received a sentence of exactly two years.

In response to decision in *Tasmania v Joseph*, CLC Tas suggested that there should be greater flexibility in the use of the DTO to allow it to be combined with a sentence of imprisonment that was served in prison (rather than in the community). In cases where the sentence imposed was longer than two years, CLC Tas suggested that the DTO should be able to be served in the community for the final two years of the sentence. In addition, CLC Tas suggested that there was a need to accommodate cases where the court's view was that the offender should serve a short sentence of imprisonment. In such cases, the DTO should be able to be partly served in prison and upon their release, in the community. The approach of CLC Tas in combining imprisonment with treatment in the community reflects the recommendations of TSAC in relation to the combined imprisonment/community correction order that would enhance the ability to provide for judicial monitoring, alcohol exclusion, curfew and non-association conditions during the component of the order that is served in the community.³²⁵ This would allow the court to impose a period of imprisonment and then impose a rigorous supervision and treatment order on release to address issues of alcohol and/or drug use. As the law currently stands, the court is able to make provision for treatment by combining imprisonment with probation or making provision for release on parole. However, these options do not have provision for judicial oversight and the therapeutic response that underpins the DTO. An alternative approach may be to adopt a model similar to that proposed in Queensland, which would allow a court to impose a sentence of imprisonment of up to four years as part of a DTO. If the offender completes the order, the remaining term of imprisonment is suspended on condition that the offender does not commit an imprisonable offence.³²⁶

In addition to concerns about the eligibility criteria for a DTO, submissions also referred to the need to expand access to the DTO. The Chief Justice expressed the view that it would be desirable if the drug treatment order was not capped at 80 participants and that ideally it should not be capped at all. His Honour observed that '[t]here are certainly far more than 80 people in Tasmania who would benefit from it at any one time'.³²⁷ It is noted that the government has since announced that it has allocated budget funding to increase the cap from 80 to 120 places to accommodate the availability of the order in the Supreme Court.³²⁸

Anglicare made reference to the key success factors and impediments in the implementation of diversionary strategies identified in a research paper published in 2008 by the National Drug Law Enforcement Research Fund (NDLERF). These related to the implementation and management of law enforcement drug diversions strategies in South Australia, Tasmania and Victoria.³²⁹ The NDLERF developed an implementation and management matrix, and Anglicare submitted that this matrix should be applied at the design, delivery and evaluation phase of any new approach to treatment in the criminal justice system (where appropriate).³³⁰ The key aspects of the matrix are:

- Policy Formulation and Policy Instrument — requires wide dissemination and awareness raising to ensure all stakeholders have the same information about the proposed policy;
- Policy Proponents — key stakeholders and interest groups need to be identified and engaged, with coordinated feedback available on implementation and efficacy, including formalised reporting and information sharing mechanisms;
- Service Delivery — early identification of gaps in capacity, geographical coverage and appropriateness/consistency of intervention;
- Attitudinal Context — ensuring attitudes amongst stakeholders are aligned with policy direction;
- Resources — adequate resourcing, including identifying unintended consequences and developing solutions to identified issues;
- Communication — use existing and (where necessary) develop new mechanisms to facilitate dissemination and reception of information;
- Monitoring and Control — develop clear/unambiguous guidelines/benchmarks/performance indicators with the involvement of key stakeholders; and

325 See [4.4].

326 Freiberg et al. above n 53, Recommendation 25.4.

327 Submission 3.

328 Guy Barnett, above n 204.

329 Submission 10 referring to Aynsley Kellow et al, *Enhancing the Implementation and Management of Drug Diversion Strategies in Australian Law Enforcement Agencies: The Cases of South Australia Police, Tasmania Police and Victoria Police during the Period 2000 – 2005* (National Drug Law Enforcement Research Fund, Monograph Series No 31, 2008).

330 Submission 10.

- Administrative processes — ensure processes are straightforward, as simple as possible, and capture necessary information/data accurately.³³¹

It was noted that some of these aspects may not have been present in court mandated diversion in Tasmania.

Other submissions made reference to concerns about the operation of DTOs more generally (rather than mandatory treatment per se). The ADS was concerned that the use of 'treatment' appears to refer to abstinence only as the treatment goal of the DTO. It observed that in the criminal justice context, treatment was related to recidivism and AOD use as a criminogenic factor rather than the health issue that it is. In contrast to the focus of the criminal justice system, the ADS and other treatment providers within the ATOD sector understood treatment to include 'a range of potentially beneficial interventions and outcomes which sit along a spectrum, ranging from abstinence to harm reduction strategies in the absence of complete cessation of use'. This highlights the tension between legal and health approaches. However, while it is requirement of a DTO, an offender must abstain from all illicit drug use³³² and graduation from the order is contingent upon full or substantial compliance with the conditions of the order; 'success' is not only measured by graduation. As the Council has previously observed, offenders who do not formally graduate may still have made significant progress in their treatment and rehabilitation, including physical and mental health, gains in literacy, increased periods of abstinence, and no further reoffending or reduced/less serious offending.³³³ In addition, the phased approach recognises that 'problematic alcohol and other drug use is an often chronic and relapsing condition that affects behaviour and for which treatment be provided on a continuum of "stepped care"'.³³⁴

Anglicare indicated concerns about the operation of the DTO, based on Anglicare's partnership with the Department of Justice from 2007 to 2010. It stated that, in its view:

the overall program had some significant design and delivery flaws. Anglicare identified the flaws as resulting from the initiative not sitting within a broader therapeutic jurisprudence and restorative justice framework resulting in many of the participants not making a connection between their participation in the program and their involvement with the justice system. We were particularly concerned that vulnerable people were not well served by the rigid approach of the program.³³⁵

The ADS also raised concerns about the operation of CMD in relation to the delivery of treatment within a justice rather than a health framework. In its view, alcohol and drug addiction are chronic and relapsing conditions that require a therapeutic response delivered by ATOD specific treatment services and clinicians for effective intervention. The ADS considered that there was a need for the CMD program to operate in accordance with drug court model, including adopting a liaison program within the CMD program to link between health and justice. The ADS also commented on the need for greater collaboration between agencies. Although an evaluation of the DTO is beyond the scope of this paper, these submissions indicate that there is concern from some alcohol and drug service providers about the operation of the order. Best practice in effective drug courts, as evaluated by Freiberg et al, is underpinned by a non-adversarial, problem oriented, therapeutic response that involves a multidisciplinary team.³³⁶

The WLST commented on the barriers that women may experience in accessing a DTO, including the limited number of women who are imprisoned, that women may be less likely to seek drug treatment due to the stigma of using drugs, particularly for those who are mothers and that women may not be willing to take part in a DTO or may be unable to do so due to caring responsibilities for dependent children.³³⁷

331 Ibid referring to Kellow et al, above n 329, 111–114.

332 Magistrates Court, *Court Mandated Diversion: Information for Service Providers*.

333 TSAC, above n 194, 50–1.

334 Freiberg et al, above n 53, 35.

335 Submission 10.

336 Freiberg et al, above n 53, 191, 194–5.

337 Submission 2.

4.4 TREATMENT AS A CONDITION OF A COMMUNITY-BASED ORDER

Assessment and treatment for drug or alcohol dependency can also be imposed as a condition of a probation order (used as a stand-alone order, or in combination with a sentence of imprisonment or a fully or partly suspended sentence). As discussed at [3.4], considerable legal powers already exist in Tasmania to direct an offender to take part in the treatment in the community as a condition of a probation order. In its proposal to introduce a CCO (a new sanction to accompany the phasing out of suspended sentences) the Council has recommended that these powers be enhanced to the ability to provide for judicial monitoring, alcohol exclusion, curfew and non-association conditions. The DPP commented that the increase of powers to include orders such as alcohol exclusion, a curfew and non-association conditions, 'may very well have the ability to assist offenders in their rehabilitation.' However, the DPP noted that these conditions 'would put an increased burden on Tasmania Police and other organisations to monitor compliance with those orders and consequently would put an additional strain on judicial resources, prosecution and defence counsel due to an increased likelihood that offenders would not comply with those orders, thus necessitating a resentencing process'.³³⁸

The WLST argued that there was a need for sentencers to make greater use of existing legal powers noting that female offenders receive fewer custodial sentences of imprisonment compared to male offenders with the consequence that most female offenders are not eligible for a DTO. The WLST urged that treatments separate from a DTO or CDTTP be adopted for female offenders with alcohol or drug dependency. The WLST suggested that a well-tailored detailed probation order could have a somewhat similar effect to that of a DTO.³³⁹ However, for such a model to be effective, the WLST indicated that a framework would need to be put in place to ensure that female offenders obtaining alcohol and drug treatment with the assistance of their probation officers via community corrections and were able to receive a similar kind of intensive assistance as their female counterparts engaging in a court-imposed DTO.³⁴⁰

Beyond the issue of legal powers to mandate treatment, many of the submissions referred to gaps in the treatment services or programs that are currently available and the need for focus on community-based treatment (rather than imprisonment). The ATDC commented on the need to consider the consequences of incarcerating young offenders, or those who have committed minor offenses, especially those with AOD issues. Its view was that prison was likely to be harmful to these offenders and that it was more desirable to keep young people out of prison with greater access to potential new AOD treatment options specific to young people.³⁴¹ Holyoake also commented on the need to carefully consider community-based treatment for offenders, 'especially for a certain cohort of drug users for whom prison is profoundly detrimental, exposing them to more criminal associates and reducing future legal employment opportunities'.³⁴²

4.5 CONCLUSION

The Council has examined the issue of mandatory treatment for drug and alcohol and the legal mechanisms that may be used to create a mandatory treatment regime for offenders serving sentences in prison and in the community. The Council has identified the considerable powers that currently exist to facilitate an offender's participation in treatment both in prison, as a condition of parole, as a condition of a drug treatment order and/or as a condition of a probation order. It has identified a compulsory drug treatment order (based on the New South Wales approach) as a means to introduce mandatory treatment in prison. As noted, this model was carefully designed to counter anti-therapeutic effects arising from its compulsory nature and evaluations have found positive results in terms of offender health and attitudes towards the program. However, there are no published evaluations of its effectiveness in terms of reducing recidivism and long-term drug use. It is also noted that this is a costly intervention and that, despite its mandatory nature, the order cannot compel an offender to participate and the order may be revoked and the offender returned to mainstream prison.

338 Submission 7.

339 Submission 2.

340 Ibid.

341 Submission 6.

342 Submission 5, referring to Kevin Schnepel, 'Economics of Incarceration' (2016) 49 *Australian Economic Review* 515.

While research has shown the complexity of the relationship between substance use and offending, evidence suggests that well designed and well implemented treatment within the criminal justice system can be effective in reducing recidivism and substance use. There are also other health and social benefits for the individual offender and the community that may result from providing treatment to offenders with drug and alcohol issues. However, the value of treatment should not be overstated in terms of its ability to reduce overall drug use and offending in the community. As Freiberg et al, write, 'it is tempting to believe that if society were only able to "cure" offenders of their drug or alcohol dependence or abuse, then drug-or alcohol-related crime would diminish or disappear', however, this does not recognise the multiple causes that contribute to offending.³⁴³ In addition, while there is evidence that coerced treatment (ie where there is legal coercion to participate in treatment but an offender has a choice as to whether to take part) can be effective, there is no research base to support mandatory treatment (ie where there is legal coercion and the offender is not given a choice as to whether to take part). Mandatory treatment is also considered to raise significant ethical and human rights concerns. Other concerns exist in Tasmania in relation to the appropriateness of expanding mandatory treatment in light of the current availability of treatment for offenders who wish to engage in treatment.

Accordingly, the Council's view is that any expansion of mandatory treatment within the criminal justice system in Tasmania should be approached with considerable caution.

343 Freiberg et al, above n 53, 63.

Appendix A: Coerced treatment in Tasmania

Path to coerced/mandatory treatment	Benefit for compliance?	Penalty for non-compliance?
<p>Probation order (May be combined with suspended sentence)</p> <p>A court may order an offender be released into the community under the supervision of Corrective Services officers. Such an order may require the offender to submit to medical, psychological or psychiatric assessment or treatment as directed by a probation officer (<i>Sentencing Act 1997</i> (Tas) s 37(2)(d)).</p>	<p>Allows the offender to be in the community under supervision.</p>	<p>If the probation order is breached, the court may (among other options) re-sentence for the original offence but must take into account the extent of the offender's compliance with the order (<i>Sentencing Act 1997</i> (Tas) ss 42(6), (9)).</p>
<p>Suspended sentence</p> <p>A court may impose a suspended sentence with a condition that the offender submit to the supervision of a probation officer and the court may impose a treatment condition (as above) ((<i>Sentencing Act 1997</i> (Tas) ss 24(2)(b), (5)).</p>	<p>Allows the offender to be in the community under supervision.</p>	<p>If a suspended sentence is breached by a failure to comply with the conditions of a suspended sentence, the court may activate the sentence (<i>Sentencing Act 1997</i> (Tas) s 27(4E)).</p>
<p>Drug treatment order</p>	<p>Allows the offender to be in the community under supervision.</p>	<p>If a drug treatment order is breached, the court may activate the sentence (<i>Sentencing Act 1997</i> (Tas) s 27M(1)).</p>
<p>Parole order</p> <p>The Parole Board may release an offender into the community from prison on a parole order. The parole order can be subject to terms and conditions as the Parole Board considers necessary (<i>Corrections Act 1997</i> (Tas) s 72(5)).</p>	<p>Allows the offender to be released into the community to serve a period of a sentence of imprisonment.</p>	<p>Parole may be revoked and the offender will be required to serve unexpired portion of imprisonment (<i>Corrections Act 1997</i> (Tas) s 79(5)).</p>

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