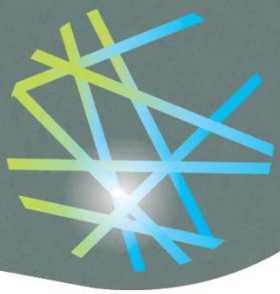
DRUG AND SPECIALIST COURTS REVIEW



PART A

Foundational Principles

QUEENSLAND COURTS

November 2016

1 FUNDAMENTAL CONCEPTUAL ISSUES

1.1 INTRODUCTION

This chapter addresses a number of the basic issues and concepts that have guided the approach adopted by the Review and that underpin its findings and recommendations. It first addresses the terminology used to describe the various courts and programs and suggests that the use of the term 'specialist courts' to describe drug courts and other similar programs is too limited and fails to describe their function and operation properly. It also argues that use of the terms 'diversion' and 'diversionary' is misleading and suggests that what occurs at various stages of the criminal justice system is better described as 'interventions' rather than diversions. Secondly, this chapter suggests that the overall approach to these courts and interventions should be understood within a framework of non-adversarial justice with particular emphasis on the use of therapeutic and restorative justice concepts. Finally, it suggests that a broad approach is required to the problems of substance abuse, requiring an understanding of the role of both illicit and licit drugs such as alcohol in the commission of crime.

1.2 TERMINOLOGY

1.2.1 Why is terminology important?

The names that programs are given are important not only as descriptions of what they are or do, but also for what they represent. Names communicate meaning from those who develop programs or policies to those who operate programs, those subject to them and to the community more generally. The criminal justice system involves a wide variety of actors, including police, courts, judicial officers, health professionals, correctional personnel and victims as well offenders and their families. If the courts, lists and programs are to succeed, it is crucial that they be accurately described, their place in the criminal justice system properly represented and the values they convey and their aspirations be clearly communicated. For example, whereas the term 'specialty court' has a relatively narrow meaning, the term 'problem-oriented court' conveys a considerably more ambitious agenda for these forums.

1.2.2 Specialist courts versus problem-oriented or solution-focused courts

The terms ‘specialty’ or ‘specialist’ courts are widely used to describe the range of courts, or court lists, such as drug courts, mental health courts, family violence courts, Indigenous courts, special circumstances courts and similar programs. However, there are conflicting views as to how they should best be styled.

The terms ‘specialist’ or ‘specialised’ court are often used to describe a court with a ‘limited or exclusive jurisdiction in a field of law presided over by a judge with expertise in that field’ (King et al. 2014:156). Examples of specialised courts or lists are those that deal with building cases, commercial cases, intellectual property, family law and others.

On the other hand, the terms ‘problem-oriented’ or ‘solution-focused’ courts or lists are used to describe programs that seek ‘to use the authority of the courts to address the underlying problems of individual litigants, the structural problems of the justice system, and the social problems of communities' (Berman and Feinblatt 2001, p. 125). The term ‘problem-oriented’ refers to the idea that courts should change their focus from individuals and their criminal conduct to offenders’ problems and their solutions (King et al. 2014, pp. 155-6). ‘Solution-focused’ refers to offender-focused programs that recognise the centrality of the offender’s motivation for change (King et al. 2014:157). Problem-oriented or solution-focused courts aim to reduce recidivism, improve health outcomes for offenders (and, in some courts, for victims, and, where appropriate, to improve relationships between offenders and victims), produce system change, utilise judicial monitoring, encourage collaboration between courts and service agencies and draw on the theories and practices of a number of disciplines (King et al. 2014, pp. 157-8). Thus King et al argue that:

> While a particular problem-oriented court may well be a specialised court, not every specialised court is a problem-oriented court. This distinction is significant. Though specialised courts may be distinguished by their procedures or

> the expertise of the presiding officers, unless they adopt the features outlined below (judicial supervision or control, inter-sectoral collaboration and the like), they cannot be regarded as problem-oriented courts. (King et al. 2014, p. 157)

Accordingly, we prefer, and have adopted, the terminology of 'problem-oriented' or 'solution-focused' courts or lists in preference to 'specialty courts' throughout this report in order to emphasise the fact that their role is not just to concentrate expertise in one particular area but to employ and embrace the broader philosophy of seeking comprehensive solutions to seemingly intractable legal and social problems.

1.2.3 Diversionary programs versus interventions

Another term that is widely used in the criminal justice system is 'diversion'. 'Diversion' is used to describe funding programs, legislative schemes and a variety of criminal justice activities that ostensibly aim to minimise the adverse effects of the criminal justice system on alleged offenders or those convicted of crimes. It is a term with many meanings and is used inconsistently between jurisdictions, in different contexts and over time. Diversion may mean a scheme or program that is intended to obviate completely the need for judicial involvement (diversion from the court system); or a means by which a person is brought before a court and then re-directed, either permanently or temporarily, into a program for some form of intervention and then possibly returned to court for a final disposition; or a scheme that provides some form of external intervention at some stage of the criminal justice system, be it before arrest, after arrest, during the bail process, post-plea, at sentence or with or without supervision (Richardson 2016, p. 5).

The word 'diversion' implies a departure from some predetermined path that is prima facie necessary or appropriate (King et al. 2014, p. 194). It assumes that in relation to any dispute or conflict with the law a diversion is an act that amounts to an act of leniency or grace or a derogation from some ideal form of, usually adversarial, justice.

A better conceptual approach to schemes or programs currently labeled 'diversionary' is not to consider them as legal detours or deviations from a true path but as identifiable stages in the criminal justice continuum at which the law can intervene effectively, proportionately and responsively to an alleged crime and to the person who is alleged to have committed it. State actions at these junctures are therefore better described as 'interventions' rather than 'diversions'.

Interventions can take many forms and take different forms for different purposes at different points of the criminal justice system. A generic definition of an 'intervention program' can be found in the *Criminal Procedure Act* 1986 (NSW) s 347 which describes an 'intervention program' as:

> … a program of measures for dealing with accused persons, or offenders, for the purposes of promoting their rehabilitation, respect for the law, their acceptance of accountability and responsibility for their behaviour, their reintegration into the community and for encouraging and facilitating the reparation by offenders to victims and the community.[1]

The term 'intervention' is not unknown in Queensland. The *Bail Act 1980* (Qld), s 11(9) refers to an intervention program as a condition of bail that requires a person to 'participate in a rehabilitation, treatment or other intervention program or course' while the *Penalties and Sentences Act 1992* (Qld), s 9(2)(n) requires a court in sentencing an offender to take into account the person's successful completion of a program or course. The *Domestic and Family Violence Protection Act 2012* (Qld), s 75(2)(a) refers to intervention programs as those that aim (i) to increase participants' accountability for domestic violence; (ii) help participants change their

[1] See also Bail Act 1985 (SA), s 3; Criminal Law (Sentencing) Act 1988 (SA), s 3.

behaviour; and (iii) increase the safety, protection and well-being of persons against whom domestic violence has been committed. A program must satisfy any other criteria prescribed under a regulation.[2]

The new Queensland *Mental Health Act 2016*, s 136, also provides for the Mental Health Court, in making a forensic order for a person, to make recommendations it considers appropriate about particular intervention programs that should be provided for the person by an authorised mental health service. Such programs may include alcohol and other drug programs, anger management, counselling programs and sexual offender programs.

The advantage of the term 'intervention' rather than 'diversion' is that it focuses on the program - its aims and content - rather than on the time of intervention or the order to which it is attached. In our view, what is important is the nature, extent and duration of the intervention, not where it might lead. Unlike the term diversion, 'intervention' does not imply a move in a direction from or to a court or a particular disposition. Accordingly, in this Report we use the term 'intervention' in preference to 'diversion' to focus upon programs rather than pathways.

In South Australia, the *Intervention Orders (Prevention of Abuse) Act 2009* (SA), s 3 states that an intervention program is one that provides:

a) supervised treatment; or
b) supervised rehabilitation; or
c) supervised behaviour management; or
d) supervised access to support services; or
e) a combination of any 1 or more of the above, and

designed to address behavioural problems (including problem gambling), substance abuse or mental impairment.

We also distinguish between interventions and referrals. A referral program is one that operates to transfer a person, or facilitates access to, an intervention program or service but does not provide the service itself. The *intervention* is the program that provides the substantive treatment, rehabilitation or behaviour change regime.

1.3 A NON-ADVERSARIAL APPROACH

Problem-oriented courts and intervention programs sit within a broader conceptual framework that has been termed 'non-adversarial justice' (King et al. 2014). This has been described as (King et al. 2014, p. 5):

> … an approach to justice, both civil and criminal, that focuses on non-court dispute resolution, including the role of tribunals and public and private ombudsmen…. However, it also includes processes used by courts that may not involve judicial determination, or court processes that involve judicial officers both pre- and post-determination of guilt or sentence in exercising more control over process …. Its basic premises are prevention rather than post-conflict solutions, cooperation rather than conflict, and problem solving rather than solely dispute resolution. Truth-finding is the aim, rather than dispute determination, and there is a multidisciplinary rather than a pre-dominantly legal approach.

This approach draws upon a number of disciplines, approaches and theories of justice including appropriate dispute resolution, restorative justice, therapeutic jurisprudence, problem-oriented courts, Indigenous courts, diversion and intervention programs and others (King et al 2014, p.6). Among its basic premises are that (King et al. 2014, pp. 12-16):

- dealing with the problems of crime requires an understanding that the task extends beyond the courts alone: it is an issue that must be dealt with by the justice system more broadly and beyond that, the private and non-government sectors and the community generally;

[2] *Domestic and Family Violence Protection Act 2012* (Qld), s 75(3). A list of approved intervention programs is held by the Chief Executive Officer of the Magistrates Court and a copy of the list must be provided to the Chief Magistrate.

- the aim of the system should move beyond dealing with or responding to an immediate problem to that of attempting to 'solve' a problem or seek longer term solutions that address the underlying reason for conflict with the law;
- process may be as important as outcomes, which requires an understanding, and application of, the principles of procedural justice;
- process and programs should build on the notions of cooperation with communities, a range of criminal justice and other agencies including treatment agencies; between prosecution and defence lawyers and judicial officers and between disciplines;
- judges should be more active in appropriate criminal justice procedure through such means as judicial monitoring.

A theory of non-adversarial justice therefore encourages a comprehensive approach to the criminal justice system that addresses the rights, responsibilities and needs of all of the parties in a conflict: offenders, victims, judicial officers, justice and health workers, and promotes attempts to address the underlying problems that brought a person to court, including substance abuse. A comprehensive approach deals not only with the substance abuse but also employment, accommodation, family violence, life skills and cognition issues (King et al. 2014, pp. 17-18).

1.4 THERAPEUTIC JURISPRUDENCE

Although problem-oriented courts and intervention programs originally developed independently of any theoretical foundation, the conjunction of these initiatives with the concept of therapeutic jurisprudence has provided a firm foundation for their operation and further development.

Therapeutic jurisprudence has been described as being:

> …"an interdisciplinary approach to law", a "research tool", a "useful lens", a "perspective", a "research program", a "project", "a framework for asking questions and for raising certain questions that might otherwise go unaddressed" and "simply a way of looking at the law in a richer way". (King et al. 2014, p. 24)

Its main contention is that the law may have anti-therapeutic effects and that if used appropriately, it can improve the law and its operation by minimising its adverse effects and promoting the well-being of all those affected by the law, not only offenders but all participants including victims, judicial officers, lawyers and litigants (King et al. 2014, pp. 24-25).

A 'therapeutic experience' has been described as being:

> … "positive and encourages meaningful change, while an anti-therapeutic experience is negative and has adverse consequences for the actors involved. Therapeutic jurisprudence explores ways of maximising potential benefits. Proponents claim that encounters with the legal system, like encounters with the health system, should leave them better off, not worse off, than before…. Courts employing a therapeutic jurisprudence approach would remain conscious of the positive and negative tendencies in the justice system and seek to minimise the negative tendencies. The approach encourages courts to adopt an analytical stance in relation to the cases coming before them". (Blagg 2007, pp. 12)

Elements of a therapeutic approach include (Richardson 2016, pp. 81-82):

- promoting behavioural change intended to promote compliance with the criminal justice system;
- adopting a forward looking approach rather than focusing upon the apportionment of blame;
- acknowledging that the community can be protected by treating and monitoring offenders;
- adopting an evidence-based approach to determining measures that are effective and consistent with criminal justice principles; and
- a recognition of the importance of procedural justice in all proceedings. This involves:
  - an affirmation of a person's status as a competent, equal citizen;
  - giving a person voice, validation and respect;
  - treating people with dignity

- applying an ethic of care;
- active judicial involvement;
- active participation of all participants; and
- encouraging self-determination and individual choice.

In developing a comprehensive framework, this Review accordingly suggests that non-adversarial and therapeutic approaches be adopted where appropriate in dealing with alcohol- and drug-related crime.

1.5 SPECIALISATION OR MAINSTREAMING?

In 2014-15, the Queensland criminal courts finalised over 120,000 defendants where 20% had an illicit drug offence as the principal offence (23,970 defendants) (ABS 2016b).[3] The number of defendants convicted of illicit drug and/or other offences, whose offending was substantially influenced by drug or alcohol dependence, is more difficult to estimate, but analysis of QCS administrative data suggests that the numbers are significant. Of those convicted of crimes and sentenced to supervision (including a probation, intensive correction or imprisonment order) in 2014-15, 43% had a drug and/or drug-motivated offence and 55% were assessed as having a high risk of a substance misuse issue.[4]

In 2014-15, some 9,500 people were referred by the Queensland Police Service (QPS) to the Police Drug Diversion Program and just under 6,000 people were referred to the Drug and Alcohol Assessment Program through court-related processes.[5]

The previous Queensland Drug Court, in its various locations, managed approximately 134 offenders at any one time. It is readily apparent that the problems of people who come into contact with the criminal justice system with drug and/or alcohol abuse or dependency cannot be managed by one, or even a small number of problem-oriented courts. Re-establishing the drug court in one or more locations, the Murri Court in multiple locations and the Domestic and Family Violence Court are worthwhile initiatives for what they will be able to do with, and for, the offenders and victims who come before them. However, in total, they will only be able to deal with relatively few offenders. They are resource intensive, often limited in scope geographically and result in what has been termed 'postcode justice' which excludes, on relatively arbitrary grounds, those who could be provided with useful interventions (King et al. 2014, p, 189). While it may be possible to expand the number of such courts, the experience in Australia is that this unlikely to occur. Queensland's Drug Court operated in five locations, New South Wales' (NSW) Drug Court in three, Victoria's, until recently, in one and in other jurisdictions, in only a very few locations. They can never be a panacea to substance abuse-related crime.

The reality of criminal justice in Queensland is that the vast majority of offenders are, and will, in the foreseeable future, be dealt with in the mainstream courts. The drug court, as proposed in this Review, will only deal with relatively few of the most serious offenders in a limited number of places.

Many of the people with alcohol and other drug problems who come into contact with the law and will not have access to a drug court also require appropriate assessment, referral and treatment resources prior to, or after sentence. And because, as we suggest, the non-adversarial and therapeutic approaches provide a holistic and probably more effective approach to dealing with substance abuse-related crime, it would be sensible to adopt these approaches, where appropriate, across the criminal justice system. What is required is a comprehensive approach to substance abuse-related crime from first contact with police through to bail, sentencing and parole, which can be implemented on a statewide basis.

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[3] These data exclude defendants with a principal offence relating to traffic and regulation offence/s; in total more than 170,000 defendants were finalised in 2014-15.

[4] QCS administrate data.

[5] DJAG administrative data.

In relation to the courts, therapeutic/problem-oriented principles can be applied throughout the state by adopting the underlying philosophical approaches outlined above, using existing resources, modifying existing, or creating new, dispositional options and adapting administrative procedures (Spencer 2012).

If so adopted, many of the strategies and interventions successfully adopted by problem-oriented courts can be used more broadly. However, this would require a number of significant changes in the manner in which courts dealing with drug- and/or alcohol-affected offenders are managed across the state. Victorian magistrate Pauline Spencer has outlined the types of changes that would be required to 'mainstream' these more responsive and effective approaches (Spencer 2012):

- **Changes in court craft**: judicial officers have wide discretion as to how they manage their courts and, subject to the resources and dispositional options available and the judicial officer's willingness to adopt a problem-oriented approach, a mainstream court can accommodate a different model;
- **Judicial supervision or monitoring**: can be implemented through existing court powers or proposed new ones;
- **Targeting**: to ensure that appropriate interventions are only used for suitable offenders;
- **Changes to listing practices**: courts can manage their lists to allow for sufficient time to run separate or different lists that involve problem-oriented approaches;
- **Partnerships**: Although problem-oriented courts or lists have treatment and rehabilitation resources made available to them, generic services may be available or there may be services in the community that can provide support and treatment to offenders dealt with in mainstream courts;
- **Court leadership**: if problem-oriented, therapeutic approaches are to be mainstreamed, the Chief Magistrate and Chief Executive Officer of the court must be committed to the enterprise and create a culture in which such an approach can be successful;
- **Court-level reforms**: Court management and administrative systems can be put in place to support solution-focused approaches;
- **Governance**: A cohesive statewide framework is necessary to support this approach, but such an approach must allow adaptation to local circumstances;
- **Access to services**: where no government funds are available to provide services, partnerships with local services or providers may be sought;
- **Support for judicial officers and court staff**: judicial officers and staff must receive support through education relating to therapeutic jurisprudence and problem-oriented approaches. Access to training must be available as well as access to, and knowledge of, resources such as the Solution-focused Judging Bench Book authored by Magistrate Michael King.[6]
- **Professional development**: As well as judicial officers, prosecutors, counsel and support agencies must be provided with education and training relating to therapeutic jurisprudence and problem-oriented approaches.

We recognise that in some circumstances this may require the appointment of additional magistrates who are sympathetic to these approaches, continuing education and engagement with sitting judicial officers, court staff, corrections staff, legal representatives, police and related agencies regarding the application of non-adversarial and therapeutic justice principles, in particular those relating to the vital role that they play in non-adversarial and therapeutic practices.

[6] See http://www.aija.org.au/Solution%20Focused%20BB/SFJ%20BB.pdf .

1.6 RESTORATIVE JUSTICE AND THE RIGHTS OF VICTIMS

The criminal justice system is not only concerned with the rights and responsibilities of offenders and the interests of the state acting on behalf of the community. Victims are an important part of the criminal justice system and their interests and role must be recognised throughout the criminal justice process. This may take the form of providing them with information about court processes, about their rights in the process, their entitlement to restitution and compensation and their voice in the sentencing process through such mechanisms as the victim impact statement.

One mechanism for victim involvement is through restorative justice processes. Restorative justice has been described as comprising

> … principles that promote the more inclusive, comprehensive and satisfying resolution of the effects of harmful behaviour. It seeks the restoration of victims, offenders and society through the application of these principles in processes dealing with the aftermath of wrongful behaviour generally. (King et al. 2014, p. 41)

Fundamental principles of justice for victims

1. Fair and dignified treatment
2. Privacy of victim
3. Information about services
4. Information about investigation of offender
5. Information about prosecution of offender
6. Victim to be advised on role as witness
7. Contact between victim and accused to be minimised
8. Giving details of impact of crime on victim at sentencing
9. Reading aloud of victim impact statement during sentencing
10. Special arrangements for reading aloud of crime impact statement during sentencing
11. Providing information about convicted offender

Restorative justice is becoming increasingly widely used in the criminal justice system in the form of family group conferencing for young offenders, Indigenous sentencing circles, victim-offender mediation and other forums that may occur at the pre-arrest and arrest stages, while the offender is on bail, as part of the sentencing process and in some cases, post-sentence. In appropriate circumstances victims of crimes committed by alcohol- and drug-dependent offenders may wish to become involved in restorative justice programs, though their involvement can only ever be voluntary. This may occur at various stages in the criminal justice system including after arrest, while the offender is on bail or when sentence is adjourned or deferred.

In general terms, victims are likely to be able to manage their experiences through the criminal justice system more successfully if provided with appropriate information and support, including with the assistance of victim support services.

In Queensland, fundamental principles of justice for victims of crime are set out in the *Victims of Crime Assistance Act 2009* (the Act) which outlines the standards to be applied by government agencies when providing services to a victim of crime who has suffered personal harm. The purposes of declaring these principles, as set out in section 5 of the Act, are to advance the interests of victims by stating some fundamental principles of justice that government entities and officers are to observe in dealing with them, and to inform victims of the principles they can expect will underlie their treatment by government entities and officers.

Victim Assist Queensland (VAQ) is an assistance scheme that provides access to specialised support services and financial assistance to help victims' recovery. VAQ can play a critical role in supporting victims throughout the court process, including as part of a future Drug Court.

In Part C we discuss the operation of the proposed Drug Court and the involvement of victims as part of this process in more detail.

1.7 SUBSTANCE ABUSE

Illicit drugs such as cannabis, heroin, methamphetamines, opioids and, more recently, a host of synthetic drugs have long been identified as major contributors to criminal behaviour, adverse health outcomes and a range of social pathologies. However, throughout history, alcohol abuse has been a far greater social problem and continues to be a significant contributor to crime, family violence, family breakdown and unemployment. Drug and alcohol abuse are not unrelated and often co-exist with other psychosocial problems. Cause and effect are often difficult to disentangle.

Research has found that alcohol is a common principal drug of concern among people accessing alcohol and other drug treatment services (AIHW 2016a) and levels of alcohol consumption among offenders are substantially higher than those found among the general population (AIHW 2015).

Among prison entrants, 38% reported levels of alcohol consumption that placed them at high-risk of alcohol-related harm (as measured by the AUDIT C) indicating hazardous levels of drinking or active alcohol use disorders (AIHW 2016b). Other research has shown that police detainees reported drinking 23 standard drinks (on average) on their last drinking occasion (AIC 2015a).

With reference to the re-establishment of the drug court, a review of the literature observed that many drug courts in Australia exclude alcohol. The US National Association of Drug Court Professionals (NADCP) Queensland Network of Alcohol and other Drug Agencies key components for the operation of drug courts make clear that alcohol use is included in the purview of drug courts. There is no evidence to suggest that offending alcohol abusers would not benefit from a drug court program. This is particularly relevant for Queensland in addressing offending by Aboriginal and Torres Strait Islander people, for whom the primary substance abused may not be the illicit drugs traditionally included in Australian drug courts.

Many of those consulted in the course of this Review supported a broad approach to substance abuse that includes alcohol addiction and addiction to other legal drugs commonly abused in the community. This broader approach reflects the community experience that problematic substance use and links to criminal offending are not limited to people who use illegal drugs. The corollary of this is that in considering eligibility for, and the operation of, intervention programs, possible problem-oriented lists and the proposed drug court, alcohol abuse/dependency should be included as a relevant factor. Such an inclusion would likely increase the participation rates for those Aboriginal and Torres Strait Islander offenders for whom alcohol abuse is a serious problem.

1.8 CAUSE AND EFEFECT

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. This simple hypothesis holds that where a crime has been committed by a person who is drug addicted, alcohol dependent or mentally ill, the offence is the direct product of the underlying problem. The consequence of such analysis is that the most appropriate method of dealing with the offender is to provide treatment for the identified disorder, which, if successful, will reduce the offending behavior. This approach has been described as the 'direct cause model' (Richardson 2016, p. 271).

However, crime is the product of multiple factors, both personal and environmental. The personal factors may involve substance abuse, personality disorders, past history of abuse, family breakdown and others while the environmental factors may involve social disadvantage, poverty, peer group pressure and others. Some factors such as age and criminal history may be '*static*', that is, they are not changeable and some, such as substance abuse or employment status are '*dynamic*' and amenable to change.

It is misleading and dangerous to infer a direct causal relationship between a particular condition and the commission of a crime. In fact the relationship between offending behaviour and an underlying disorder such

as substance abuse or mental disorder is far more complex. Five different relationships between an underlying disorder and criminal behaviour can be hypothesised: [7]

1. The anti-social behaviour is directly related to or driven by aspects of the underlying disorder. In this case, effective treatment of the underlying disorder would be likely to reduce the risk of further anti-social behaviour.
2. The anti-social behaviour is indirectly related to the underlying disorder. Treatment would be likely to make a contribution to a reduction in offending but would not be sufficient in itself to tackle offending behaviour.
3. The anti-social behaviour and the underlying disorder are related by some common antecedent, for example childhood abuse. Treatment of the underlying disorder in itself would not be sufficient to tackle re-offending.
4. The anti-social behaviour and the underlying disorder are coincidental.
5. The underlying disorder is at least partly secondary to the anti-social behaviour.

In the best-case scenario, effective treatment of the underlying disorder is likely to reduce crime. However, this is premised upon the ability of criminal justice professionals and others to diagnose accurately the cause or causes of the 'problem' that need to be addressed through an intervention or a 'problem-oriented' court. However, if an offender's problems are multi-factorial and the offences committed various (such as property offences, family violence offences, offences of personal violence generally, offences against the administration of criminal justice) then individual court programs, or interventions alone, such as drug court, or family violence court, may not be able to address all the factors involved. Problems of co-morbidity (alcohol/drug/mental disorder) may be addressed by more generic responses such as broad-based intervention programs rather than specific courts or lists or by lists with expanded remits such as the Family Drug Treatment Court in the Childrens Court of Victoria, that recognises the interactions between substance abuse, family breakdown and child protection issues (King et al. 2014, p. 188).

In all these circumstances, expectations of the outcomes of these programs should be realistic and informed by an understanding that they can make a small but significant contribution to reducing crime in Queensland.

[7] Adapted from Lord Keith Bradley, The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System (London, Department of Health, April 2009) 17; [from Richardson 2016:27].

2 A CONTINUUM OF INTERVENTIONS

2.1 INTRODUCTION

A drug court is one of a number of interventions that can be made by the criminal justice system in response to drug- and alcohol-related crime. Some of these interventions are made by the police service, some by the courts, and some by corrections and most with the cooperation of other government agencies such as Queensland Health (QH) and community organisations that provide housing, education, training, health and other social services. The drug court should, accordingly, be understood as only one small part of a long continuum of referral services and intervention programs that are required to reduce crime and the risk of crime, decrease the pressure on prison populations and improve the health and social outcomes of offenders and their families.

The challenge of developing such a system is to ensure that the work of police, courts, corrections, government agencies and private or community organisations is integrated, effective and efficient. Feedback provided to the Review indicates that the current system does not meet these criteria. A number of interventions are locality based rather than being based on the requirements of the eligible offender. A lack of coherence between programs contributes to confusion among treatment agencies, which places pressure on justice and law enforcement resources. Programs that are very similar in terms of their therapeutic intent are linked to separate legislative and administrative regimes and there appears to be duplication of services that provide different outcomes for the same participant.

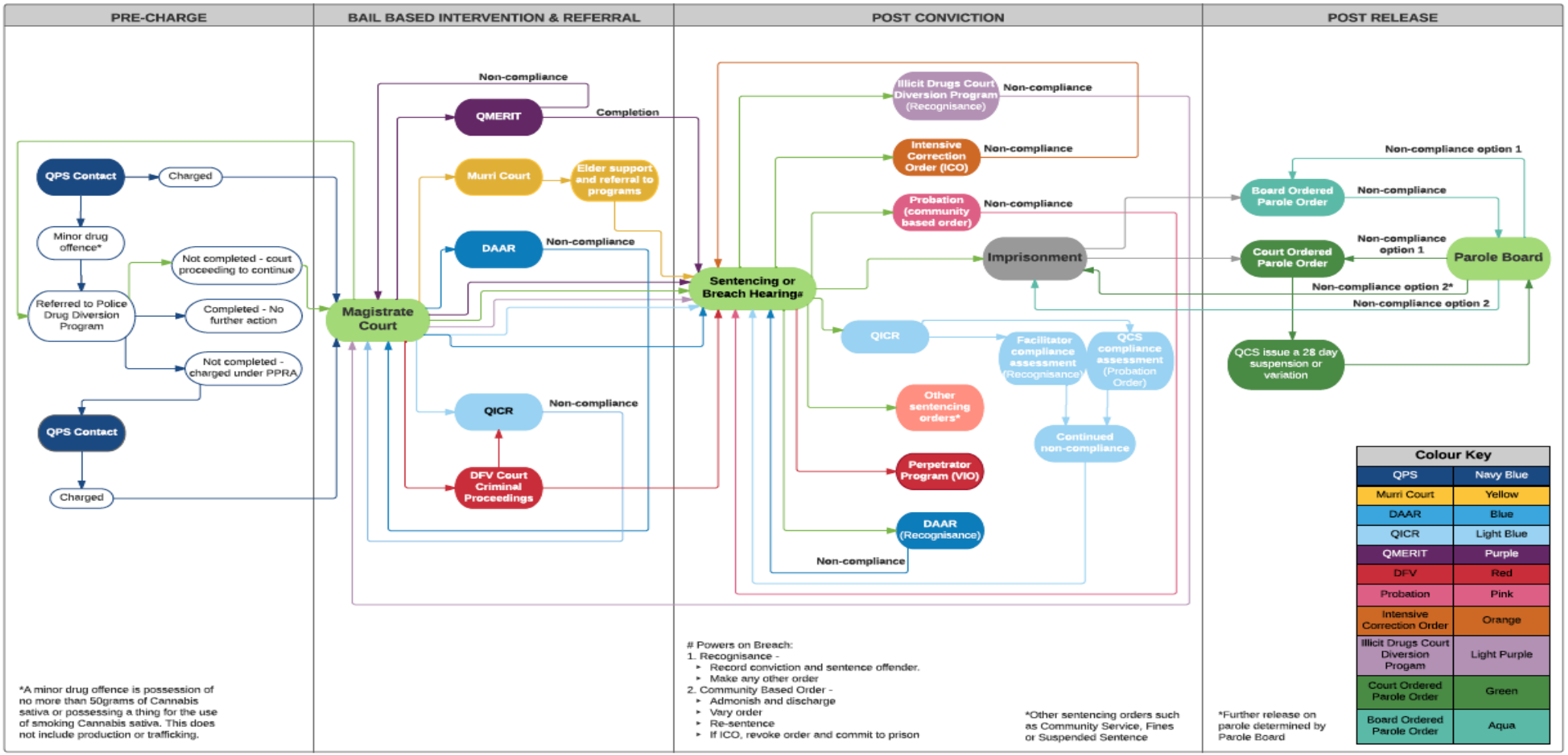
In response to this feedback, and as a first step towards improving the integration, effectiveness and efficiency of Queensland's approach to drug- and alcohol-related crime, this Review has aimed to develop a comprehensive criminal justice model that identifies a range of interventions along the criminal justice continuum.

2.2 MODEL OF CURRENT INTERVENTION PROGRAMS

Figure 1 below shows the various stages of the Queensland criminal justice system and the various legal frameworks, referral programs, interventions and sentencing dispositions that apply from first contact with police through to parole release. The criminal justice system deals with cases from very minor to the most serious. It can be viewed sequentially, in that an offender may progress through the various stages from arrest, to bail, to sentence to parole, or recursively, by progressing through parts of the system and, either by breaching an order, or re-offending, return to an earlier stage.

What is evident from the depiction of the process is that some interventions are available at different stages and, as will be indicated, some operate in very similar fashions, but under different names and with different funding sources.

Figure 1: Queensland criminal justice system pathways



2.3 CRITERIA FOR INTERVENTIONS

This criminal justice continuum can be conceived of not only as a process map but as a complex set of relationships between offence seriousness, offender characteristics, treatment requirements and legal power. In developing a comprehensive criminal justice framework, a balance between these various elements must be struck.

Figure 2: Relationship between offending history, drug use and level of treatment

Offence seriousness will limit the degree of intervention that the state may make into the life of an offender so that even if an offender has very high treatment needs, what the state can do will be tempered by the nature of the offence committed. An offender who has committed a very serious offence, on the other hand, may have very limited treatment needs and may not be suitable for treatment intervention. Even a long history of offending may not warrant a very long sentence if the offence committed is less serious.

In designing a coherent and effective overarching framework for criminal justice interventions, the following criteria should be used to determine the stage in the criminal justice system when the intervention takes place and its nature:

2.3.1 The nature and seriousness of the offence

This criterion assists in determining not only the appropriate intervention but the proportionality considerations that should apply.

2.3.2 The history of involvement in criminal justice system

This criterion assists in determining the offender's past criminal history, which also assists in assessing an offender's past responses to criminal justice interventions, their attitude to those interventions and to court and other orders, as well as determining the proportionality considerations that should apply.

2.3.3 Risk, need and responsivity

The risk, need and responsivity (RNR) principle assists in determining which treatment modalities will be most effective, as it stipulates that interventions be targeted appropriately to meet an offenders' risk of reoffending, their criminogenic needs and level of responsivity.

Among all the interventions examined in this report, the RNR principle ensures that the intervention is appropriate to the offence and the offender, thus tailoring aspects of programs to meet individual needs. Using this principle, more intensive (and more costly) interventions tend to be reserved for high-risk, high-need offenders, while briefer (and cheaper) interventions are given to low-risk, first offenders. Additionally, many of the interventions draw conceptually from the therapeutic jurisprudence literature and its associated development of solution-focused responses to criminal behaviour – solutions that attempt to address the underlying causes of offending, rather than simply offering punitive responses.

2.4 CLEAR CONCEPTUALISATION OF PROGRAMS

In designing intervention programs, it is necessary to ensure that each intervention program is clearly conceptualised in order to ensure that it is properly targeted, proportionate, necessary, cost-effective and meets its stated aims. Such a conceptualisation requires:

- a clear set of reasons or logical basis for the course of action (program logic);
- a clear articulation of the causal model that links the offending behaviour, and the intended outcome of the intervention;
- a clear set of objectives or statement of what the intervention program seeks to achieve; and
- a clearly identified target group (Richardson 2016, pp. 263-264).[8]

2.5 A CLEAR LEGISLATIVE AND REGULATORY FRAMEWORK

Many existing programs are based on uncertain or vague legal foundations. Many programs are based upon a judicial officer's powers to grant bail, some are based on general powers of adjournment, some on general sentencing powers and others on specific statutory provisions. There are differing views as to the appropriateness of using bail or general powers of adjournment to underpin interventions (Freiberg & Morgan 2004). Bail has the advantage of flexibility by allowing judicial officers to craft schemes that suit their purposes. The nature of such schemes may result in a blurring of the boundaries between bail and sentencing. The question remains whether this use is consonant with the purpose of bail, which is primarily to ensure that an offender returns to court to respond to the charges laid against them. Lack of clarity can lead to net-widening, disparity between courts and judicial officers resulting in idiosyncratic behaviour and unjustifiable or disproportionate interventions.

King et al. (2014, p. 206) have argued that:

> … it is important that clear distinctions are maintained between sentencing and non-sentencing powers; that the interventions or programs are appropriate and proportionate to the stage of the proceedings at which they occur and to the harm that has been alleged; that the interventions or programs are relevant to the purpose of the power; and that appropriate legal protections are in place to preserve the rights of offenders or alleged offenders.

The Law Reform Commission of Western Australia (2008) recommended that court intervention programs be underpinned by legislation 'in order to ensure that the programs are able to meet the aim of rehabilitating offenders and reducing crime'. The Commission argued that legislation had an important role in:

- ensuring programs are valued and understood in the criminal justice system and by the wider community;
- promoting consistency, accountability and confidence in programs;
- strengthening rehabilitative efforts and preventing future offending;
- promoting equality of justice;
- promoting awareness of a program and the benefits;
- providing legitimacy of a program and engendering community support by clearly stating the purpose of the program;
- promoting the objectives of a program and encouraging systemic change;
- giving judicial officers confidence to use a program; and
- ensuring that programs are appropriately resourced.

Similarly, Pauline Spencer has argued that government policy and legislative change are the key to driving systemic and cultural change in courts (Spencer 2012, p. 94).

There is a diversity of views as to the desirability of providing clear legislative foundations for intervention programs. Those opposing a legislative approach point to the flexibility and innovation in programs that is

[8] These matters are discussed further below in Paragraph 10.5.6 where we recommend that some intervention programs be gazetted if they meet certain criteria set out in regulations.

possible when judicial officers are not constrained by firm and specific legislative mandates. However, this Review takes the view that flexibility and pragmatism are uncertain foundations upon which to build a coherent framework of interventions and that a better approach 'where the coercive power of governments is involved, is to clearly set out in statute what the rights and responsibilities of the various parties are, what are the limits of state power and what sanctions may be imposed on persons before the courts' (King et al. 2014, p. 193).

Recommendation 1	**Need for a clear program logic and legal foundations**

Intervention programs should be:

- **clearly conceptualised in order to ensure that they are properly targeted, proportionate, necessary, cost-effective and meet their stated aims; and**
- **underpinned by legislation to provide a stable and clear legal foundation for these programs to operate and to identify their intended target group and purpose.**

2.6 PRINCIPLES

Interventions along the criminal justice continuum should be governed by a set of principles that can determine which are appropriate at each stage of the process. We have discussed some of the criteria for interventions: offence seriousness, offender history and RNR.[9] These, in turn, must be informed by a broader set of principles that can guide the development of policy and decision-makers within the system.

2.6.1 Proportionality

Proportionality is a sentencing principle that holds that the severity of a punishment imposed should be commensurate with the seriousness of the offending, which involves both the degree of harmfulness of the conduct and the extent of culpability of the offender. The principle of proportionality applies to rehabilitative sanctions as much as punitive sanctions. The Victorian Court of Appeal has held in a case relating to the principles that should apply to a community correction order that considerations of proportionality apply to all elements of the sentence, including punishment and rehabilitation.[10]

Accordingly, the approach adopted by this Review is that an intervention or a sanction should not be longer or more onerous because of the desire to treat, rehabilitate or assist a person than if that were not a major purpose. Where an intervention program is not part of a sentence, and therefore the principles of proportionality do not strictly apply, we believe that there should be a relationship between the seriousness of the offending conduct and the length and severity of the program.

2.6.2 Parsimony

A sub-set of the principle of proportionality is that of parsimony, which holds that a sentence, or sanction, or intervention should not be more severe than that which is necessary to achieve the purpose or purposes for which that sentence, sanction or intervention is imposed (Freiberg 2014, p. 245). This means that in using the authority of the state, where possible, the least restrictive alternative should be used.

2.6.3 Minimising net-widening and sentence escalation

The ostensibly benign intentions of a non-adversarial approach should not have the consequence that more people are brought within the operation of the criminal justice system, that they are under state control for

[9] See Paragraph 2.3

[10] *Boulton* [2014] VSCA 342.

longer periods than they otherwise would have been and that the sanctions imposed upon them or the conditions of the sanctions are more onerous than they would otherwise have been.

Net-widening refers to unintended effects of what are ostensibly 'diversion' programs when more people are enmeshed in the criminal justice system than previously due to the desire to provide those with programs that would not otherwise be available were they not charged with criminal offences. Sentence escalation occurs when a more severe sentence is imposed that would otherwise be warranted in order to receive the benefits of an intervention program (King et al. 2014, p. 190).

Net-widening and sentence escalation can take a number of forms:

- the length of a program may be longer due to treatment or rehabilitation requirements than it would have been if treatment or rehabilitation had not been a purpose of the intervention;
- intervention programs may supplement rather than replace community interventions, thus increasing the total duration of government or other forms of interventions in an offender's life;
- the conditions of a program may be more numerous and onerous than they otherwise would be if treatment or rehabilitation had not been a purpose of the intervention; the greater the number of conditions and their stringency may result in a greater number of breaches that may in turn result in an increased number of sanctions being imposed that may also be more severe; and
- the use of sanctions and rewards within an intervention program or as part of a sentence may result in more severe sanctions than if no such mechanisms were operating within such a program or as part of a sentence.

A comprehensive system of criminal justice interventions must therefore ensure that no more people are brought within the operation of the criminal justice system, or are brought under state control for longer periods than they otherwise would otherwise have been, or that the sanctions imposed upon them or the conditions of the sanctions are more onerous than they would have been had treatment or rehabilitation not been a purpose of the intervention.

2.6.4 Privacy

A comprehensive criminal justice response to offending often requires co-operation between criminal justice agencies as well as those delivering health and other ancillary services. This may require the sharing of information originally collected by those agencies for their own purposes. This may be done with the (genuine) consent of the offender. On the other hand, the state may deem it necessary or desirable that personal information be shared as part of an integrated, holistic approach to the appropriate dispositions for that person.

Overarching privacy principles require that personal information collected about a person remains confidential and that their rights to privacy are respected. However, a comprehensive criminal justice response may require amendments to laws relating to privacy and confidentiality to expand the ability of agencies to share information;[11] any such expansion should adhere as closely as possible to the National Privacy Principles set out in Schedule 4 of the *Information Privacy Act 2009* (Qld).

2.6.5 Minimal coercion

A non-adversarial justice system underpinned by the principles of cooperation, therapeutic jurisprudence and restorative justice usually requires that the offender acknowledge guilt or plead guilty to an offence. Access to intervention programs or problem-oriented courts is contingent on such pleas or acknowledgements. This may be regarded as representing a degree of coercion, particularly in respect of offenders with some form of disability (King et al. 2014, p. 190). An offender who pleads guilty may consequently acquire a criminal record, which may affect their future prospects.

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[11] See Information Privacy Act 2009 (Qld).

However, the criminal justice system is founded on the presumption of innocence and the requirement of the prosecution to prove its case beyond reasonable doubt.

Although there is some evidence that a degree of coercion may be useful in encouraging offenders to enter into, and remain in, intervention programs, a fair, non-coercive system must ensure that offenders who wish to contest charges brought against them be able to do so in an appropriate forum and no unnecessary or unethical interventions be used in relation to them.

2.6.6 Consent

Referral to an intervention entails a degree of interference into the liberty of the individual. It is important that the person be able to consent freely to the process and its consequences. Consent may be relevant at different stages of the referral and intervention process. Richardson identifies these stages (Richardson 2016, p. 321):

- consent to be referred to in the [intervention] process which involves consent to be screened and assessed, for health records to be accessed and for an intervention plan to be developed;
- consent to participate once the intervention plan has been determined; and
- consent to use and sharing of personal and medical information about the participant and regarding time limits on the use of that information.

The matters to be explained to the offender at each stage include:

- that the program is voluntary and what this means;
- what processes at each stage (that is, referral, screening and assessment, judicial hearings) involves;
- what the overall program participation involves;
- what is required for successful completion of the program;
- what would happen if the person does not participate, and ways to access treatment if the person does not participate. Linkages and referrals should also occur if the person decides not to participate; and
- what conditions are attached to the order and the expectations of the court and external treatment providers of the offender.

A just system of criminal justice interventions must ensure that where a person's consent is required, that person is freely able to consent to the intervention and its consequences.

Recommendation 2	**Guiding principles for interventions in a criminal justice context**

The criteria including the nature and intensity of alcohol and other drug treatment interventions and the stage in the criminal justice system at which they are offered (pre-arrest, post-arrest, bail, pre-sentence, post-sentence) should be guided by the following principles:

- **An intervention or a sanction should not be longer or more onerous because of the desire to treat, rehabilitate or assist a person than if that were not a major purpose (principle of proportionality).**
- **Where an intervention program is not part of a sentence, and therefore the principle of proportionality does not strictly apply, there should be a relationship between the seriousness of the offending and the length and intensity of the program.**
- **When using the authority of the state to encourage engagement with treatment services, where possible, the least restrictive alternative should be used to ensure the intervention is not more severe than that which is necessary to achieve its purpose (principle of parsimony).**
- **Interventions should be designed to minimise the unintended consequences of net-widening and sentence escalation – that is, avoid bringing people within the operation of the criminal justice system, or under state control for longer periods than they otherwise would otherwise have been, or that will result in sanctions being imposed or the conditions of those sanctions being more onerous than they would have been had treatment or rehabilitation not been a purpose of the intervention.**

- **Interventions must respect a person's right to privacy, providing for information sharing with the person's consent wherever reasonably possible, unless this impedes the ability of agencies to share information required to support comprehensive criminal justice response.**
- **Interventions should employ minimal coercion to encourage participation – although there is some evidence that a degree of coercion may be useful in encouraging offenders to enter into, and remain in, intervention programs, a fair, non-coercive system must ensure that offenders who wish to contest charges brought against them be able to do so in an appropriate forum and that no unnecessary or unethical interventions be used in relation to them.**
- **As a referral to an intervention entails a degree of interference into the liberty of the individual, steps should be taken to ensure that the person is able to freely consent to the intervention and understands the consequences of giving this consent at key stages of the referral and intervention process.**

3 SYSTEM DEMANDS

3.1 INTRODUCTION

This chapter provides information on the number of people in contact with Queensland's criminal justice system. It shows increasing system pressures and a growing number of people in contact with the system for drug offences.

Much of the data presented in this chapter uses the principal offence to identify changes in drug offending trends. This practice (commonly used to deal with complex data) disguises the full nature and extent of drug offending by only counting the most serious offence within a criminal justice incident. For example, a person convicted for arson and drug possession will only be counted as committing arson. The use of the principal offence also provides no indication of incidents involving drug-related offending not involving drug offences, such as acquisitive offending to support illicit drug purchases. Therefore, this section concludes with the provision of information on the prevalence of drug offences and drug-related offending across all offenders, not just those with an illicit drug offence as their principal offence.

3.2 CURRENT CRIMINAL JUSTICE SYSTEM ENVIRONMENT

The number of people in contact with Queensland's criminal justice system is increasing in an environment of limited funding for criminal justice agencies.[12] Increasing numbers of people are being arrested by the police, which in turn has affected court activity and the number of people held in custody (both on remand or as sentenced offenders).[13] The number of Aboriginal and Torres Strait Islanders and women held in custody is growing a rate higher than overall system growth.

3.2.1 Criminal justice system activity

Figure 3 shows criminal justice system indicator data for the period of 2010–11 to 2014–15. Although each of these system indicators uses different counting rules, they all demonstrate increases in criminal justice system activity.[14]

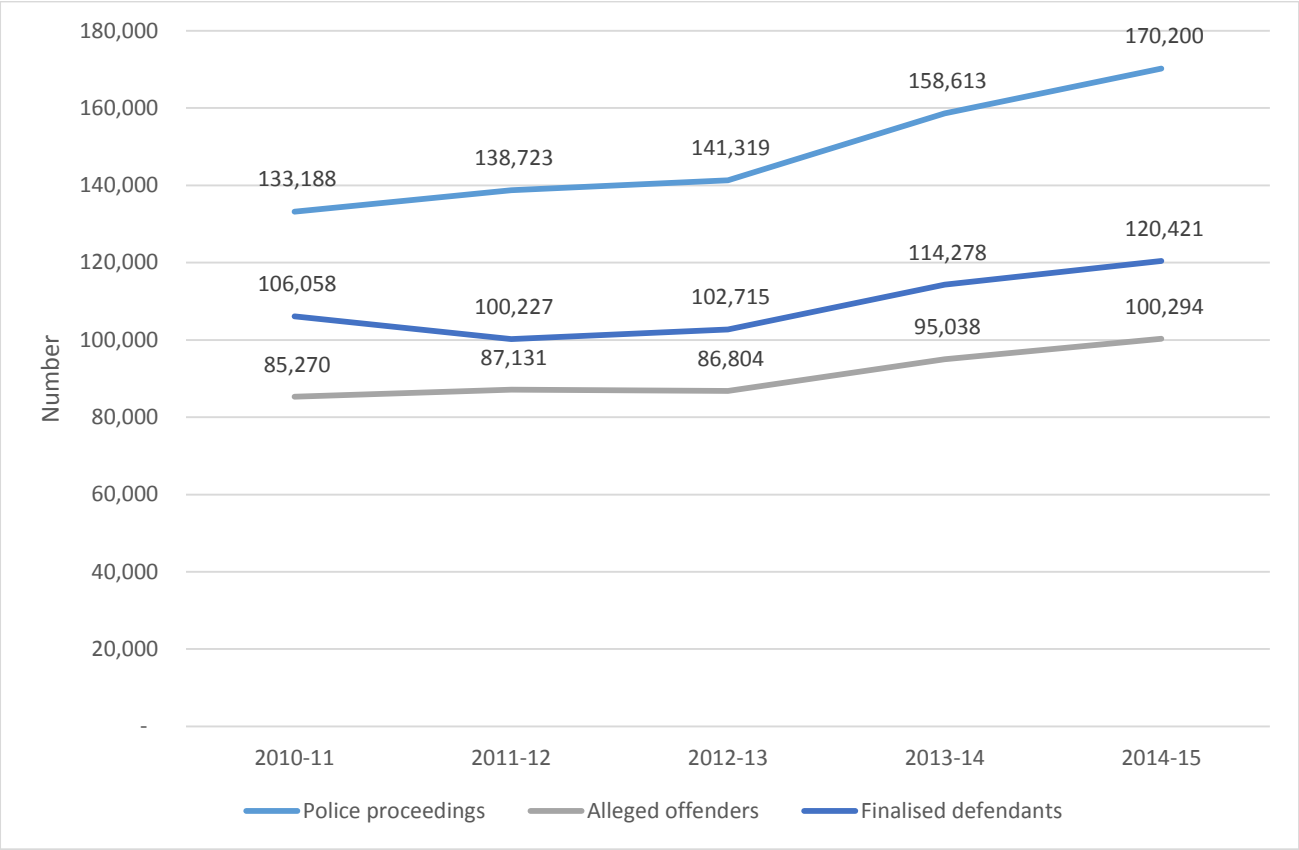
The number of adults arrested by the police increased from 85,270 in 2010–11 to 100,294 in 2014–15 (an increase of 18%). The number of police proceedings increased from 133,188 in 2010–11 to 170,200 in 2014–15 (an increase of 28%) and the number of adult defendants finalised by the courts increased from 106,058 in in 2010–11 to 120,421 in 2014–15 (an increase of 14%).

[12] This economic austerity limits availability of funds for offender management and support services. For example, Report on Government Services data indicates that QCS' offender-to-operational staff ratio in 2014–15 was 35.1 in Queensland compared with 21.2 nationally.

[13] Further information about the data used in this section is provided in the *Data for drug and specialist courts review* at Appendix B.

[14] Alleged offenders data only count unique individuals arrested by the police during the reporting period, police proceedings data excludes matters relating to traffic offences, which are the most common offences heard by the Magistrates Court.

Figure 3: Number of alleged offenders, police proceedings and defendants finalised, Queensland, 2010– 11 to 2014–15



Source: Australian Bureau of Statistics (ABS) Recorded Crime, Offenders, 2014–15 and ABS Criminal Courts, Australia 2014–15

Note: As police data do not include traffic offences, these offences have been excluded from the courts data.

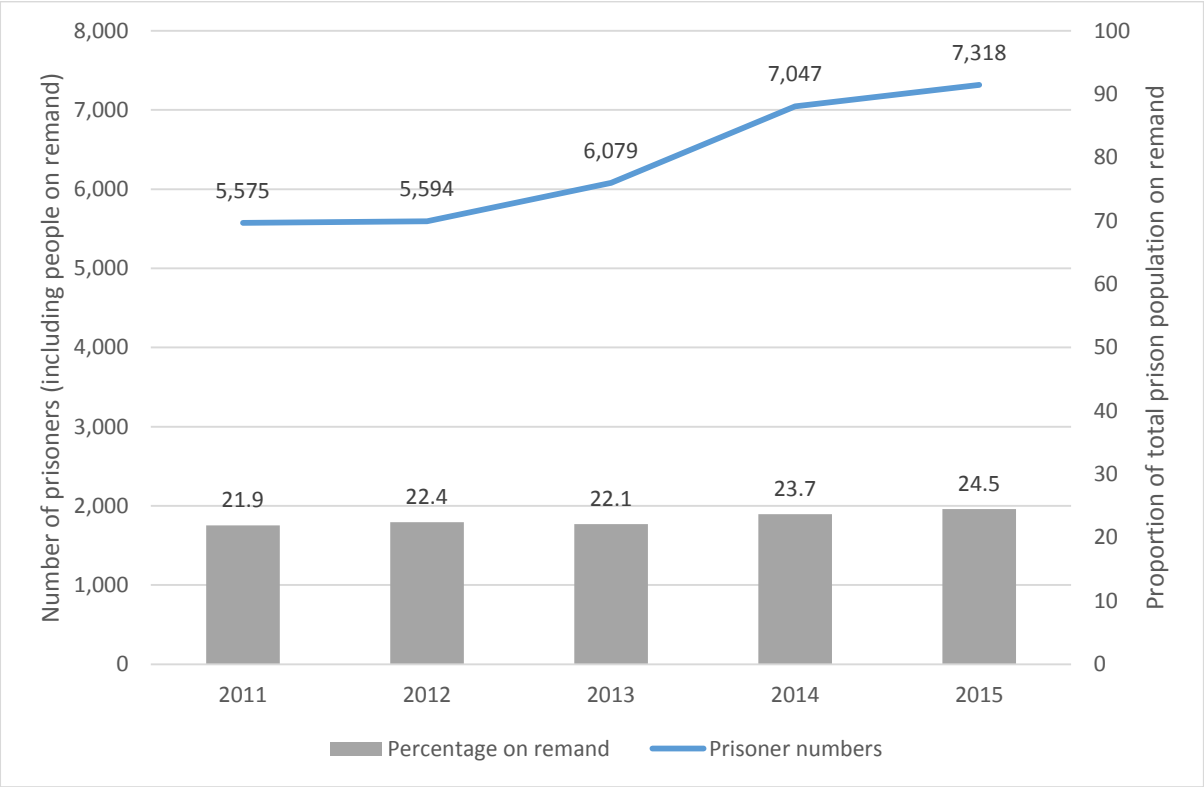
The growing number of people arrested by the police is also evident in Queensland's prisoner population, which increased from 5,575 in 2011 to 7,318 in 2015 (an increase of 31%). See Figure 4.

The proportion of total prisoners held on remand has increased in recent years (from 22% in 2011 to 25% in 2015). This suggests that growth in the number of unsentenced prisoners was higher than that for sentenced prisoners. Indeed, the number of unsentenced prisoners increased by 47%, while the number of sentenced prisoners increased by 26% between 2010–11 and 2014–15 (ABS 2015). Increases in remand numbers are more likely to be explained by the growing number of people arrested by the police and not released on bail, rather than increased time spent on remand, given that the median number of months spent on remand was 3.4 months in 2011 compared with 3.5 months in 2015 (ABS 2015). Offenders returned to custody under suspension of their parole order also contribute to the prisoner population.

The level of growth in adult prisoner numbers is not evident in the number of adult offenders supervised in the community. The average number of offenders on supervised orders in Queensland was 13,636 in 2010–11 compared with 14,144 in 2014–15 (an increase of 4%) (Australian Government Productivity Commission 2016). However, there is indication that this relative level of stability is changing given that more recent data indicate that the number of offenders serving probation orders increased by 16% between 30 June 2015 (9,037) and 30 June 2016 (10,495).[15]

[15] QCS administrative data. See 11.6 for further information on number of offenders on probation orders.

Figure 4: Total number of prisoners and proportion of total prisoners on remand, Queensland, 2011 to 2015



Source: ABS Prisoners in Australia, 2015

Note: Prisoner numbers are number of people in prison as at 30 June each year.

There has also been an increase in the number of young people (aged 10 to 17 years) in contact with the criminal justice system. For example, the number of young Queenslanders in detention on an average day increased from 138 in 2010–11 to 172 in 2014–15 (an increase of 25%) (AIHW 2016a). The majority of these young people were unsentenced. On average, young remandees accounted for 72% of the youth detention population in 2010–11 compared with 84% in 2014–15 (AIHW 2016a).

The increasing number of people in contact with the criminal justice system has driven a growing demand for alcohol and other drug treatment as the number of people referred to these services as part of criminal justice diversionary schemes (such as the Police Drug Diversion Program) or rehabilitation efforts as part of order supervision has, expanded.[16]

3.2.2 Aboriginal and Torres Strait Islander people

People in contact with the criminal justice system are typically from highly disadvantaged backgrounds and Aboriginal and Torres Strait Islanders are the most disadvantaged group in Australia. Aboriginal and Torres Strait Islanders are overrepresented in all areas of the criminal justice system (including as victims of crime) and this overrepresentation continues to increase. For example, Aboriginal and Torres Strait Islanders accounted for 25% of the Queensland prisoner population in 2005, growing to 30% in 2011 and 32% in 2015.[17] In 2015, Aboriginal and Torres Strait Islanders were 13 times more likely to be in custody than non-Indigenous people. The increasing overrepresentation of Aboriginal and Torres Strait Islanders in custody is also evident

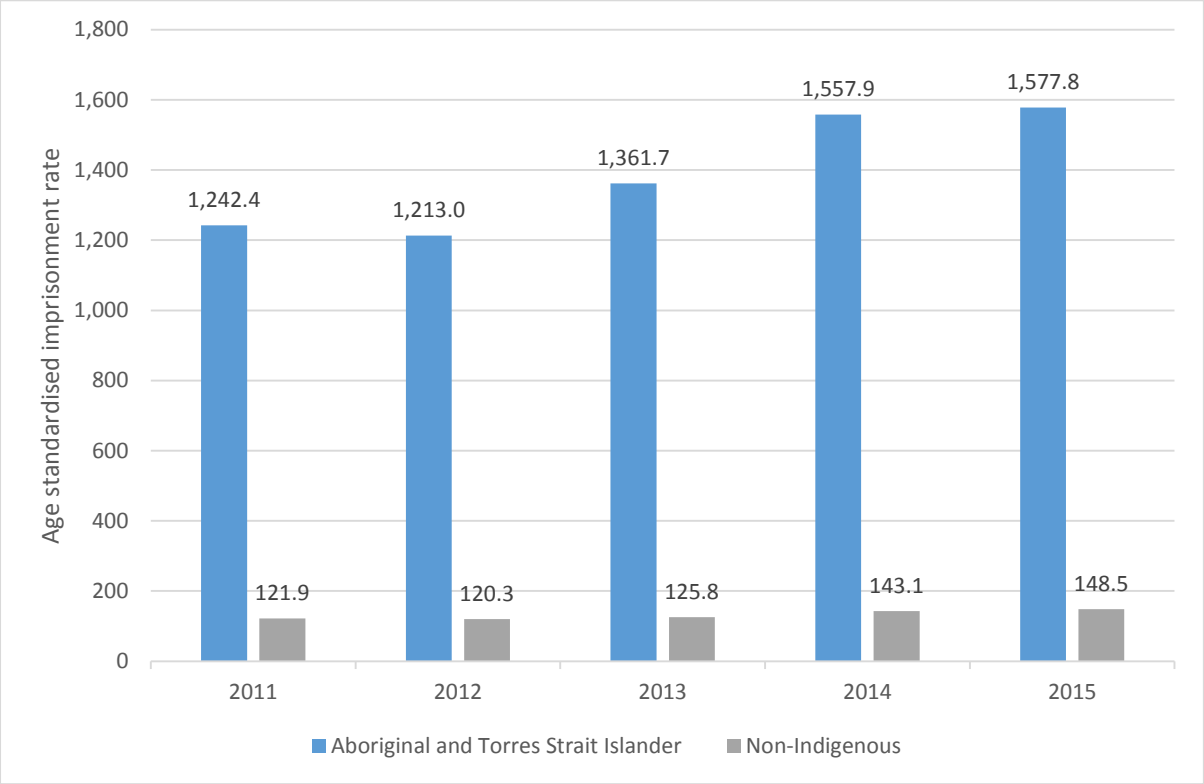
[16] See Chapter 7 for further information on alcohol and other drug treatment services in Queensland.

[17] Aboriginal and Torres Strait Islanders represented 3.6% of Queensland's total population in 2011 (ABS, Census of Population and Housing, 2011, Indigenous profile).

in other Australian jurisdictions. Figure 5 shows the age standardised imprisonment rate for adult Aboriginal and Torres Strait Islanders compared with adult non-Indigenous Queenslanders. Although the rate of imprisonment has increased for both Aboriginal and Torres Strait Islanders and non-Indigenous Queenslanders in recent years, the rate of imprisonment is substantially higher for Aboriginal and Torres Strait Islanders than non-Indigenous Queenslanders and relative increases in incarceration rates are higher for Aboriginal and Torres Strait Islander people. The imprisonment rate for Aboriginal and Torres Strait Islanders grew from 1,242 per 100,000 of the adult population in 2011 to 1,578 per 100,000 of the adult population in 2015 (an increase of 27%), while the rate for non-Indigenous Queenslanders grew from 122 to 149 per 100,000 of the adult population respectively (an increase of 22%).

Aboriginal and Torres Strait Islander youth are also overrepresented in the criminal justice system and this overrepresentation is increasing. For example, 58% of young people in detention (on an average day) in 2010–11 identified as Aboriginal and Torres Strait Islander compared with 65% in 2014–15 (AIHW 2016a).

Figure 5: Age standardised imprisonment rate for Aboriginal and Torres Strait Islanders and non-Indigenous adults, Queensland, 2011 to 2015



Source: ABS Prisoners in Australia, 2015.

Note: Prisoners rates are per 100,000 of the adult population. Age standardisation adjusts crude imprisonment rates to account for age difference between study populations. Crude imprisonment rates for the adult prisoner population are calculated using the estimated resident population of each state and territory. Aboriginal and Torres Strait Islander rates are based on estimated resident Aboriginal and Torres Strait Islander population of each state and territory.

3.2.3 Women

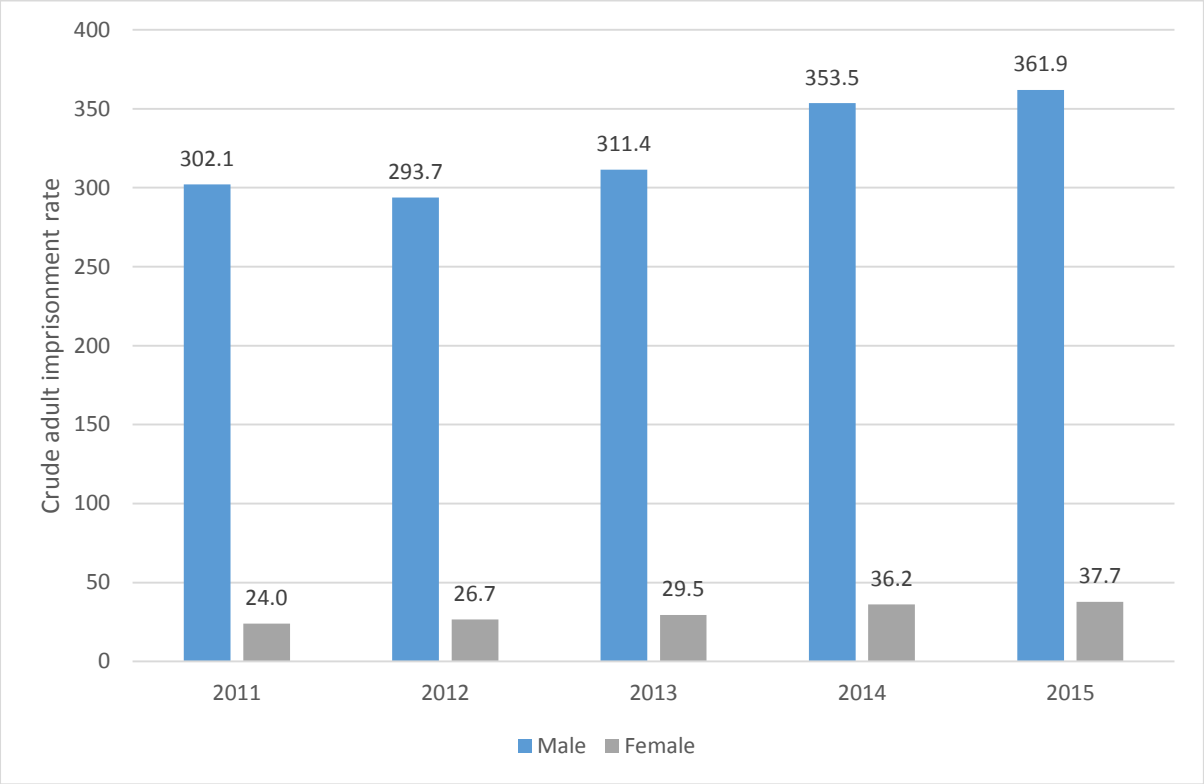
Women are less likely than men to have contact with the criminal justice system. They are more likely to commit acquisitive crimes and less likely to commit serious violence offences when compared to men. In 2015, women made up 10% of the prisoner population in Queensland (ABS 2015). Women represented 24% of total alleged offenders (ABS 2016a) and 24% of total finalised defendants (ABS 2016b) in 2014–15.

Figure 6 shows the crude imprisonment rate for male and female adults. While the imprisonment rate has increased for both men and women, increases were more substantial for women. The imprisonment rate for

women grew from 24 per 100,000 of the adult population in 2011 to 38 per 100,000 of the adult population in 2015 (an increase of 57%), while the rate for men grew from 302 per 100,000 of the adult population to 362 per 100,000 of the adult population during this time (an increase of 20%).

The growing female prisoner population has significant implications for offender management given the specific issues experienced by women prisoners.[18]

Figure 6: Crude imprisonment rates for women and men, Queensland, 2011 to 2015



Source: ABS Prisoners in Australia, 2015.

Note: Prisoner rates are per 100,000 of the adult population. Crude imprisonment rates for the adult prisoner population are calculated using the estimated resident population of each state and territory.

Gendered differences apparent in the adult criminal justice system are also evident in the youth justice system. Although caution is required in interpreting data given the small population sizes, the number of girls in detention on an average day increased by 138% between 2010–11 and 2014–15 (from 13 in 2010–11 and to 31 in 2014–15), while the number of boys in detention rose by 38% (from 125 in 2010–11 and to 172 in 2014–15) (AIHW 2016a). These data suggest that growth in the adult female prisoner population is likely to continue at least in the short-term.

3.2.4 Queensland compared with other states

The alleged offender and imprisonment rates for each Australian jurisdiction are presented in Figure 7.

It shows that young people (aged under 17 years) are generally more likely to be arrested by the police than adults and that adults are more likely to be incarcerated than young people. It also shows that Queensland has higher alleged offender rates and youth detention rates than those in most other jurisdictions. However,

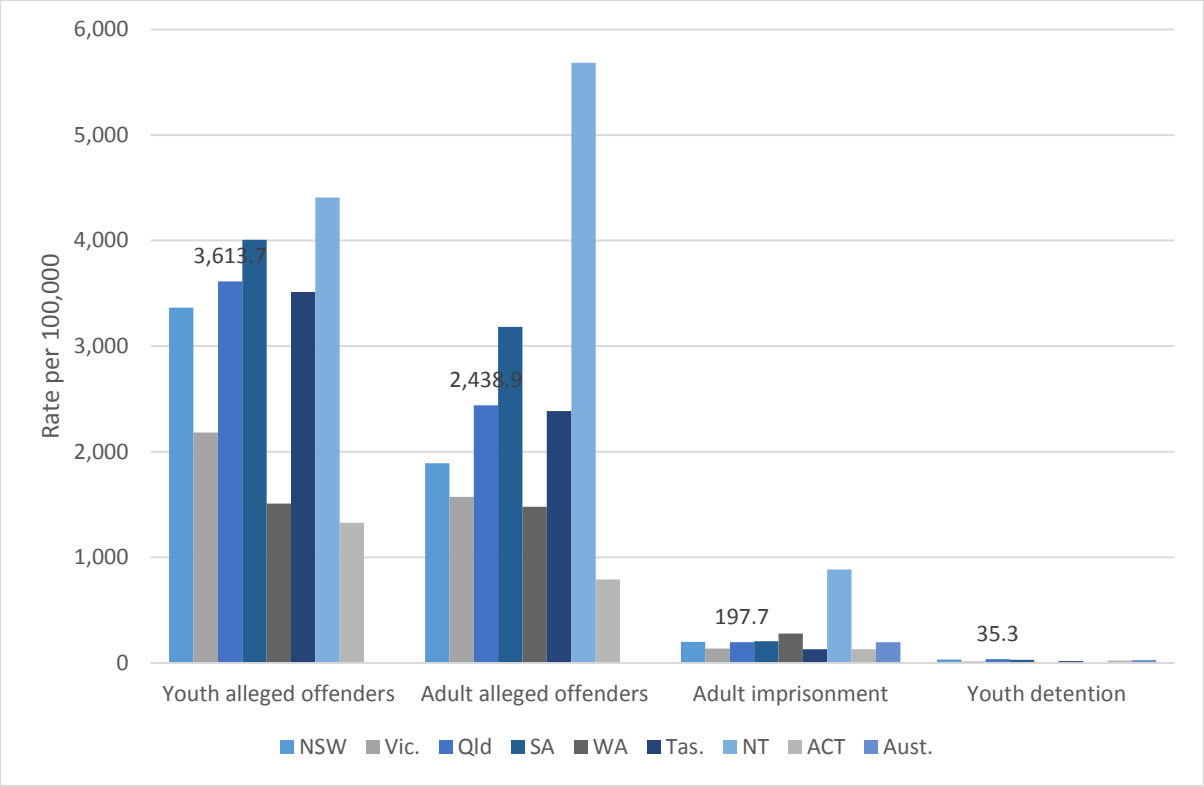
[18] Male and female prisoners are characterised by similar criminogenic issues, such as unemployment, substance misuse, poor mental health and lack of accommodation, however the prevalence and/or magnitude of these issues can be different. Women also have specific issues (such as far higher rates of physical, emotional and sexual victimisation histories) that make their management in prison more complex.

Queensland's adult imprisonment rate is similar to the national total and some other states including NSW and South Australia.[19]

Queensland's alleged offender rate (2,439 per 100,000 of population aged 10 years or more) was higher than that found in NSW, Victoria, Western Australia (WA), Tasmania and the ACT, but lower than South Australia's and the Northern Territory's (NT). Queensland's adult imprisonment rate (198 per 100,000 of people aged 10 years or older) is similar to NSW and South Australia, but lower the rate evident in WA and the NT. Queensland's adult imprisonment rate was only higher than Victoria's and the ACT. Queensland has higher youth alleged offender and detention rates than most other jurisdictions.

Other Australian jurisdictions are also experiencing increases in the number of Aboriginal and Torres Strait Islander people and women in contact with the criminal justice system, as well as, an expanding remand population. However, these increases are not necessarily as high as those evident in Queensland (ABS 2015).

Figure 7: Alleged offender and incarceration rates, Australian states and territories, 2015 and 2014–15



Source: AIHW Youth Justice in Australia 2014–15 (youth detention rates); ABS Prisoners in Australia, 2015 (adult imprisonment rates) and ABS Recorded Crime, Offenders, 2014–15 (youth alleged offender rates and alleged offender rates).

Note: Adult imprisonment rates relate to 2015, all other data relate to 2014–15. Youth detention rates exclude Western Australia and the NT. ABS alleged offender information relates to people aged 10 years or more unless specified otherwise, ABS imprisonment information relates to adults only.

3.3 DRUG OFFENDERS AND OFFENCES

This section shows that the number of people in contact with the criminal justice system for drug offences has exceeded overall system growth. The number of drug offences committed by people has also increased in

[19] Some variation in alleged offender and incarceration rates across the jurisdictions may be explained partially by differences in the representation of Aboriginal and Torres Strait Islander people in different jurisdictions, as this cohort is overrepresented in both the criminal justice system and in other indicators of social disadvantage.

recent years. These findings signify a growing need for interventions and problem-oriented courts that address substance misuse.

3.3.1 Alleged drug offenders

There has been a rise in the number of alleged offenders recorded by police in Queensland in recent years. This includes alleged offenders with an illicit drug offence as their principal offence.

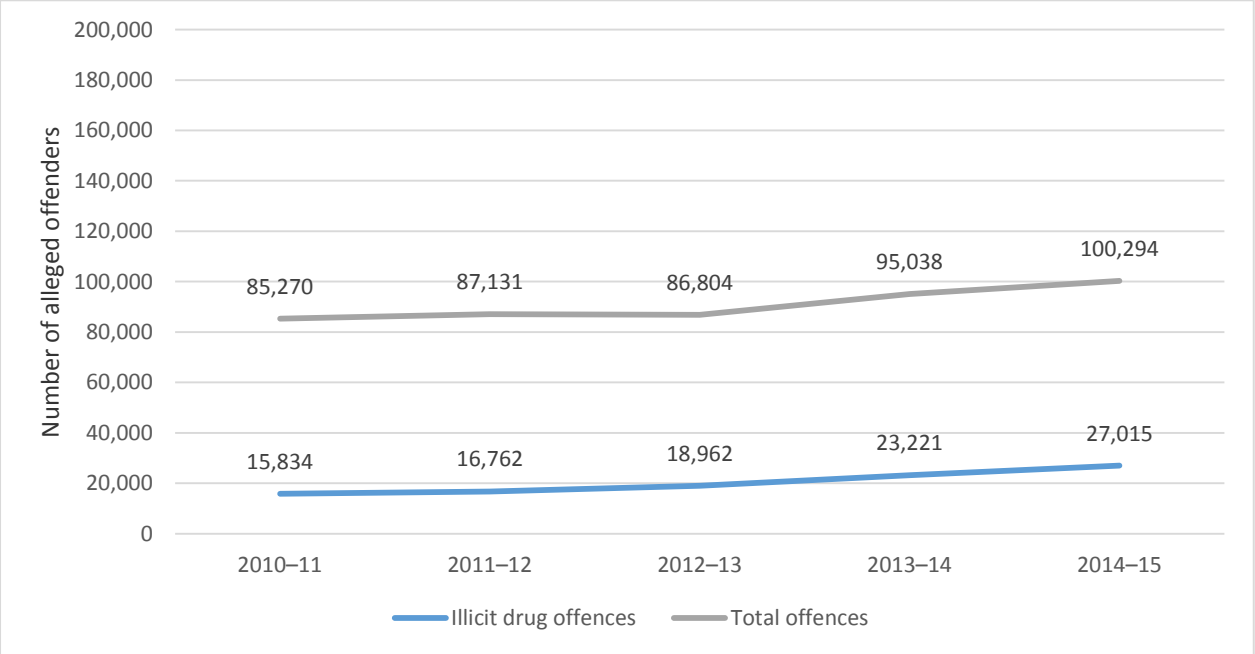
The total number of alleged offenders in Queensland between 2010–11 and 2014–15 is shown in **Figure 8**.[20] These offenders increased in number from 85,270 in 2010–11 to 100,294 in 2014–15 (an increase of 18%). However, the number of alleged offenders with a principal offence involving an illicit drug offence grew from 15,834 to 27,015 (an increase of 71%).

Growth in the number of alleged offenders was most apparent in 2013–14 and 2014–15.

Not surprisingly, given the different rates of growth, the proportion of total alleged offenders with a principal offence relating to illicit drugs grew from 20% in 2010–11 to 28% in 2014–15 (ABS 2016a). Furthermore, these increases are not explained by population growth in Queensland. The rate of alleged offenders (per 100,000 people) with an illicit drug offence as the principal offence increased from 412.0 in 2010–11 to 656.9 in 2014–15 (ABS 2016a).

Analysis of courts data suggests that some of the growth in the number of alleged drug offenders may be explained by a greater focus on drug driving and the introduction of random roadside drug testing. When examining all offences related to matters where the finalised defendant had an illicit drug offence as their principal offence, the number of traffic and vehicle regulatory offences increased by 143% between 2010–11 and 2014–15. The number of dangerous or negligent acts endangering persons increased by 247% over the same period.[21]

Figure 8: Number of total alleged offenders and alleged illicit drug offenders, Queensland, 2010–11 to 2014–15



Source: ABS 2016 Recorded Crime – Offenders

[20] Data shown in Figure **8** exclude traffic and vehicle regulatory offences.

[21] Source: DJAG administrative data.

3.4 POLICE PROCEEDINGS AND USE OF NON-COURT ACTIONS

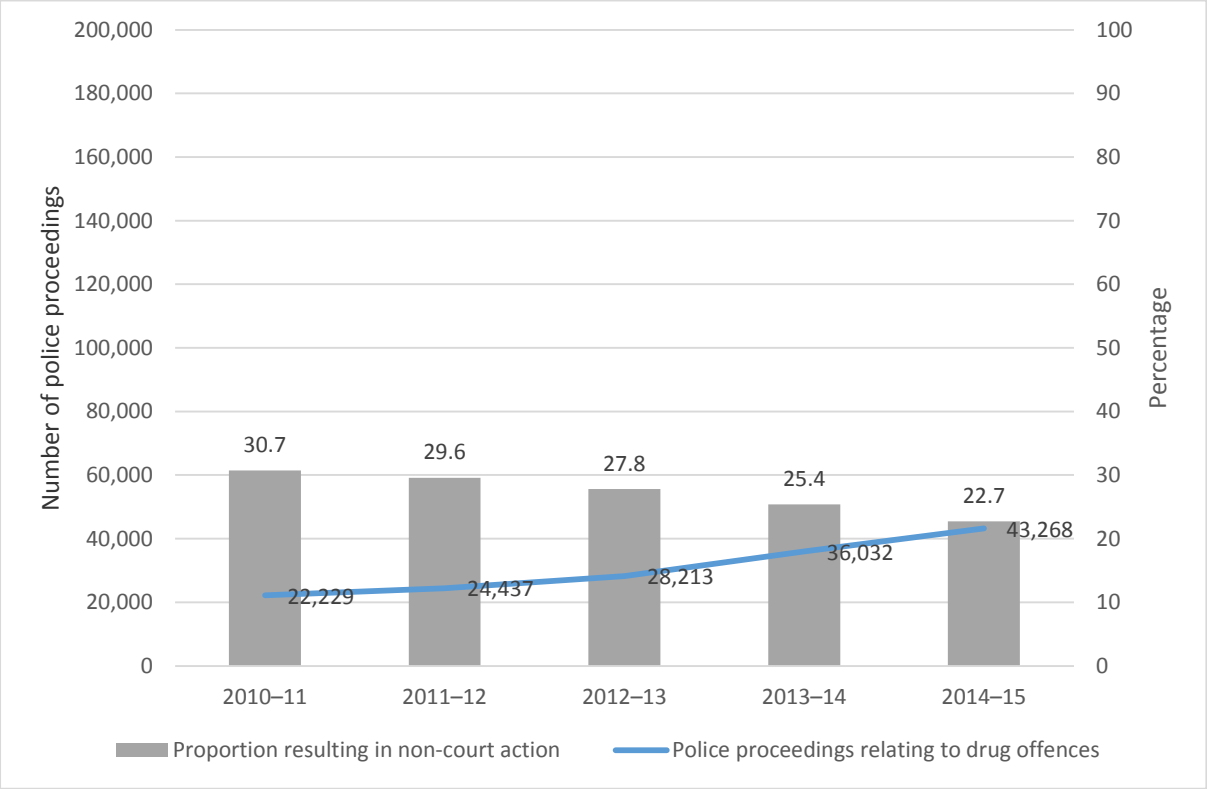
The way in which police proceed against alleged drug offenders has changed in recent years. There has been a decline in the use of non-court actions in favour of more formal proceedings.

Figure 9 shows that police proceedings relating to illicit drug offences as the principal offence nearly doubled between 2010–11 (22,229) and 2014–15 (43,268). The percentage increase in the number of illicit drug offence-related police proceedings over the reporting period (95%) was substantially higher than growth in the total number of police proceedings (28%).

The proportion of police proceedings (with an illicit drug offence as the principal offence) resulting in a non-court action declined over the reporting period – decreasing from 31% in 2010–11 to 23% in 2014–15. This decline in non-court actions occurred in a context of no change in overall police actions. This could suggest changes in police practices regarding illicit drug offences (for example, less use of diversionary strategies), a change in the profile of offending (for example, increasing seriousness of the drug-related offences or types of drugs involved), other factors or a combination of these.

Further analyses of ABS police proceedings data also shows that the proportion of total police proceedings with a principal offence relating to illicit drugs increased from 18% in in 2010–11 to 27% in 2014–15.[22]

Figure 9: Number of police proceedings with illicit drug offences as principal offence and proportion resulting in non-court action, Queensland, 2010–11 to 2014–15



Source: ABS 2016 Recorded Crime – Offenders.

Note: Missing data have been excluded when calculating percentages of totals.

[22] Missing data have been excluded in the calculation of percentages.

3.5 TYPES OF ILLICIT DRUG OFFENCES

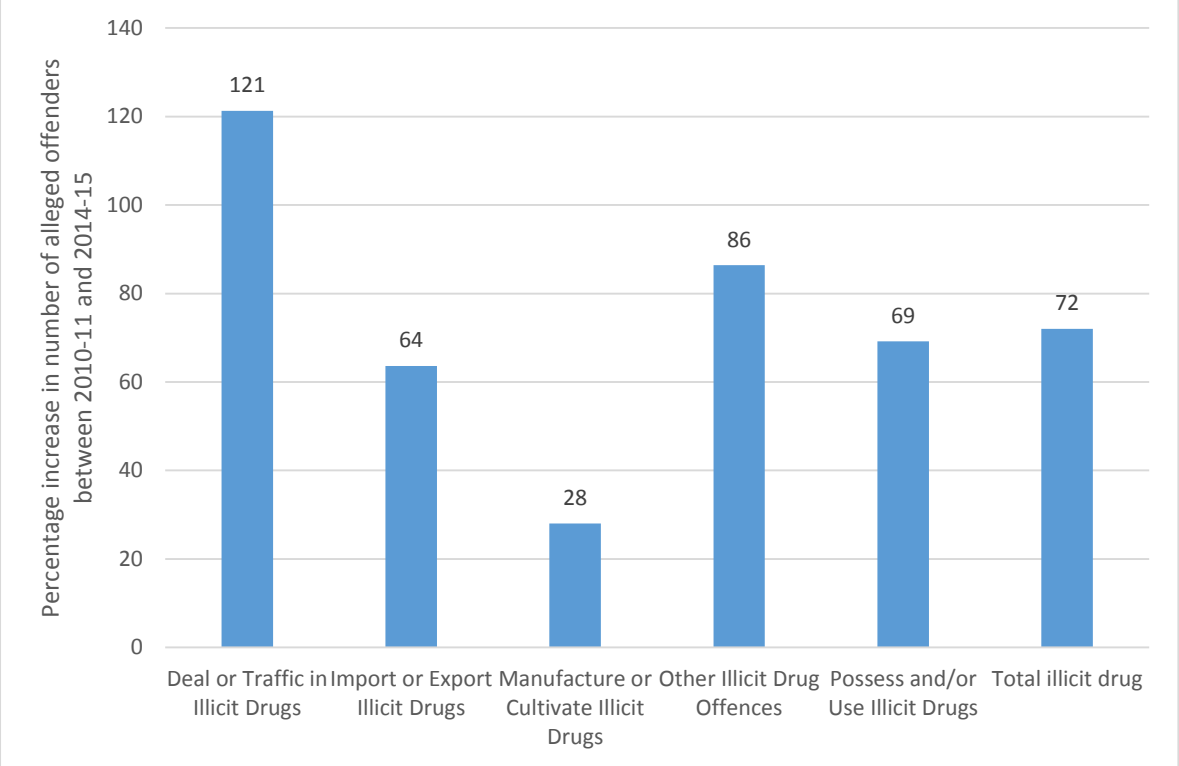
The majority of illicit drug offences tend to relate to minor drug offences such as possession and use of drugs. While the incidence of both minor and serious drug offences has increased in recent years, relative growth in the number of people with a serious drug offence as their principal offence has grown more substantially.

Analyses of QPS administrative data shows that about 65% of total alleged offenders with an illicit drug offence as their principal offence are proceeded against for possession and/or use of drugs, while about 20% are proceeded against for 'other illicit drug offences' such as possess drug utensil and possess money with intent to purchase drugs. Less than 10% of total alleged offenders with an illicit drug offence as their principal offence are proceeded against for dealing or trafficking in illicit drugs.[23]

Figure 10 shows the percentage growth in the number of alleged offenders with an illicit drug offence as their principal offence between 2010–11 and 2014–15 by type of illicit drug offence. The number of offenders with deal or traffic illicit drug offences grew by 121%, other illicit drug offences increased by 86% and possess and/or use illicit drugs grew by 69% between these years.

Queensland Corrective Services data also indicate that that the number of offenders sentenced to supervision with a serious drug offence as their principal drug offence increased by 83% between 2010–11 and 2014–15, while the number of offenders with a minor drug offence as the principal offence grew by 56%.[24]

Figure 10: Percentage growth in the number of alleged offenders with an illicit drug offence as principal offence by type of illicit drug offence, Queensland, 2010–11 to 2014–15



Source: QPS administrative data

Notes: There is consistency in findings between ABS data and QPS data analysed for the purpose of the Review. ABS data indicate that the number of alleged offenders with an illicit drug offence as their principal offence increased by 71% between 2010-11 and 2014-15, while analysis of QPS administrative data indicates an increase of 72%.

[23] Source: QPS administration data.

[24] Source: QCS administrative data

'Other drug offences' includes possess money with intent to obtain drugs; possess pipes, syringes, other utensils associated with the use of drugs; permit premises to be used for taking, selling or distributing of drugs; and fail to keep register for drugs of addiction.

3.6 DRUG OFFENDERS BEFORE THE COURTS

The growing number of alleged drug offenders, the decreasing use of non-court actions by the police for drug offenders and the increasing number of serious drug offenders occurring in recent years signals greater court workloads in response to drug-related offending.

3.7 NUMBER OF FINALISED DRUG DEFENDANTS

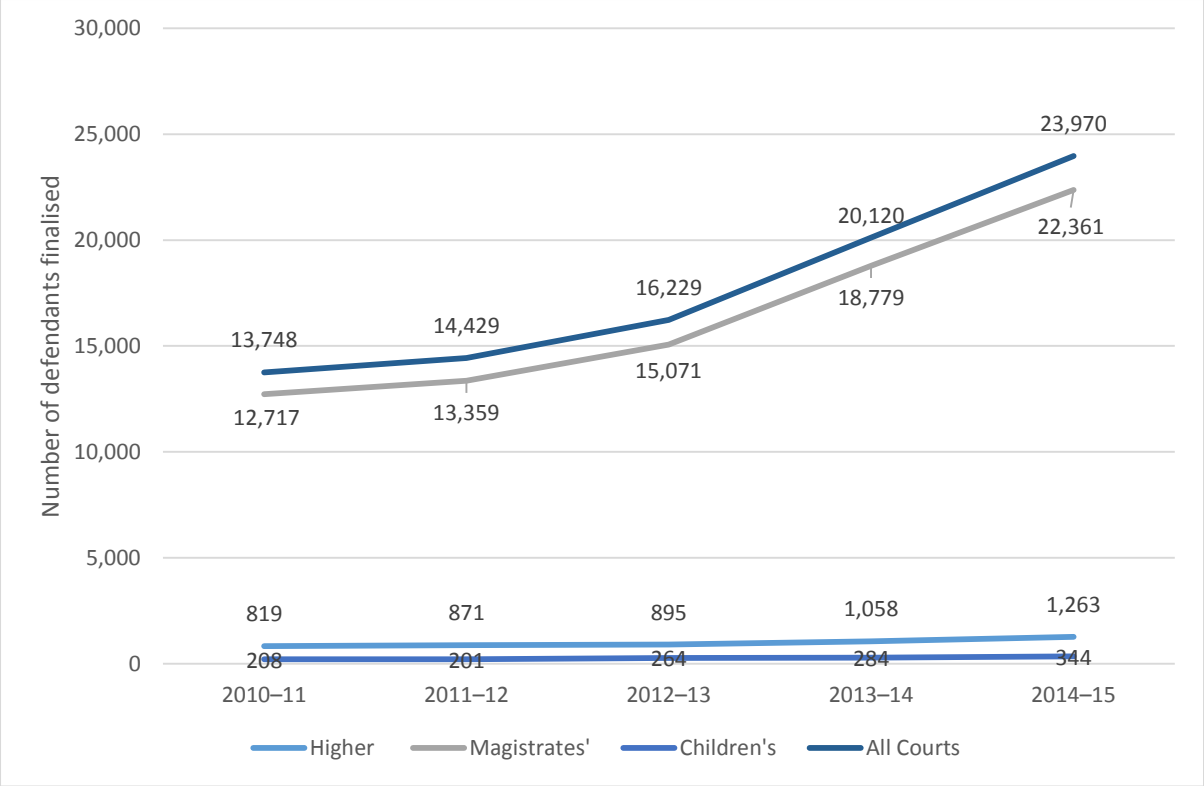
Finalised defendants with a principal offence relating to drug offences accounted for 14 per cent of total defendants finalised in Queensland's Courts in 2014-15 and the majority of drug-related matters were finalised in the Magistrates Courts.

Figure 3 showed that the number of finalised defendants increased by 14% in Queensland between 2010–11 and 2014–15. the number of finalised defendants with an illicit drug offence as their principal offence grew more than overall court system growth.

Figure 11 shows that the total number defendants finalised with an illicit drug offence as the principal offence increased from 13,748 in 2010–11 to 23,970 in 2014–15 (an increase of 74%). The number of defendants finalised with an illicit drug offence as the principal offence between 2010–11 and 2014–15 increased by 76% in the Magistrates Courts, 65% in the Childrens Court and 54% in the Higher Courts (Supreme and District Court).

The increase in illicit drug offences as a principal offence took place at the national level – albeit at a lower level than the Queensland experience. Nationally, there was a 51% increase in the number of defendants finalised in 2014–15 with an illicit drug offence as the principal offence when compared to 2010–11 (ABS 2016b).

Figure 11: Number of defendants finalised with illicit drug offences as principal offence by type of court, Queensland, 2010–11 to 2014–15

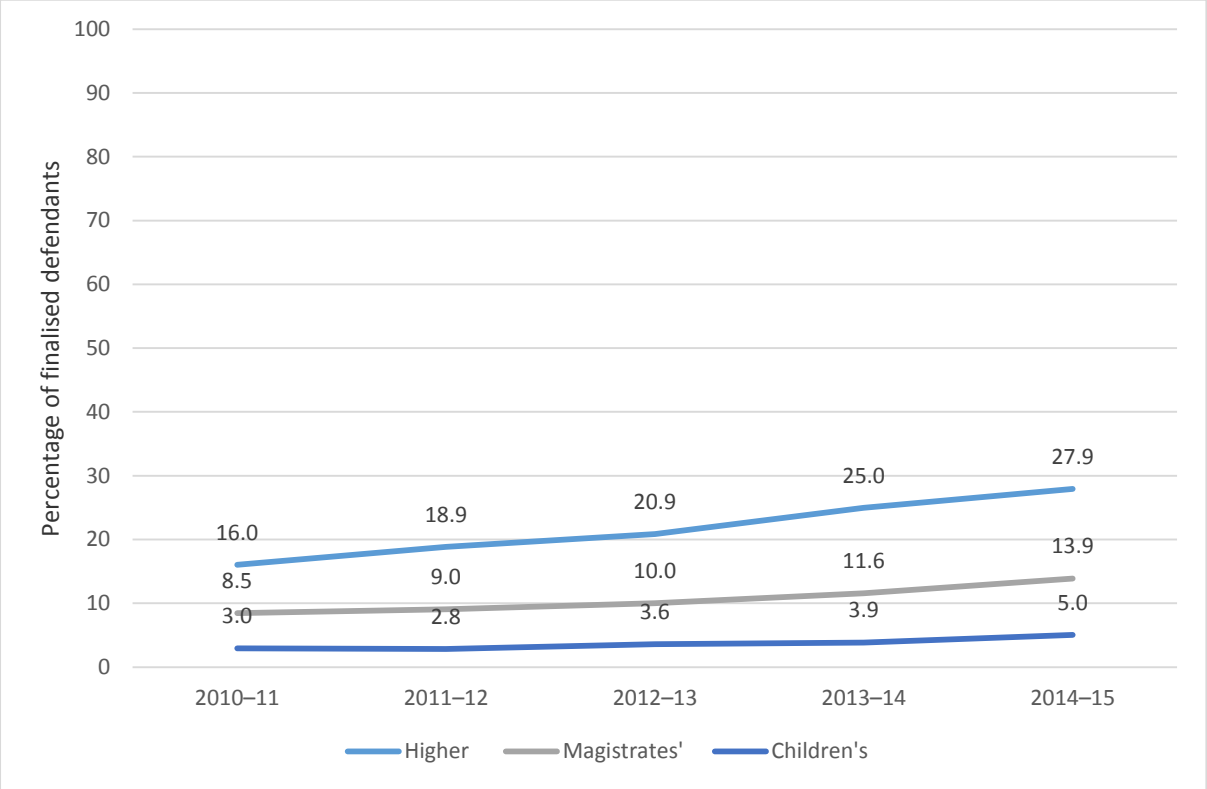


Source: ABS 2016 Criminal Courts Australia.

The share of all finalised defendants with an illicit drug offence as their principal offence has also increased in recent years – growing from 9% in 2010–11 to 14% in 2014–15. This growth was most apparent in the Higher Courts. In the years between 2010–11 and 2014–15, the share of all finalised defendants with illicit drug offences as their principal offence increased from 16% to 28% in the Higher Courts, 8% to 14% in the Magistrates Courts and 3% to 5% in the Childrens Court (see Figure 12).

Further analysis of 2014–15 courts data shows that most finalised defendants with an illicit drug as their principal offence have either single (40%) or multiple (42%) drug offences only. Eighteen per cent have a combination of drug and non-drug offences. These patterns have not changed in recent years.[25]

Figure 12: Proportion of finalised defendants with illicit drug offence as principal offence by type of court, Queensland, 2010–11 to 2014–15



Source: ABS 2016b

The increasing share of total finalised defendants with an illicit drug offence as the principal offence suggests growth in illicit drug offences in a context of decline for other types of offences.

Further analysis shows that there was a decline in the share of total finalised defendants with a principal offence relating to traffic and vehicle regulatory offences (36% in 2010–11 compared with 30% in 2014–15). Other offence types with a slight decline included public order offences (14% to 11%) and acts to cause injury (6% to 5%). Other principal offence types exhibiting growth between 2010–11 and 2014–15 (albeit very slight) included prohibited and regulated weapons and explosive offences (1% to 3%) and offences against justice procedures, government security and government operations (9% to 11%) (ABS 2016b).

[25] Source: DJAG administrative data.

3.8 SENTENCE OUTCOMES FOR DRUG OFFENDERS

Nearly all defendants found guilty of an illicit drug offence as the principal offence receive a non-custodial sentence.

Table 1 shows that the majority (82%) of defendants finalised in the Higher Courts received a custodial order (including community custody orders and fully suspended sentences), however the number of these defendants is relatively small. The majority (95%) of defendants finalised in the Magistrates Courts received a non-custodial order and nearly two thirds (62%) received a monetary order. These sentence outcomes reflect the drug offending patterns discussed above, which showed that the majority of incidents relating to a drug offence as the principal offence involved a minor drug offence (such as possession and use of drugs).

Table 1: Sentence outcome of guilty defendants with illicit drug offence as principal offence, Queensland Higher and Magistrates Courts, 2014–15

Sentence outcomes	Court level	
	Higher Courts (%)	Magistrates Courts (%)
Custody in a correctional institution	63.1	2.8
Custody in the community	0.6	0.1
Fully suspended sentence	17.6	2.2
Community supervision/work orders	11.2	8.4
Monetary orders	5.5	62.2
Other non-custodial orders	2.2	24.3
Total (n) proven guilty	**1,085**	**20,489**

Source: ABS *Criminal Courts, Australia*, 2014–15

Note: This source does not include sentence outcomes for illicit drug defendants finalised in the Childrens Court.

In 2014–15, the median length of custody for guilty defendants finalised and sentenced to custody in a correctional institution was nine months (ABS 2016b). The median term was the same for guilty defendants with an illicit drug offence as their principal offence (ABS 2016b). Nearly three quarters (72%) of all defendants who had an illicit drug offence as their principal offence and were sentenced to custody in a correctional institution received a sentence under two years, while 21% received a sentence of two to less than five years (ABS 2016b).

Defendants with an illicit offence as their principal offence and whose cases were finalised in the Higher Courts were given longer terms of custody in a correctional institution (24 months) than those finalised in the Magistrates Courts (four months) (ABS 2016b).

Assuming that the reinstated drug court will target drug-related offending that is likely to result in a period of custody in a correctional setting, these data suggest that the number of people potentially eligible for drug court will be relatively low and that the operation of a drug court would have a modest impact on prisoner numbers (even if it aims to divert people from a period of imprisonment in custody).

3.9 SUMMARY

This chapter has shown that:

- there is a growing number of people in contact with the police, courts and corrections and this growth is higher than population growth;
- there is an expanding remand population most likely explained by a growing number of people in contact with the police and possibly a reduced likelihood of getting bail;
- the overrepresentation of Aboriginal and Torres Strait Islander people in contact with the criminal justice system continues to grow despite efforts to address this issue;
- the number of women in contact with the criminal justice system is expanding at a higher rate than increases among men;
- the rate of police contact with Queenslanders is higher than that experienced in most other Australian jurisdictions; and
- Victoria and South Australia are the only states with a lower adult incarceration rate than Queensland's;
- the majority of youth held in detention centres are not sentenced;
- growth in the number of offenders with a drug offence as their principal offence exceeds overall system growth
- most people's drug offences relate to minor offences such as possession and use of illicit substances; and
- a relatively small proportion of people sentenced by the Magistrates Court are given a term of imprisonment.

3.10 IMPLICATIONS

The data in this chapter illustrate the increasing pressure under which the Queensland justice system has been placed due to illicit drug offending. While the majority of offenders found guilty of an illicit drug offence as their principal offence did not enter the prison system, nonetheless the demands of drug offending on the system as a whole remain significant. Of additional concern, the proportion of vulnerable populations in the criminal justice system continues to grow.

4 PATTERNS OF DRUG USE AND SUBSTANCE MISUSE AMONG QUEENSLAND OFFENDERS

4.1 INTRODUCTION

This chapter explores the complex relationship between drug use and crime and identifies the potential demand for interventions and problem-oriented courts that provide a therapeutic response to drug use. Information is provided on the patterns of drug use among offender populations.[26]

The data in this chapter are presented to illustrate the extent of problematic alcohol and other drug use in Queensland and to identify the nature of the demand for appropriate criminal justice interventions.

4.2 THE DRUG-CRIME NEXUS

Beginning in the 1970s there has been significant growth in the number of academic research papers and government reports examining the drug-crime relationship. The vast majority of these studies point to a strong positive correlation between the two phenomena. These studies can be broadly categorised into three main types: (1) those examining the criminal offending patterns of drug users; (2) those examining the drug use patterns of criminally involved individuals; and (3) those using aggregate data to compare community level drug use and crime rates.

In Australia, the best and most current estimates of the criminal involvement of drug users comes from the Illicit Drug Reporting System (IDRS), funded under the National Illicit Drug Strategy (NIDS) and coordinated by the University of NSW National Drug and Alcohol Research Centre (NDARC). NDARC is one of three national centres of excellence established by the Australian Government Department of Health and Aging (DOHA) and IDRS is an annual national survey of injecting drug users from all major capital cities across Australia. In their reports on the data, Stafford and Burns (2013) estimate that one in three injecting drug users across Australia self-reported some involvement in criminal activity in the preceding month (37%), while roughly the same proportion reported having been arrested by the police (33%) at least once in the preceding year. The most common types of crimes committed by injecting drug users were property and drug dealing offences, findings that have remained stable since the IDRS first began in 1999.

In addition to the IDRS, NDARC also coordinate the Ecstasy and related Drugs Reporting System (EDRS), a sister study which seeks to capture information from a national sample of non-injecting drug users. In a summary of results from the 2012 survey, Sindicich and Burns (2013) noted that roughly two fifths of non-injecting drug users self-reported some involvement in crime during the 30 days preceding the interview, while just over one in ten (14%) had been arrested by the police in the past 12 months. Violent and drug offences were the most commonly reported offence types.

As an alternative to examining the criminal offending activities of drug users, researchers have also sought to examine the prevalence and nature of drug use among criminal justice populations with the view to demonstrating that drug use rates are higher among offenders than in the general population. From the Australian research, several consistent conclusions can be drawn, namely that:

- The prevalence of drug use is significantly higher among criminal justice populations than in the general community and the differential is greater for more serious drug types such as heroin, amphetamine and cocaine (Johnson 2004a, 2004b; Kinner 2006; Kraemer et al. 2009; Makkai & Payne 2003a, 2003b, 2005; Prichard & Payne 2005b, 2005a).
- Offenders typically experiment with illicit drugs at younger ages than those who use drugs but do not have contact with the criminal justice system (Johnson 2001). Moreover, it seems the more serious the offender

[26] Further analyses and information about data sources are provided in the *Data for drug and specialist courts review* report at Appendix B.

the younger they were when they first used drugs (Makkai & Payne 2003a, 2003b, 2005; Prichard & Payne, 2005a, 2005b);

- There is modest association between specific drug types and specific crime types (Indermaur 1995) although the association is likely the result of the pattern of usage more than the psychoactive properties of the drug (Bradford & Payne 2012);
- Some offenders attribute their own offending to the use of drugs (Indermaur 1995; Makkai & Payne 2003a), though this can vary by drug type (Payne & Gaffney 2012);
- Offending rates typically fluctuate according to levels of drug use (Dobinson & Ward 1985; Johnson 2004a, 2004b; Kraemer et al. 2009; Makkai & Payne 2003a, 2003b, 2005; Prichard & Payne 2005a, 2005b; Stevenson & Forsythe 1998), but may also vary depending on the drug being used (Makkai 2002);
- Offenders are typically more likely to report experimenting with drugs only after they are already involved in crime (Dobinson & Ward 1985; Johnson 2001; Johnson 2004a, 2004b; Makkai & Payne 2003a, 2003b, 2005; Prichard & Payne 2005a, 2005b). However, this appears less so among female offender populations (Johnson 2004a); and
- A history of drug use serves as a strong predictor of reoffending (Makkai, Ratcliffe, Veraar & Collins 2004), especially among prisoner populations who continue to use drugs in prison or who express an intention to re-use drugs upon their release (Kinner 2006).

4.2.1 Understanding the drug-crime nexus

Notwithstanding the apparently strong correlation between drug use and crime, the drug-crime debate remains plagued by the unanswered question of causality; whether it exists at all, and if it exists, in which direction it operates. In assessing the same complex mix of empirical findings Menard and his colleagues (2001) point out that there are at least four competing explanations of the drug-crime relationship, which can be summarised as:

- drug use leads to crime;
- crime leads to drug use (the inverse causality model; see Brochu 1995);
- drug use and crime influence each other in a pattern of mutual causation; and
- the relationship between drug use and crime is either coincidental or spurious and that both result from a common underlying aetiology (see also White & Gorman 2000).

The most common explanation for the relationship between drug use and crime is that drug use acts as the catalyst for criminal offending or the development of an individual's criminal career. This is, perhaps, the most common and popular public perception of drug use and was described by Goldstein (1985) as resulting from one of three mechanisms:

- the psycho-pharmacological effect – used to describe crimes that are committed under the influence or whilst intoxicated;
- the economic-compulsive – financial crimes which are presumed to be committed for financial gain and where the proceeds are typically used to fund drug purchases; and
- the systemic effect – crimes that occur as a consequence of participation in the illegal and unregulated market for drugs.

Although it is true that some crime occurs as a consequence of drug use, Menard and colleagues (2001) conclude that the simple hypothesis that drug use causes crime is 'untenable' because in the vast majority of research, particularly that conducted with criminal justice populations, the initiation of drug use typically occurs subsequent to the onset of offending. Further, they conclude that once both crime and drug use have commenced, each appears to increase the probability that the other will continue. Most importantly, they argue that crime and drug use are related to one another in different ways and in different strengths across the life-course - that while some crime is caused by drug use and some drug use is caused by crime, both are also heavily influenced by a similar set of underlying factors. White and Gorman (2000), for example, argue that it is equally possible for drug use to occur as the result of crime because:

- the aspects of the lifestyle associated with being an offender may encourage heavy alcohol and other drug use (e.g. being single, being geographically mobile, partying/using drugs when between jobs and only working occasionally);
- the extra income derived from crime may allow the offender to more easily purchase drugs; and
- offenders may use drugs as a source of self-medication, 'Dutch courage', or as a justification to continue committing crime.

Perhaps the most popular contemporary explanation for the drug-crime relationship is that while drugs and crime may influence each other at different strengths and at different times in the life-course, both are nonetheless principally the result of a process of mutual causation, influenced by other underlying causal factors. In their General Theory of Crime, Gottfredon and Hirschi (1990) argue that both drug use and crime are the result of low self-control – the common antecedent of all anti-social behavior. Others have used the 'impaired functioning' theory to suggest that altered physical, psychological and emotional functioning may result from drug use and can consequently lead to involvement in crime. Another theory proposes that the factors associated with involvement in crime (such as poverty, personality disorders, associations with anti-social peers and lack of pro-social support) are also associated with problematic drug use. The 'sociological drift theory' argues that involvement in crime creates opportunities and contexts that can result in drug problems and involvement in drug-related activities (Queensland Crime and Misconduct Commission 2008). These theories suggest a multi-directional relationship between drug use and crime. Indeed, researchers have found that drug use problems can come before involvement in crime and involvement in crime can come before using drugs.

Whichever the explanation, more than 40 years of detailed drug-crime research, including sociological, biological, medical and psychological research, has not yet answered the question of causation. Such is the complexity of these two social phenomena that it is unlikely that one, single, unifying explanation will ever be found. As a consequence, researchers and practitioners must now agree that to reduce drug related crime is a complex proposition that must take into account a diverse range of individual and social-level factors. Put simply, treating drug dependency alone without meeting and redressing other criminogenic needs will not, for the majority of drug users, be sufficient to stop their involvement in crime.

4.2.2 Drug use patterns among offenders

The drug-crime nexus is apparent when the prevalence of drug use among the general population is compared with drug use in offender populations. The evidence consistently shows higher levels of drug use among offenders than that occurring in the general population.

Table 2 shows the prevalence of drug use among the Queensland general population, people entering Queensland prisons and people being detained in the Brisbane watch-house.[27]

While 16% of the general population reported recent illicit drug use, 73% of police detainees tested positive to an illicit drug and 64% of prison entrants reported recent illicit drug use.[28]

Cannabis and methamphetamines were the most commonly used illicit drugs among offenders and illicit pharmaceutical use was also evident. Forty-three per cent of police detainees tested positive to cannabis and 38% tested positive to methamphetamines. Reported use of methamphetamine was more prevalent among prison entrants (47% reporting recent use) than cannabis use (40% reporting recent use).

Cannabis is the most commonly used illicit drug in the general population (11% used recently) and use of methamphetamines is atypical (2% recently used). The prevalence of cannabis and methamphetamine use

[27] The data presented in Table 2 have been collected using different methodologies and at different time periods. It is therefore important to exercise caution when interpreting results. These data provide an indication of drug use prevalence, but not frequency of use.

[28] Recent drug use is defined as any use of drugs within the previous 12 months.

among criminal justice populations suggests that offenders are about four times more likely to use cannabis than people in the general population and around 16 to 20 times more likely to use methamphetamines.[29]

Table 2: Comparative illicit drug use patterns, Queensland general and offender populations

	NDSHS[a]	NPHDC[b]	DUMA[c]
	General population (2013)	**Prison entrants (2015)**	**Watch-house detainees (2013)**
Type of drug	**Used in previous 12 months**		**Tested positive**
Cannabis	11.1	40	43
Cocaine	2		2
Amphetamine type stimulants	2.3	47	38
Inhalants	0.8		
Sedatives or sleeping pills	1.7		
Hallucinogens			
Opioids			23
Heroin	0.1	8	8
Methadone/buprenorphine	0.2		
Methadone			6
Buprenorphine			10
Other opiates/opioids	0.6		7
Injected drugs	0.3		
Any drug other than cannabis			58
Multiple drugs			41
Any illicit	15.5	64	73

a. NDSHS measures drug use in the general population.

b. NPHDC measures drug use among sentenced and unsentenced persons entering or leaving custody. Data presented in table includes results from prison entrants only.

c. DUMA measures drug use among people in the Brisbane watch-house.

Levels of alcohol consumption among offenders are substantially higher than those found among the general population (AIHW 2016b). Among prison entrants, 38% of prison entrants reported levels of alcohol consumption that placed them at high-risk of alcohol-related harm (as measured by the AUDIT C) indicating

[29] Results of the 2013 NDSHS show that Aboriginal and Torres Strait Islander people in the general community are more likely to abstain from alcohol than non-Indigenous people, however this pattern is not apparent in relation to illicit drug use (AIHW 2014). Over a quarter (28%) Aboriginal and Torres Strait Islanders were reported as abstainers/ex-drinkers compared with 22% of non-Indigenous people; while 47% of Aboriginal and Torres Strait Islander reported that they had never used any illicit drug compared with 59% of non-Indigenous people. Aboriginal and Torres Strait Islander people were also more likely than non-Indigenous people to report recent use of illicit drugs (24% compared with 15%) and report risky levels of alcohol use (23% compared with 18%).

hazardous levels of drinking or active alcohol use disorders (AIHW 2016b). Police detainees reported drinking 23 standard drinks (on average) on their last drinking occasion (AIC 2015a).

Other research also shows a high prevalence of criminal behaviour among illicit drug user populations. For example, the 2015 Queensland Illicit Drug Report Survey found that 33% of responding injecting drug users reported involvement in crime in the previous month and 38% reported that they had been arrested in the previous 12 months. One quarter (25%) of those arrested were arrested for use/possession of drugs (McIlwraith, Salom & Alati 2016).[30] Gisev et al. (2014) found that most people (76%) that had sought treatment for opioid-dependence in NSW were incarcerated at least once (also noting that the majority of heroin users have received opiate substitute treatment at some point of their lives).

4.2.3 Use of methamphetamine

While the use of methamphetamine in the general population has remained relatively stable in recent years, there is evidence to suggest that it is becoming more prevalent among offenders.

The levels of methamphetamine detected among Brisbane watch-house detainees via urinalysis were the highest ever recorded in 2013 and 38% reported that they needed or were dependent on methamphetamine in the previous 12 months. Watch-house detainees also believed that methamphetamine was readily available and that more sellers were entering the market (Gannoni, Goldsmid & Patterson 2015).

The increasing use of meth/amphetamine among Queensland offenders was referred to by key stakeholders consulted as part of this Review. It was also suggested that offenders using meth/amphetamines tended to escalate in offence seriousness and be considered for custodial sentences more quickly than cannabis only users. One key expert interviewed as part of the 2015 IDRS believed that methamphetamine use had 'a shorter period than with other drugs between first use and disaster' (McIlwraith, Salom & Alati 2016). [31]

Research has shown a high prevalence of violent offending among illicit drug users and that offenders who primarily used methamphetamine were more likely to have committed a violent offence in the past 12 months than offenders who were primarily heroin users (51% versus 35%) (Torok 2009).

The most recent illicit drugs intelligence assessment prepared by the Queensland Crime and Corruption Commission continues to rank methylamphetamine as the illicit drug market posing the highest risk to Queensland and indicates that there has been a greater targeting of regional areas such as Toowoomba, Mackay, Rockhampton, Gladstone, Townsville and Cairns by groups supplying illicit drugs. It also noted that the heroin market continues to be small in Queensland, however it continues to expand internationally and in other Australian states (Queensland Crime and Corruption Commission 2016).

4.2.4 Relationships between drug use and types of offending

Although polydrug use is often apparent among drug users, there is some evidence to suggest that alcohol tends to be associated with violent offending, while illicit drug use tends to be associated with drug and property offending.

About one in four Queensland police detainees (23%) surveyed as part of the Drug Use Monitoring Australia (DUMA) study attributed their current charges to alcohol or other drug use, 35% attributed their current charges to illicit drug use and half (53%) attributed their current charges to alcohol and/or illicit drug (AIC 2015a).

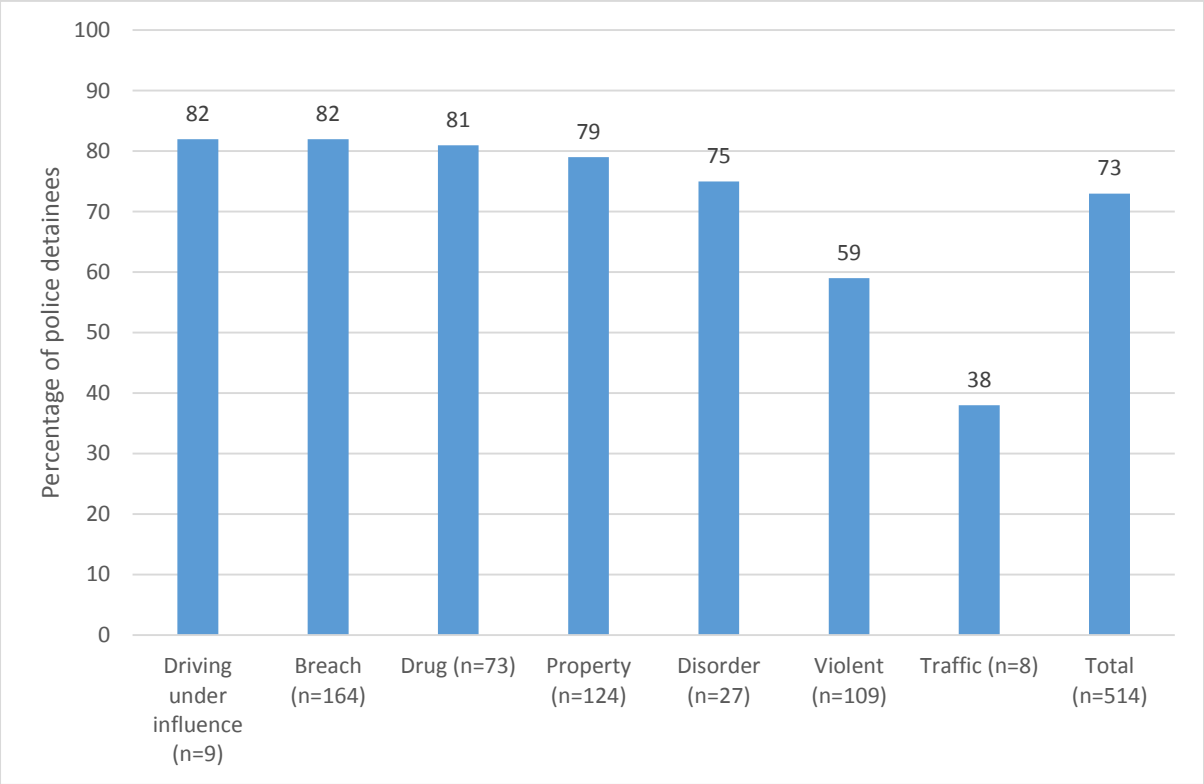
Alcohol was more likely than other drugs to be a contributing factor to involvement in driving under the influence, disorder and violent offences (AIC 2015a). Figure 13 shows that illicit drug use was most prevalent

[30] Caution should be used when interpreting these findings as the IDRS has a relatively small sample size (n=98). See Chapter 3 for more information on the IDRS.

[31] It is noted that not all drug use is related to high levels of harm (including involvement in crime and health issues).

among those with a principal offence relating to driving under the influence (82%), breach of a justice order (82%), a drug offence (81%) and property offending (79%). Recent use of illicit drugs was less prevalent among police detainees with a principal offence relating to violence (59%) or a traffic violation (38%).

Figure 13: Proportion of police detainees testing positive to any illicit drug by principal offence, Queensland, 2013



Source: AIC 2015a

Table 3 shows the principal offence among offenders under QCS supervision reporting daily or almost daily use of drugs. These data are consistent with other research showing a relationship between alcohol use and violent offences and between illicit drug use and drug and property offences.

Thirty-seven per cent of offenders using alcohol daily or almost daily had offences against the person as their principal offence compared with 24% of regular cannabis users, 18% of regular amphetamine users and 16% of regular opiate users. Nearly half of those offenders reporting amphetamine use (43%) or opiate use (48%) had a property offence as their principal offence compared with 20% of regular alcohol users and 29% of regular cannabis users. The prevalence of justice administration offences (as a principal offence) was also relatively high among regular alcohol users.

Table 3: Type of principal offence among offenders reporting daily or almost daily drug use by type of drug, 2010–11 to 2014–15, Queensland

	Daily or almost daily use of drug (percentage within type of drug)			
Principal offence type	**Alcohol**	**Cannabis**	**Amphetamines**	**Opiates**
Against the person	36.6	24.1	17.6	15.6
Drug	9.7	25.8	20.4	21.7
Justice administration	21.9	13.3	11.8	7.2
Other	10.7	7.5	7.1	7.2
Property	20.1	28.6	42.6	48.1
Sex	0.9	0.6	0.4	0.3
Total	100	100	100	100
Total (n)	2737	4318	1379	391

Source: QCS administrative data (benchmark assessment).

Note: Missing data are excluded from analyses. This includes offenders without assessment information that provides information on frequency of drug use.

4.2.5 Substance misuse issues and drug-related crime among offenders

A substantial number of offenders supervised by QCS are assessed as having a high risk of problematic substance use and a significant proportion of offending is determined to be drug-related.

Over half (55%) of offenders sentenced to supervision between 2010–11 and 2014–15 were assessed as having a high risk of substance misuse.[32] Offenders sentenced to imprisonment (65%) were more likely than offenders sentenced to probation (51%) as having a high risk of problematic substance use.

Table 4 shows the proportion of offenders under QCS supervision assessed as having a drug offence or drug-related offence by frequency of drug use. Information in this table shows that the likelihood of having a drug offence or drug-related offence tends to rise with increases in drug use frequency. This is especially apparent for illicit drug use (amphetamines and opiates in particular).

While 43% of total offenders under QCS supervision were assessed as having a drug offence or drug-related offence, 47% of daily/almost daily alcohol users, 66% of daily/almost daily cannabis users, 78% of daily/almost daily amphetamine users and 83% of daily/almost daily opiate users were assessed as drug-related offenders.

[32] Further information about QCS data is outlined in Chapter 3 of this report. Risk of substance misuse is determined via the Benchmark Assessment which is implemented on offenders managed in the community only. Offenders sentenced to imprisonment may have a Benchmark Assessment if they serve a period of parole.

Table 4: Proportion of sentenced offenders under QCS supervision assessed as having a drug-offence or drug related offending by frequency and type of drug use, Queensland, 2010–11 to 2014–15

Type of drug	Offenders with drug offence or drug-related offending				
	Frequency of drug use				
	Daily or almost daily	Weekly	Monthly	Once or twice	Never
Alcohol	46.5	41.0	40.9	45.0	49.1
Cannabis	66.5	54.5	45.8	39.3	29.4
Amphetamine	78.2	73.1	65.2	57.4	34.8
Opiates	83.4	81.8	70.6	73.1	41.7

Source: QCS administrative data (benchmark assessment).

Note: This table intersects three variables. It shows the proportion of offenders with a drug offence or drug-related offending within frequency of drug use by type of drug used.

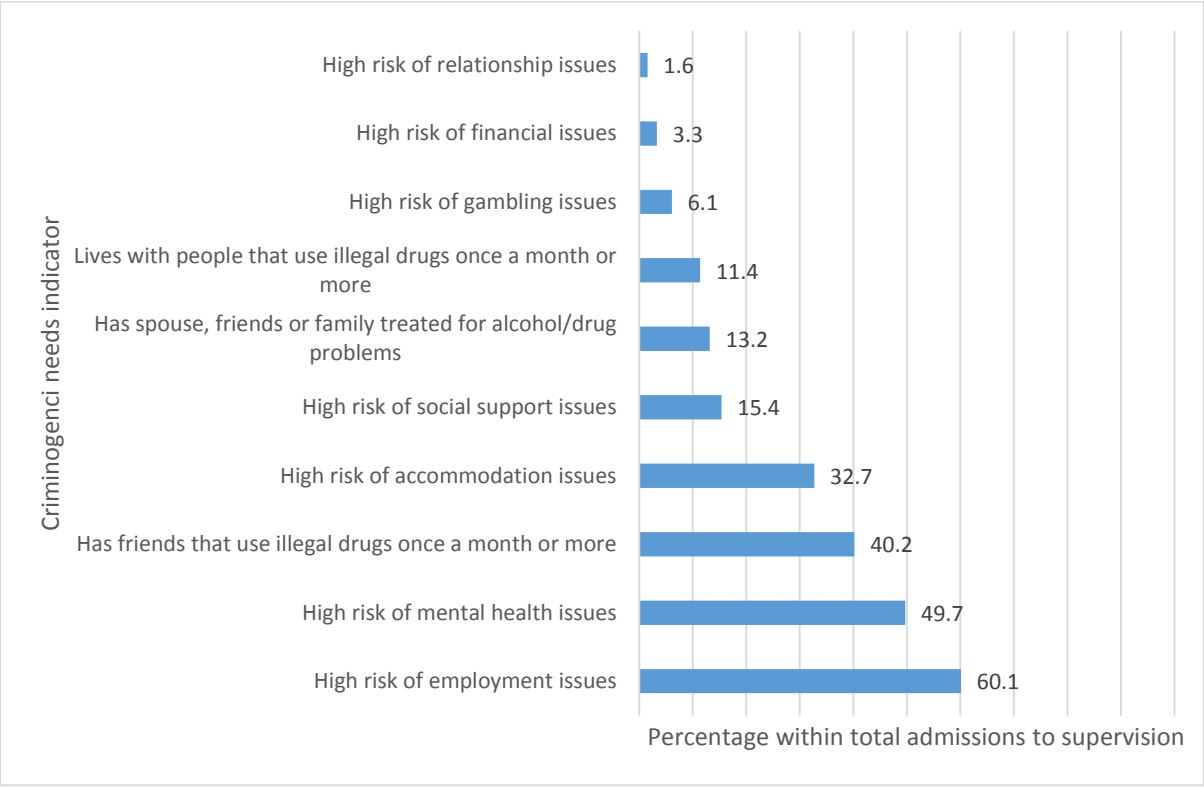
4.2.6 Other criminogenic factors

Drug use is a criminogenic factor that when addressed can assist in reducing the likelihood of reoffending. Other criminogenic factors include antisocial behaviour, anti-social personality, anti-social cognition, anti-social associates, poor family/marital circumstances, low engagement with school/work, and low levels of involvement in leisure/recreation (Andrews & Bonta 2010).

Queensland Corrective Services collects information on criminogenic needs as part of their assessment processes. Analysis of this information highlights the complex issues experienced by offenders and demonstrates the importance of designing interventions that can address the multiple and complex issues presented by individuals.

Figure 14 shows that nearly two in three offenders (60%) supervised by QCS were assessed as having a high risk of employment issues, half (50%) had a high risk of mental health issues and a third (33%) had a high risk of accommodation issues. Offenders were also exposed to anti-social associates (40% had friends that used illicit drugs once a month or more) and 15% were assessed as having a high risk of social support issues.

Figure 14: Proportion of offenders supervised by QCS by selected criminogenic need indicators, Queensland, 2010–11 to 2014–15



Source: QCS administrative data (benchmark assessment).

Note: QCS assesses an offender's risk of certain criminogenic factors based on a number of different items included its Benchmark Assessment. For example, the 'risk of unemployment' considers a range of items such as 'how long has the offender been employed/unemployed?', 'has the offender been continuously unemployed?', 'what sort of Centrelink benefit is the offender receiving?' and 'has the offender demonstrated or self-reported numeracy issues?'

The prevalence of mental health issues was apparent in the most recent Queensland prisoner health survey. Forty percent of Queensland prison entrants reported that they had been told they have a mental health disorder and 29% reported distress relating to a mental health issue (AIHW 2015).

Although not necessarily criminogenic, offenders are also characterised by relatively poor physical health when compared to the general population. Twenty-seven percent of Queensland prison entrants reported distress relating to physical health issues (AIHW 2015) and QCS assessment information indicates that 16% of offenders under supervision were assessed as having a high risk of general health issues (AIHW 2015).

The multiple issues potentially contributing to offender behaviour was also evident among early referrals to Queensland Integrated Court Referrals (QICR) (see section 5.2.8 for further information about QICR).[33] Of the first 29 referrals:

- 62% were seeking treatment for illicit drug use;
- 76% were seeking accommodation assistance;
- 31% were seeking assistance with mental health issues;
- 97% were not currently employed;
- 89% were either single or separated; and

[33] Caution is required when interpreting these data given the small number of people included in analyses. The prevalence of drug use, housing and mental health issues will reflect the QICR program which specifically targets people experiencing these issues.

- 39% had a highest level of education of Year 10 or under.

There is also a relationship between crime (including domestic violence), problematic substance use and child protection matters. Among the families worked with by Child Safety Services in 2015–16:

- approximately two-thirds of households substantiated for harm or risk of harm had a parent with a current or past drug/alcohol problem;
- nearly half had experienced domestic and family violence within the last year;
- approximately 45% had a parent who was abused as a child
- over half had a parent with a criminal history;
- nearly half had a parent with a diagnosed mental illness; and
- nearly three-quarters (73%) had more than one of the factors listed above (DCCSDS 2016).

A study of amphetamine and opioid users also found that psychostimulant use is associated with a proportion of domestic violence (Torok et al. 2008).

4.3 DRUG-RELATED OFFENDING

This section provides information that shows that drug use is not only relevant to illicit drug offences, it is also associated with other types of offending behaviour.

4.3.1 Substance misuse within different types of offending patterns

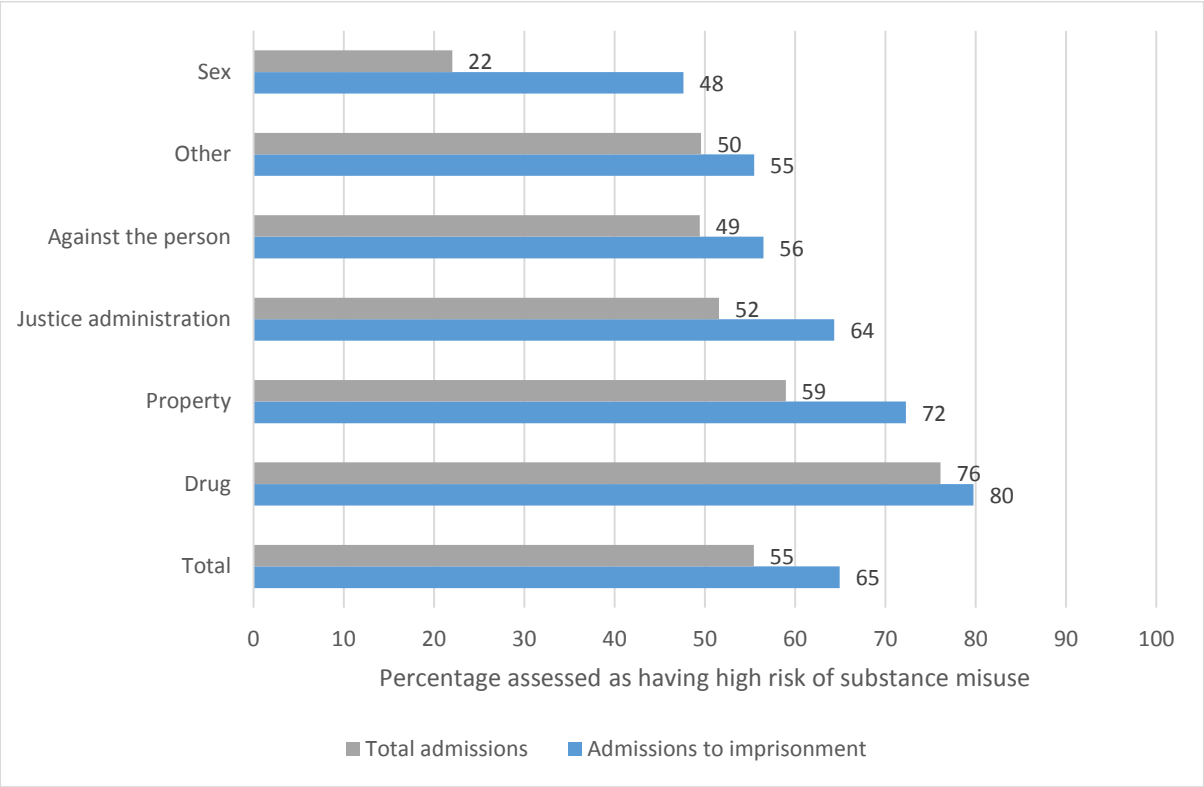
There is a high prevalence of substance misuse among all offenders, not just those with a principal offence relating to an illicit drug offence.

Figure 15 shows the proportion of offenders assessed by QCS as having a high risk of substance misuse by their principal offence at admission. A high risk of substance misuse is used here as an indicator for substance treatment need among offenders assessed as having more than a low risk of reoffending.[34]

Offenders with drug (76%) or property offences (52%) as their principal offence were more likely than offenders with offences against the person (49%) as their principal offence to have a high risk of substance misuse. However, substance misuse issues were still prevalent among violent offenders. Offenders sentenced to imprisonment were more likely than offenders in total to be assessed as having a high risk of substance misuse. Substance misuse issues were least prevalent among sex offenders.

[34] See Appendix B for more information about use of QCS administrative data.

Figure 15: Proportion of offenders assessed as having a high risk of substance misuse by principal offence type, Queensland, 2010–11 to 2014–15



Source: QCS administrative data (benchmark assessment).

Note: These data do not include admissions to parole from court and offenders only include those with Benchmark Assessment information.

4.3.2 Drug offences within different types of offending patterns

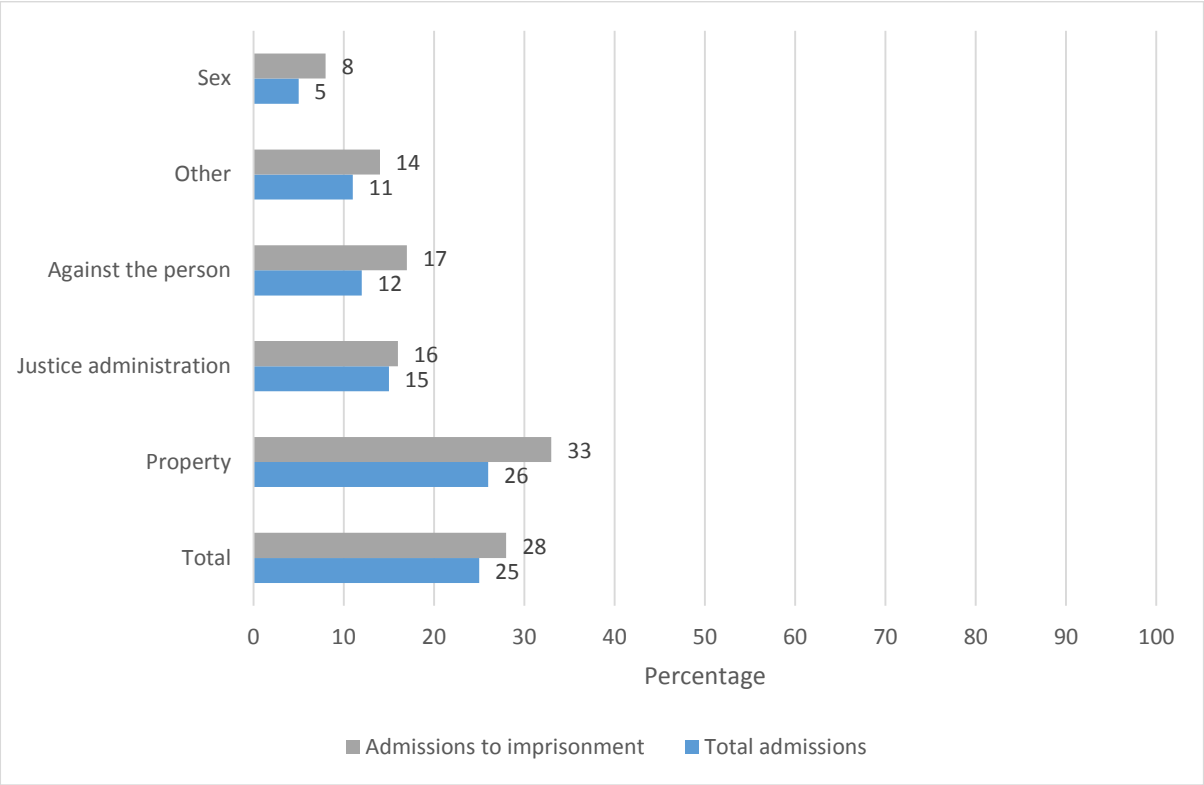
Offenders with an illicit drug offence as the principal offence are not the only offenders to be convicted of illicit drug offences. This suggests that the need for drug interventions may be broader than offenders with a principal offence relating to illicit drugs.

Figure 16 shows the proportion of offenders with an illicit drug offence at admission to supervision by QCS by their principal offence at admission.

One in four offenders (25%) sentenced to supervision have been convicted of at least one illicit drug offence. The prevalence of illicit drug offences within non-drug offence categories was highest among offenders with a principal offence of property offences (26%). About 12% of offenders admitted to supervision with an offence against the person as their principal offence were also convicted of at least one illicit drug offence.

The likelihood of being convicted of a drug offence increases slightly with more serious sentence outcomes. Twenty-eight person of offenders sentenced to imprisonment had been convicted of at least one illicit drug offence.

Figure 16: Proportion of offenders convicted of at least one illicit drug offence by principal offence type, Queensland, 2010–11 to 2014–15



Source: QCS administrative data (benchmark assessment).

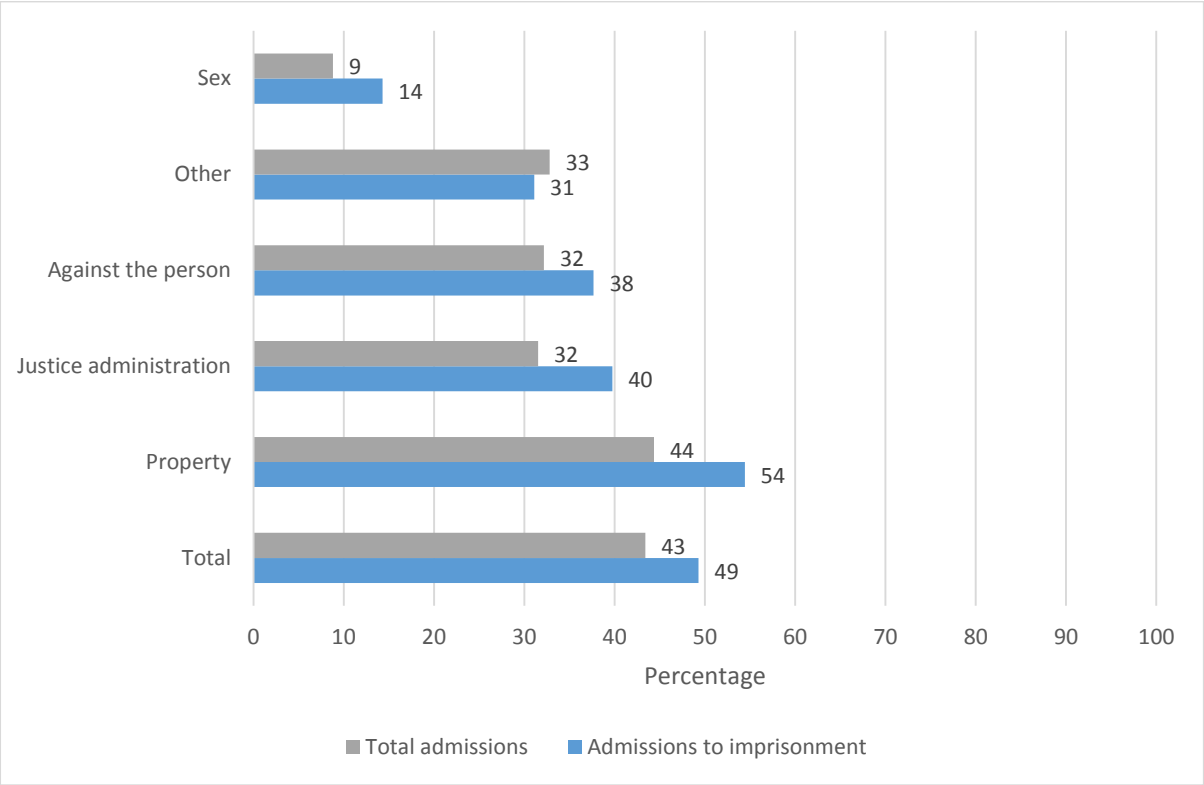
Note: These data do not include admissions to parole from court. All offenders convicted of a drug offence have at least one illicit drug offence.

4.3.3 Drug-motivated offending within different types of offending patterns

Queensland Corrective Services collects information on whether offenders have been sentenced for a drug offence and/or their offending is drug-motivated as part of their assessment process. Analysis of this information shows that 43% of offenders sentenced to a supervised order had a drug or drug-motivated offence/s and these types of offences were prevalent among half (49%) of those sentenced to imprisonment (see Figure 17).

The presence of drug and/or drug-motivated offences was prevalent across different offending patterns including offenders sentenced to supervision with a principal offence relating to a property offence (44%) and offences against the person (32%). Drug-offences and/or drug-motivated offences were least prevalent among offenders with a principal offence relating to sex offending (9%).

Figure 17: Proportion of offenders convicted of at least one illicit drug offence and/or drug motivated offence by principal offence type, Queensland, 2010–11 to 2014–15



Source: QCS administrative data (benchmark assessment).

Note: These data do not include admissions to parole from court. All offenders within the drug offence category are convicted of at least one illicit drug offence and/or drug motivated offence.

4.3.4 Substance misuse and risk of reoffending

The risks-needs-responsivity model argues that criminal justice interventions should be designed and implemented in relation to reoffending risk. Information in Table 5 provides another indication of the level of demand for interventions and specialist court responses to drug use by exploring the risk of recidivism against assessed risk of substance misuse issues among offenders sentenced to supervised supervision.

It shows that nearly one in five people (18%) supervised by QCS (both in the community and in custody) have a high or very high risk of reoffending as well as a high risk of substance misuse. About one in four (23%) have a medium risk of recidivism and a high risk of substance misuse. This latter group is a sizable offender cohort that may benefit from a less intensive intervention than a drug court.

Table 5: Risk of substance misuse and recidivism matrix, offenders under QCS supervision, Queensland, 2010–11 to 2014–15

Risk of substance misuse	Percentage within total offenders under supervision			
	Risk of recidivism			
	Low	Medium	High	Very high
Low	9	7	2	1
Medium	9	10	5	1
High	15	23	13	5

Source: QCS administrative data (benchmark assessment).

Note: Risk of recidivism categories correspond to QCS levels of management categories – low (low risk), medium (standard), high (enhanced) and very high (intensive). The risk of recidivism information presented in above table does not factor in excluding factors that may affect levels of QCS management. For example, sex offenders may have a low risk of reoffending, but are excluded from the low risk management stream by QCS.

4.4 SUMMARY

This chapter has shown that:

- the demand for responses that address substance misuse is high and has been increasing in recent years;
- high levels of substance misuse is evident among offenders with different offending patterns (including violent offending), levels of supervision (including probation orders) and levels of recidivism risk (including low, medium and high);
- high levels of substance misuse are most prevalent among those committing drug and/or property offences, offenders sentenced to imprisonment and offenders with high risks of reoffending;
- the number of people potentially eligible for an intensive drug court intervention (that is, sentenced to imprisonment involving custody) is very small when compared to the number of coming people before the courts; and
- the re-establishment of an intensive drug court intervention is unlikely to reduce prisoner numbers in any substantial way; additional interventions for drug-related offending are therefore needed.

4.5 IMPLICATIONS

The analyses presented in this chapter show that there is a high demand in Queensland for various criminal justice intervention programs, including problem-oriented courts, in response to alcohol and other drug related offending. The following chapter considers whether Queensland currently has the appropriate range of responses in place to be able to supply such interventions in an effective and efficient manner.

5 THE CURRENT QUEENSLAND CRIMINAL JUSTICE CONTEXT

5.1 INTRODUCTION

The Queensland criminal justice system has a number of different points at which people who are suspected of committing, or who are convicted of drug-related offending, can be referred to assessment or treatment programs, from their first contact with police, through to their post-sentence management following a finding of guilt or conviction. Suspected offenders who come into contact with police may be referred to the Police Drug Diversion Program.

Current court-based intervention and referral programs operate within this broader context. Some referrals and interventions are available once a person has been charged with an offence, but before a person has entered a plea or indicated their intention to plead. Others can be accessed only once a person has pleaded guilty or expressed an intention to plead guilty and is on bail. Some are available only post-sentence. In some cases, interventions are also available to defendants at more than one point in the system.

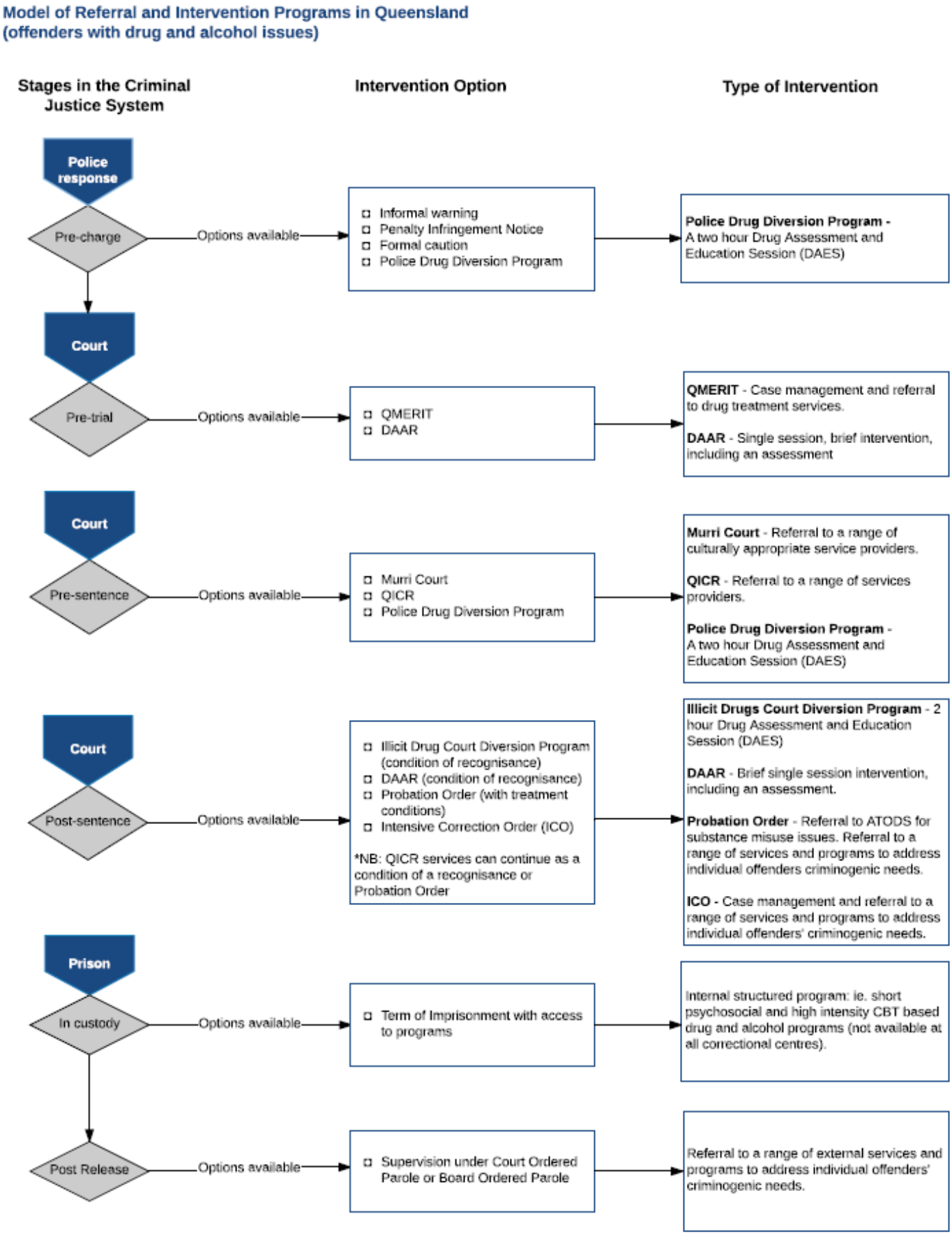
Some forms of interventions and programs are available only to adult defendants while others are also available to young people.

Some programs have specific offence-based eligibility criteria. Others base eligibility on the nature of the issues being experienced by the defendants.

The majority apply, either by intention or effect, to less serious forms of drug-related offending and/or offenders with less extensive criminal histories – for example, through the types of offences they target, or the fact the person must be eligible for bail in order to access the program.

This chapter provides an overview of current court-based referral and intervention programs and also explores the current operation of the criminal justice system and key trends. This information is presented to illustrate Queensland's current responses to its demand for alcohol and other drug related criminal justice interventions.

Figure 18: Model of referral and intervention programs for offenders with alcohol and other drug issues.



5.2 QUEENSLAND'S CURRENT PROBLEM-ORIENTED COURTS AND INTERVENTION PROGRAMS

5.2.1 Introduction

DJAG currently coordinates and supports a range of court-based referral programs and problem-oriented courts that deal with defendants with mental health issues (including impaired decision making capacity), problematic alcohol and other drug use issues or who are otherwise vulnerable, such as defendants who are homeless, where these issues have contributed to them coming into contact with the criminal justice system.

The development of an overarching framework for all problem-oriented courts and intervention programs in Queensland as part of the Review is intended to ensure that these programs work together effectively and in an integrated way.

Some of the programs currently offered are outlined below.

5.2.2 Community Justice Groups

The Community Justice Groups (CJG) program provides essential support and services to Aboriginal and Torres Strait Islander victims and offenders within the criminal justice system. DJAG provides funding to 49 CJGs to support Aboriginal and Torres Strait Islander victims and offenders during the legal process and assist the judiciary by making appropriate cultural submissions to the courts.

The CJG program provides community members with the opportunity to work collaboratively with the courts, police, and staff from other government agencies to address criminal behaviour, and provide support and assistance to victims of crime.

CJGs provide over 9000 bail and sentencing court submissions each year and support to an estimated 5,000 victims of crime throughout Queensland each year. CJGs develop strong working relationships with many non-government agencies to identify and promote referral pathways for Aboriginal and Torres Strait Islander defendants and link victims and defendants to support services. These agencies include Aboriginal and Torres Strait Islander health services, rehabilitation centres, Relationships Australia, the Salvation Army, Centacare, employment agencies, sexual assault services, youth support groups, and men's and women's groups. The CJGs help reduce the likelihood of conflict and crime in Aboriginal and Torres Strait Islander communities by assisting offenders in prison and upon release and resolving conflict and mediating disputes before they escalate.

5.2.3 Remote Justice of the Peace (Magistrates Court) Program

The remote Justice of the Peace (JP) Courts Program was initiated by the Queensland Government in 1993 as part of its response to the recommendations of the Royal Commission into Aboriginal Deaths in Custody.

SPECIALIST COURTS AND COURT PROGRAMS IN QUEENSLAND

- Community Justice Groups
- Murri Court
- Remote Justice of the Peace Court Program
- Queensland Magistrates Early Referral into Treatment Program
- Illicit Drugs Court Diversion Program
- Drug and Alcohol Assessment Referrals
- Queensland Integrated Court Referral
- Former Special Circumstances Court Diversion Program
- Former Queensland Courts Referral
- Domestic and Family Violence Protection Court in Southport

The JP Courts Program seeks to assist Aboriginal and Torres Strait Islander peoples to overcome disadvantages they may face in coming into contact with the criminal justice system, whether as a victim of a criminal act, an accused person, or otherwise.

Under the JP Courts Program, Aboriginal and Torres Strait Islander JPs, may constitute a Magistrates Court in the absence of a magistrate to hear and determine charges for specified minor offences where the defendant pleads guilty.

Four Aboriginal and Torres Strait Islander communities currently convene remote JP Courts: Cherbourg, Kowanyama, Lockhart River and Mornington Island.

5.2.4 Queensland Magistrates Early Referral into Treatment Program

The Queensland Magistrates Early Referral into Treatment (QMERIT) program is a bail-based diversion program for defendants with illicit drug use problems. The QMERIT program operates in the Maroochydore and Redcliffe Magistrates Courts.

The program engages defendants charged with an offence relating to illicit drug use with drug rehabilitation services through bail conditions. QMERIT combines treatment and support services for defendants with problematic drug use during their contact with the criminal justice system.

QMERIT provides an opportunity for eligible defendants to participate in a structured intervention that aims to give defendants the skills and confidence needed to improve their health and well-being and significantly reduce offending behaviour.

An outcome evaluation of the QMERIT program completed in 2010 found improvements in health and well-being, as well as, reduced offending among program completers. Among QMERIT evaluation participants:

- 52% reported not using drugs three months after exiting the program;
- the average Severity of Dependence Score reduced from indications of clinical drug dependence at program entry to an average score equivalent to that found in the general community at program exit;
- the average physical and mental health scores improved (although the improvement in physical health was not statistically significant);
- reductions in levels of psychological distress; and
- 24% were engaged in full time employment at program entry compared with more than 50% at program exit and six months after program exit (Turning Point 2010).

The evaluation also calculated that there were higher rates of re-offending predicted for program non-completers (40% within 200 days of program termination) than program completers (10% predicted to re-offend within program completion).

Evaluations of similar programs operating in other jurisdictions also show promising results. For example, an evaluation of the Magistrates Early Referral into Treatment program implemented in NSW found that program completers were less likely than non-completers to re-offend within 3, 6 and 12 months after completing the program (Matruglio 2008).

5.2.5 Illicit Drugs Court Diversion Program

The Illicit Drugs Court Diversion Program (court diversion program) targets offenders who plead guilty to eligible minor drug offences. For adult offenders, the court orders these offenders to attend a Drug Assessment and Education Session (DAES) as a condition of a recognisance order imposed. The court refers juvenile offenders to a DAES by way of a verbal direction. The program is available in all Magistrates Courts and Childrens Courts in Queensland.

Evaluations of brief interventions offered as part of police and court diversionary initiatives indicate positive results. For example, a national evaluation of police drug diversion programs found that the majority of people

referred to a police drug diversion program either did not reoffend or, if they did reoffend, had very few subsequent offences in the 12 to 18 months post diversion (Payne, Kwiatkowski & Wundersitz 2008).

Results for Queensland's Police Diversion Program showed that around one-third of the 4,700 people diverted to the program were re-apprehended within 12 months of being diverted, while half of those who continued to offend committed just the one offence (Najman et al., 2009). A subsequent evaluation of the Police Diversion Program involving interviews with 152 participants at the time of diversion and six weeks later observed reductions in self-reported cannabis, ecstasy, amphetamine and tranquiliser use, along with improvements across a number of other health indicators (Najman et al., 2009).

Overall, brief interventions appear to be a promising option for mild-to-moderate drug users; however, more intensive interventions tend to yield greater outcomes than brief interventions, albeit at higher cost. Brief interventions are more effective for less serious or entrenched substance users, with those showing signs of dependence less likely to benefit from short, motivational interviewing programs (Nathan & Gorman 2015). For these reasons, there is a growing consensus that brief interventions should be offered as part of a broader continuum of 'stepped care' that allows treatment and health practitioners to respond appropriately to clients who are not engaging or who are identified throughout the brief intervention as having more complex or significant treatment needs (Breslin et al., 1997; Sobell & Sobell 2000).[35]

5.2.6 Drug and Alcohol Assessment Referrals

The Drug and Alcohol Assessment Referrals (DAAR) program was established as part of the Safe Night Out Strategy aimed at reducing alcohol and other drug-related violence in Queensland's nightlife.

When the DAAR program was first introduced, a mandatory bail condition was applied by police officers or the court and required offenders to complete a one-off course involving a drug and alcohol assessment, and information about treatment options. Offenders must have been charged with a particular offence of violence, where alleged in the charge that the offence was committed while in a public place and intoxicated. The relevant offences to which this mandatory bail condition applied included grievous bodily harm, wounding, serious assaults, common assault, affray, assault occasioning bodily harm and assault or obstruction of a police officer.

As a result of recent legislative changes the DAAR bail condition is no longer mandatory and courts have a discretion to include a bail condition, in relation to any offence to which the *Bail Act 1980* applies, that the person complete a DAAR course by a stated date. In deciding whether to impose this condition, the court must have regard to the nature of the offence in relation to which bail is proposed to be granted; the person's circumstances, including any benefit the person may derive by completing a DAAR course and the public interest. However, the court may not include this condition if the person has completed two DAAR courses within the previous five years, is under 18 years or provisions relating to the release of a person with impairment of the mind apply. These changes also confine the imposition of the condition to cases where the bail granting authority is a court and, in recognition of its therapeutic nature, provides that a failure to comply with the condition does not constitute an offence of breaching the conditions of bail.

The completion of a DAAR course may be added as a condition of a recognisance order upon sentence with the consent of the defendant.

[35] See Appendix D for further information.

5.2.7 Murri Court

As part of stage one of the reinstatement project, work has been completed to reinstate the former Murri Court.

The first Murri Court was established in 2002 and, prior to it being de-funded in 2012, operated in 17 locations across Queensland. Murri Courts operated within a Magistrates Courts framework, but provided opportunities for greater involvement of Aboriginal and Torres Strait Islander Elders and respected persons, the offender's family, Aboriginal and Torres Strait Islander community organisations and CJGs in the sentencing of Aboriginal and Torres Strait Islander offenders. While the program began as a sentence-based program, it evolved into a bail-based rehabilitation program in a number of locations.

Following the de-funding of the Murri Court in 2013, an Indigenous Sentencing List (ISL) was established and operated in 13 locations across Queensland.

The Murri Court has been formally reinstated in the 13 current locations: Brisbane, Cleveland, Caboolture, Cairns, Cherbourg, Mackay, Mount Isa, Richlands, Rockhampton, St George, Toowoomba, Townsville and Wynnum.

The reinstated Murri Court is very similar to the former ISL. It operates under both bail and sentencing powers.

Eligibility requirements are that a defendant must identify as an Aboriginal and/or Torres Strait Islander, be on bail or be eligible for bail, have committed an offence within the jurisdiction of the Magistrate Court or Childrens Court, and agree to participate in the Murri Court.

An evaluation of the Queensland Murri Court operating before it was defunded in 2013 found that it met many of its objectives (Morgan & Louis 2010). It offered a culturally-sensitive approach to sentencing and the involvement of Elders and respected persons in court processes increased perceptions of judicial fairness. The court was highly valued among stakeholders and assisted with the development of local collaborations (Morgan & Louis 2010).

However, the Murri Court did not decrease the likelihood of reoffending among participants with little change in the frequency or seriousness of their offences after involvement in the court (Morgan & Louis 2010). Furthermore, Murri Court participants were no more or less likely to receive a custodial sentence than defendants heard in the mainstream court (Morgan & Louis 2010). This meant that the Murri Court did not assist in reducing the overrepresentation of Aboriginal and/or Torres Strait Islanders in the criminal justice system.

The evaluation identified a number of recommendations that could potentially enhance the operation of the Murri Court. Recommendations of relevance to the design of the reinstated drug court include:

- continued involvement of Elders and respected persons;
- funding for local program providers that target the specific needs of Aboriginal and/or Torres Strait Islanders in order to support a reduction in reoffending;
- ongoing training, mentoring and professional development for those involved in implementing the program;
- consideration of the Murri Court's relationship with other court-based diversion programs;
- clear definitions regarding the role of all stakeholders (including CJGs, magistrates, Aboriginal and/or Torres Strait Islander community organisations and police liaison officers) in supporting the program;
- providing debriefing opportunities and support for elders involved in the court's operation; and
- enhancing the court' use of victim impact statements and its ability to support victims when they attend court (Morgan & Louis 2010).

5.2.8 Special Circumstances Court Diversion Program and Queensland Courts Referral

As part of stage one of the reinstatement project, work has been completed to reinstate the former Special Circumstances Court Diversion Program (SCCDP). The SCCDP operated in Brisbane from 2009-2012 and was a

court-based rehabilitation program for offenders who were homeless or suffered from impaired decision making capacity.

A review of the SCCDP collected information that enabled a description of SCCDP participants (through use of participant observation) and the operation of the court (through face-to-face interviews) (Walsh 2011).[36]

Some of the benefits of the court described by program participants included:

- the dignity and respect shown by court staff (including the magistrate);
- the practical advice and support provided by court staff;
- facilitated access to support services; and
- renewed respect for the justice system (Walsh 2011).

These benefits were seen to be assisted by participants' regular contact with the court. Some review participants also described improved outcomes such as access to housing, reduced drug use, separating from a violent partner and meeting education and employment milestones (Walsh 2011).

Court staff described the strengths of the court:

- the ability to develop relationships with offenders that enabled the ability to contextualise offending behaviour and effect change;
- the ability to facilitate access to support services; and
- the capacity of the court to use its authority to encourage and enable change (Walsh 2011).

After SCCDP's closure in December 2012, the Queensland Courts Referral process was initiated in eight locations: Brisbane, Beenleigh, Cairns, Holland Park, Ipswich, Mount Isa, Pine Rivers and Southport. QCR is a bail-based process under which defendants are referred to services provided by non-government organisations (NGOs) and government agencies to address the underlying causes of offending behaviour.

The reinstated model is Queensland Integrated Courts Referral (QICR). QICR encourages defendants' engagement with service providers through short term bail-based referrals and then longer-term treatment and rehabilitation post-sentence. When QICR is implemented in a location, the QCR process will cease.

QICR will operate in a number of locations throughout Queensland including Brisbane, Cairns, Southport, Ipswich and Mt Isa. QICR may then be rolled-out to other locations in the future.

Defendants are eligible for QICR if they are on bail or eligible for bail, charged with at least one summary offence, and if they have a drug or alcohol dependency, mental illness, cognitive impairment, intellectual disability or are homeless or at risk of homelessness. The court-based facilitator is responsible for conducting initial non-clinical screenings and referring eligible defendants to the Case Assessment Group.

5.2.9 Domestic and Family Violence Specialist Court

A trial of a specialist Domestic and Family Violence (DFV) court commenced at Southport on 1 September 2015. The trial builds on the existing Gold Coast Domestic Violence Integrated Response (GCDVIR) and involves dedicated magistrates presiding over all civil domestic and family violence proceedings, as well as breach proceedings and associated criminal charges including committal hearings.

The trial involves close collaboration between all stakeholders including Legal Aid Queensland (LAQ), QPS Queensland Corrective Services (QCS), Department of Communities, Child Safety and Disability Services (DCCSDS) and other members of the GCDVIR.

The long term objectives of the DFV court are:

[36] Information on participant recidivism was not collected as part of the Review.

- the delivery of a coordinated, fair, consistent and timely response to domestic and family violence matters by the specialist court;
- increased safety and improved court safety for victims of domestic and family violence;
- perpetrators are more accountable and demonstrate behaviour change;
- the development of strong local service provider partnerships.

One of the reasons Southport Magistrates Court was selected as the pilot site was that the Gold Coast Domestic Violence Integrated Response (GCDVIR) – a community-based network that delivers an integrated response to domestic violence with the focus on coordinated interventions – was established as a key current scheme that could assist the work of a specialist court. The GCDVIR have been a vital service on the Gold Coast for 18 years and includes access to duty lawyers (through LAQ), police, court support workers, perpetrator information workers, providers of perpetrator programs and specialist domestic violence counselling. The high ratio of DFV proceedings presented before this Magistrates Court was another reason to establish the pilot in Southport. In addition, the prospects for investigating how the court systems for domestic violence matters could be coupled with associated child protection and family law matters was considered an important aspect of the pilot as the Federal Circuit Court of Australia, which exercises family law jurisdiction, also sits in Southport.

The pilot centres on dedicated magistrates hearing both applications for Domestic Violence Orders (DVOs) and associated criminal matters. The dedicated magistrates are assisted by a DFV Registry and a Court Coordinator. Additional duty lawyers provided by LAQ and prosecutors by QPS are assigned to support the court assembled by the dedicated magistrates. Local service providers important to the operation of the DFV court are co-located, to offer assistance and information to the aggrieved and respondents.

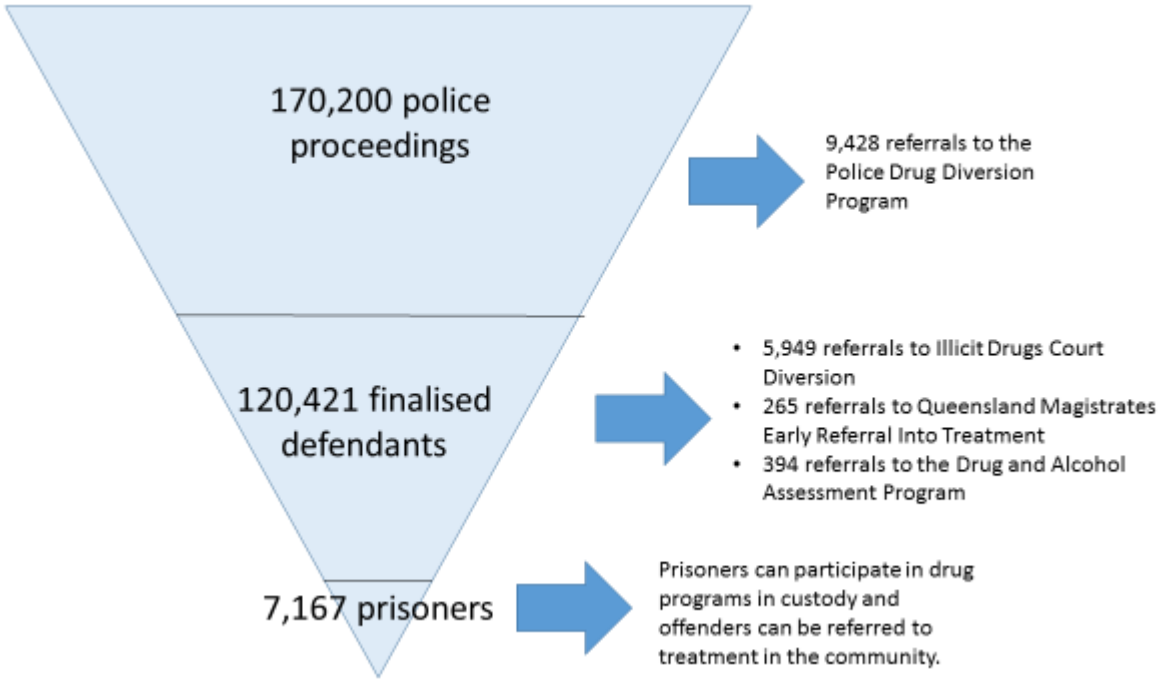
5.3 CRIMINAL JUSTICE REFERRALS TO ILLICIT DRUG INTERVENTIONS

5.3.1 Number of referrals

Figure 19 shows that a relatively small proportion of people in contact with the criminal justice system are referred to drug interventions. In 2014–15, 9,428 people were referred to the Police Drug Diversion Program by QPS, 5,949 people were referred to the Court Diversion Program, 265 people were referred to QMERIT and 394 people were referred to DAAR.

Chapters 3 and 4 shows how the demand for illicit drugs interventions is likely to be substantially higher than the current supply available.

Figure 19: Indicators of criminal justice system demand and number of criminal justice referrals to illicit drug interventions, 2014–15



Source: ABS Recorded Crime, Offenders, 2014–15 (number of alleged adult offenders in 2014–15), ABS Criminal Courts, Australia 2014–15 (number of finalised defendants in 2014–15), ABS Prisoners in Australia, 2015 (number of adult sentenced and unsentenced prisoners in 2015) and DJAG administrative program data (number of referrals to programs in 2014–15).

5.4 IMPLICATIONS

This chapter has presented a picture of Queensland's current supply of criminal justice interventions in response to alcohol and other drug related offending. But when considered in conjunction with the data on the demand for such interventions (presented in the previous chapters), it is clear that a more effective and efficient criminal justice model is required.

6 COST EFFECTIVENESS OF DRUG INTERVENTIONS

6.1 INTRODUCTION

The growing number of people in contact with Queensland's criminal justice system for illicit drug offences and with drug-related issues has considerable economic and social cost implications – both tangible and intangible. Tangible costs associated with crime include police, court and corrections expenditure, medical fees and lost productivity. Intangible costs include psychological and emotional harm and lost quality of life (Dossetor 2011).

Research has shown that behavioural treatments and medications administered in both community and criminal justice settings can reduce problematic substance use and drug-related criminal behaviour and are cost-effective in doing so (Chandler, Fletcher & Volkow 2009). Diverting funds to enable effective therapeutic responses to drug-related crime is likely to result in future cost savings (including costs related to administrating the criminal justice system, health and victim harm) (Morgan et al. 2012).

6.1.1 The cost of crime in Australia

In 2014, the Australian Institute of Criminology (AIC) estimated that the cost of crime in Australia for 2011 was $47.6 billion (Smith et al. 2014). These estimations began with establishing the number of crime events through the use of reported crime and the crime victimisation survey. Costs that accounted for actual loss, intangible loss, loss of output caused by the crime and other related costs (such as medical expenses) were then applied to these crime events. The costs of preventing and responding to crime in the community were then added to these costs. Recovered values (for example, recovered property and funds) were subsequently deducted from these costs to produce final costs by crime categories (Smith et al. 2014).

The AIC calculations indicated that fraud offences accounted for the highest cost of all crime types, followed by drug abuse and assault (Smith et al. 2014).

The estimated cost of Australia's drug abuse problem was $3.2 billion in 2011 (Smith et al. 2014). These estimations principally related to the human cost of drug-related crime (as opposed to the cost of offending to fund a drug habit and the cost of law enforcement activities related to the prevention of drug trafficking, drug use and drug-related crime).[37] They factor in costs associated with loss of life, hospitalisation, treatment and lost productivity (Smith et al. 2014).

The economic values developed by the AIC offer one of the few sources of information on the costs of crime and are often used to underpin economic evaluations of criminal justice programs implemented in Australia, for example, KPMG's economic evaluation of Victoria's CISP (KPMG 2009). However, some crime types are not included in the AIC estimations because of a lack of data on their incidence and/or cost (Smith et al. 2014) which may limit the accuracy of economic evaluations using these estimates.[38]

6.1.2 The cost of Queensland's criminal justice system

Available information on the costs associated with administrating criminal justice services in Queensland is summarised in Table 6. Although caution is required when interpreting these figures, costs were substantial

[37] The AIC posited that the costs of crime perpetrated to fund drug addiction are included within other crime categories (for example, burglary and assault). These estimations do not include the human cost of alcohol consumption.

[38] Crimes not included in AIC cost estimates are kidnapping, extortion, blackmail, abduction, criminal defamation, environmental crime, good order offences, regulatory offences, illegal immigration, road traffic offences, human trafficking, corporate crime, tax evasion, cybercrime, identity crime, child exploitation offences and organised crime.

at $1.54 billion in 2014–15.[39] These costs do not represent the full cost of crime in Queensland as they exclude a range of tangible and intangible costs associated with crime.

Table 6 Estimated cost of administrating criminal justice in Queensland, 2014–15

	($'000)
Crime management by police	588,700
Criminal courts	146,781
Adult corrections	670,307
Youth corrections	137,278
Total	**1,543,066**

Source:

Police. Estimated costs are 35% of real recurrent expenditure on police services as reported by Australian Government Productivity Commission in 2015 Report on Government Services. The QPS 2011 Annual Report indicated that 35% of the police budget was directed towards crime management, rather than other functions such as traffic management (cited in Allard et al 2013). This may have changed over time.

Criminal Courts. Real net recurrent expenditure on criminal courts as reported in Australian Government Productivity Commission's 2015 Report on Government Services.

Adult corrections. Real net expenditure on prisons and corrections (plus depreciation) as reported in in Australian Government Productivity Commission's 2015 Report on Government Services.

Youth corrections. Department of Justice and Attorney-General (DJAG) expenses for Youth Justice as reported in the Queensland Government Service Delivery Statement for (DJAG).

6.1.3 The cost of Queensland offender trajectories

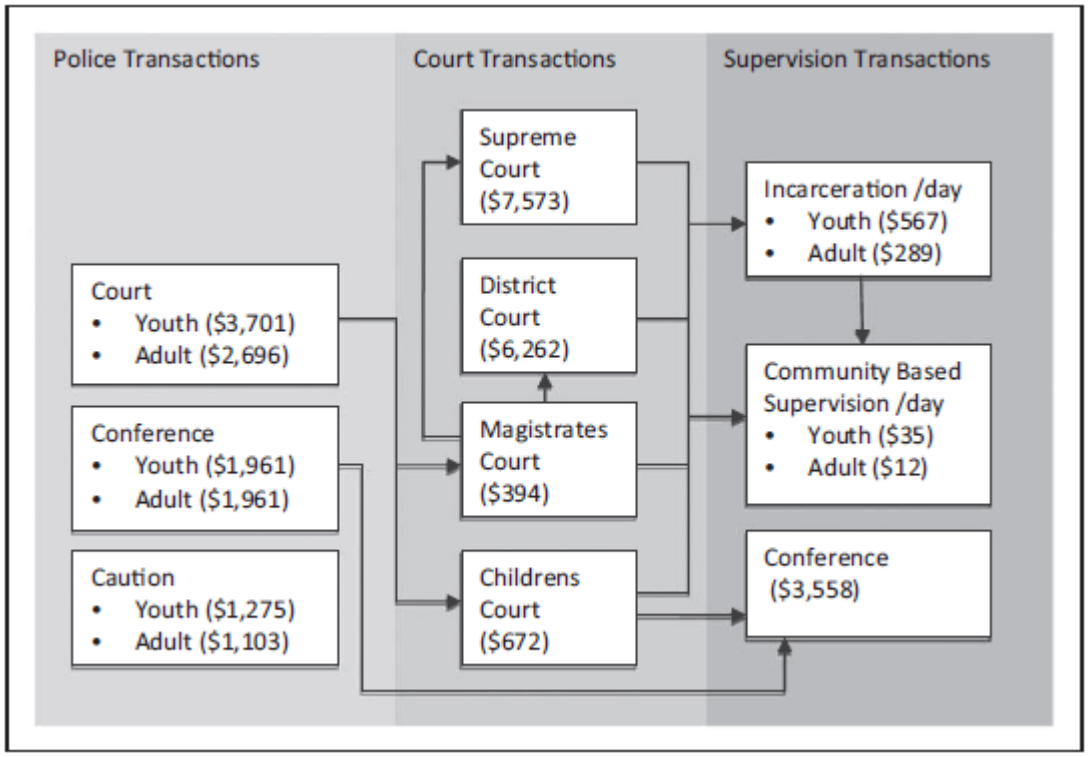
The cost of Queensland offender trajectories has been valued by Allard and colleagues (2013).

These estimations were based on the number and type of finalised criminal justice events (including police, courts and supervision) for individuals committing offences between the ages of 10 and 25 years and the costs of crime as estimated by the AIC (which enabled the wide social and economic costs of crime to be factored into analyses) (Allard et al. 2013).

The average cost of criminal justice system transactions used by the study are shown in Figure 20. Although these costings will understate the current value of criminal justice responses to crime, they illustrate how criminal justice transaction costs can be minimised if offenders are not unnecessarily progressed through the system.

[39] These costs do not represent the full cost of crime in Queensland. They do not include the wider social and economic costs including ancillary costs (such as those associated with legal representation and the provision of programs by other government agencies to support offender rehabilitation). They do not include intangible costs such as harm to victims and communities.

Figure 20: Cost of justice system transactions



Source: Allard et al 2013:91

The results of the offender trajectory costings showed that a small proportion of offenders (4.8%) accounted for a substantial share (41.1%) of overall crime costs and that on average, chronic offenders each cost between $186,366 and $262,799 by the time they turned 26 years old (Allard et al. 2013). Analyses of the same data also showed that some communities were more likely to generate chronic offenders and therefore carried the 'cost burden' of chronic offenders, to a greater extent than other communities (Allard, Chrzanowski and Stewart 2012). These communities were predominately located in north and far north Queensland and had a relatively high proportion of young Aboriginal and Torres Strait Islander people (Allard, Chrzanowski and Stewart 2012).

These findings indicate that reducing the incidence of crime among chronic offenders with high risk, high need (such as those referred to drug courts in Australia) will have the biggest impact on the total costs of crime.

6.1.4 The cost of providing drug interventions to people in contact with the criminal justice system

The total funding allocated to support people referred to drug interventions by criminal justice agencies is difficult to quantify accurately. Funded organisations can be responsible for delivering services to people referred by the police and the courts as well as people accessing services from non-criminal justice referral pathways, including self-referrals. Accurate information on the number of interventions provided against each program name is not systematically collected or reported on by support services.

Based on information provided by the Department of Health, nearly $11 million was allocated in 2015–16 to provide drug treatment services to people referred to treatment services by the police and the courts.[40] Some of this funding is redirected funding from the former drug court.

[40] E-mail communication, Department of Health, 15 June 2016.

This includes funding provided to non-government agencies for the delivery of treatment and referral and coordination services, as well as funding provided to government agencies (including DJAG and QPS) for program support.

The $11 million excludes some funding required for program support staff, which is sourced from other budgets. For example, the nursing staff, social workers and psychologists that support the operation of QMERIT are funded from regional Health and Hospital Services budgets.[41]

Funding provided to NGOs is used to support the assessment and education sessions provided as part of police and court drug diversion and DAAR, as well as the residential drug treatment provided as part of the QMERIT and QICR programs.

The estimated average cost of delivering assessment and education sessions is approximately $250 per session.[42] However, the average cost of delivering this intervention will depend on local issues and economies of scale (which is affected by the number of people referred to the intervention).

6.2 COST EFFECTIVENESS OF POLICE DRUG INTERVENTIONS

There are no robust cost-effectiveness evaluations of Australian police drug intervention programs.

Only one evaluation has even attempted to examine the cost-effectiveness of a police intervention program. The study of the cost-effectiveness of the NSW Cannabis Cautioning Scheme found positive results in savings to the criminal justice system. In the first three years of operation it was estimated that over 18,000 police hours were saved as a result of not having to charge offenders at the time of detection of the offence and not having to prepare matters for court or attend subsequent hearings. The evaluation calculated that the scheme resulted in total savings of more than $1 million during the first three years of operation, but also cost approximately $1,096,000. The evaluators therefore concluded that the scheme had paid for itself in its first three years. They also noted that most of the costs identified were establishment costs, which would reduce over time, thereby increasing potential savings (Baker & Goh 2004). However, many of the people consulted as part of the evaluation commented that there was no evidence that the scheme kept people out of court in the longer term, and in fact had instead led to net-widening, as people who would previously have been dealt with informally were given a formal caution. As this cost-effectiveness evaluation was based not on actual hours and dollars saved, but on a series of assumptions and estimates about savings that might have accrued, it should be viewed with some caution.[43]

6.3 COST-EFFECTIVENESS OF COURT INTERVENTIONS

This section discusses available information on the cost-effectiveness of Australian court-related interventions.

6.3.1 Queensland Magistrates Early Referral into Treatment

The QMERIT outcome evaluation reported that the estimated cost per client in the QMERIT program during 2007-08 was $8,574, involving 112 days in the program. This is substantially less than the estimated cost per prisoner over the same period at $29,456 – although not all QMERIT participants would have necessarily been required to go to remand without the establishment of QMERIT (Turning Point 2010).

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[41] The Redcliffe QMERIT team includes two full time clinical nurses and two part time social workers. The Maroochydore QMERIT team includes a Nurse Unit Manager and five case managers (nurses, social workers and psychologists).

[42] E-mail communication, Department of Health, 15 June 2016.

[43] The authors themselves note that 'this analysis is in no way intended to constitute a full cost-benefit analysis' of the scheme: Baker and Goh 2004, p. 35.

An economic assessment of NSW's Magistrates Early Referral into Treatment program found a potential ratio of benefits to costs of between 2.41 and 5.54 to the dollar, with a conservative estimate of an annual net benefit of $914,214 for a yearly average of 55 program completers, or $16,622 per completer (Northern Rivers University Department of Rural Health 2003).

6.3.2 Court Integrated Services Program

The Court Integrated Services Program (CISP) is a bail-based program operating in Victoria. It aims to provide integrated support to people in order to address factors contributing to offending behaviour.[44]

The average length of participation in the CISP program is four months and the operating costs of this program are lower than the cost of imprisonment.

KMPG (2014) estimated that the cost per CISP graduate was $7,268 and the cost of each CISP terminate was $4,080. This was less than the cost of a four-month imprisonment term estimated to be approximately $34,000.[45]

A benefit-cost analysis estimated the benefits associated with the CISP program through a reduced rate and length of imprisonment for program participants, as well as a reduction in the re-offending rate, compared with the costs of administering the program (PricewaterhouseCoopers 2009).

The total days of imprisonment imposed across the sample of 200 CISP participants was 1,592 (sentences post-CISP completion), compared with the total days of imprisonment imposed on the control group of 8,116 (most recent sentence). The sample survey of CISP participants found that the 100-week recidivism rate amongst CISP participants was 40%, compared with 50% among the control group. When reoffending does occur, the average time to the offence is longer for the CISP group, and the average seriousness of reoffending is lower (PricewaterhouseCoopers 2009). Comparing the sample of 200 CISP participants with 200 similar offenders who had not been through CISP,[46] the evaluation estimated a benefit-cost ratio ranging from 1.7 to 5.9.[47] The benefits were comprised of avoided costs of sentencing, avoided costs of imprisonment, avoided costs of crime and avoided costs of order breach (PricewaterhouseCoopers 2009). The evaluation concluded that there are significant potential benefits associated with CISP. The key driver of these benefits are a reduction in reoffending and concomitant reduction in factors such as the costs associated with sentencing for reoffenders and costs associated with imprisonment.

The current approximate program cost per client episode (including graduates and terminates) is $4,300 (excluding court costs). The breakdown of costs under the CISP model is estimated at staffing (47%), drug and alcohol treatment (18%), housing (24%) and brokerage funds (11%).[48]

[44] Further information about the CISP program is at Chapter 10.

[45] Cost of imprisonment uses daily cost of imprisonment ($280) cited in KPMG (2014) evaluation report.

[46] The two samples were matched on factors such as age, gender, type of offence and offending history (PricewaterhouseCoopers 2009).

[47] Three scenarios were created to estimate the duration of the impact of CISP: two years, five years and 30 years. If the impact of CISP lasts two years, the benefit-cost ratio is 1.7. If the impact lasts five years, it is 2.6. If the program impact lasts a lifetime (30 years), the benefit-cost ratio is 5.9 (PricewaterhouseCoopers 2009).

[48] E-mail/telephone communication, Court Support and Diversion Services, Victoria, 28 October 2016.

Most economic evaluations of drug courts operating in Australia find that they are cost-effective given that they are more likely to reduce reoffending than imprisonment.[49] To date there have been no cost-benefit analyses of drug courts in Australia.

6.3.3 Former Queensland Drug Court

Three evaluations have been conducted on the former Queensland Drug Courts. Two evaluations focused on implementation issues (the North Queensland Drug Court Evaluation and the South East Queensland Drug Court Evaluation), while the third evaluation focused on recidivism.

The North and South East Queensland evaluations found early indications of:

- time-graded reductions in drug use among participants while on the drug court program – with fewer positive drug tests occurring the further a participant progressed through the program;
- significant improvements in health and well-being across a range of health measures (at the time of graduation, graduates' health status was the equivalent to Queensland population norms); and
- reductions in the likelihood of reoffending among graduates and reductions in the time to reoffend among those graduates who did reoffend (Payne 2005; Makkai & Veraar 2003).

The recidivism evaluation was able to examine reoffending patterns within a two-year follow up period. It established that drug court graduates had improved criminal justice outcomes when compared with drug court terminates and a prisoner comparison group. It showed that:

- 70% of drug court graduates and 92% of drug court terminates committed offences while on the program. Most of these offences were breach-related offences. Graduates had significant reductions in overall offending frequency when compared to the previous 12 months.
- 59% of drug court graduates compared with 77% of drug court terminates reoffended within two years of completing the program, or in the case of drug court terminates, exiting custody.
- The average time to reoffend was 379 days for graduates and 139 days for terminates.
- Both drug court graduates and terminates committed fewer offences after program involvement, however decreases were greater among drug court graduates (80% decrease) than for drug court terminates (63% decrease).
- Post-offending patterns among drug court terminates were similar to patterns observed among a prisoner comparison group (Payne 2008).

These results show some of the benefits of the former Queensland Drug Court. Costs were avoided through the reduced use of imprisonment and reductions in offending behaviour among graduates. However, less than a third (28%) of offenders issued with an Intensive Drug Rehabilitation Order (IDRO) graduated from the drug court,[50] which highlights the high level of complexity involved in responding to people with entrenched offending patterns and substance misuse.

There is minimal costing information available regarding the operation of the former drug court and analysis of this information indicates that it was more costly than imprisonment. However, evaluations found that the former drug court was more effective at reducing reoffending than imprisonment (Payne 2008). The cost-benefits of reduced drug use and reoffending were not measured.

The overall whole-of-government per annum cost of the former Queensland Drug Court was estimated to be $14.3 million. This includes $6.72 million allocated to Queensland Health to support the provision of drug

[49] Information on drug courts operating in the United States and other countries is not described here given the differences between these courts and those established in Australia.

[50] DJAG administrative data. Total Queensland Drug Court results for 2000 to 2012.

treatment services and $4 million allocated to Queensland Corrective Services to support the supervision of IDROs and undertake urinalysis.

On average, 134 people were referred and accepted into the drug court program each year. Just over 70% of participants were terminated from the program and the average (mean) time to termination was less than one year (281 days) (Payne 2008). In other words, most of the offenders sentenced to an IDRO were on the former drug court program for less than a year. The average (mean) time for graduates to complete the program was about 14 months (420 days) (Payne 2008).

The average cost per person referred to drug court was about $107,000, which was higher than the approximate cost of imprisonment per person per year ($69,000).[51] However, the reduction in reoffending among program graduates and terminates means that the program is likely to have contributed to saved criminal justice system costs (including police, courts and corrections).

Economic evaluations often calculate the unit cost of programs by dividing total program funding by the average number of people on the program during the funding period. For example, the Drug Court of Victoria unit cost was estimated to be $26,000 and the unit cost of the NSW Drug Court was estimated to be $24,000 (KPMG 2014).

Information on the average number of people on the former Queensland Drug Court at any one time is not currently available. However, the number of places on the program was capped at 221. This suggests that the unit cost for the former Queensland Drug Court was at best $59,000.

Unlike Queensland where program costs included substantial funds for health services, other drug courts operating in Australia are generally able to utilise existing health services to support the provision of drug treatment, which will partially explain why unit costs in other jurisdictions are lower than those identified for Queensland.

Furthermore, it is not clear if the $14.3 million attributed to the operation of the Queensland Drug Court was solely expended on drug court activities. Consultation with key stakeholders suggests that some of these funds were absorbed into supporting other 'business-as-usual' government functions or supporting other people in contact with the criminal justice system. This means that the $14.3 million estimate may be an inflated cost-estimate.

These results highlight the importance of locating the reinstated drug court in locations where economies of scale can be achieved (so that the program operates efficiently and unit costs are not artificially inflated due to low program participant numbers) and collecting accurate information regarding program resourcing. It may also be important to quarantine drug court funding to ensure that resources are solely directed into the operation of the drug court to maintain its effective implementation.

6.3.4 NSW Drug Court

An evaluation of the NSW Drug Court was finalised in 2002. It found that the drug court was more effective than conventional courts in reducing the risk of recidivism, although the effect was fairly modest. The average (mean) time to the first reconviction for NSW Drug Court participants was marginally longer than that for the control group (325 days compared with 279 days) and they were also convicted of fewer further offences for drug offences only. Comparing those who had completed the program with those who had not, a second analysis showed that treatment completers were significantly less likely to reoffend, to take longer to reoffend and to have fewer reconvictions for a range of theft and drug offences (Lind, Weatherburn & Chen 2002).

The cost per day per participant in the drug court program ($143.87) was slightly less than the cost per day for offenders sanctioned by conventional means ($151.72). The most significant contributors to the cost of the

[51] In 2012–13, the average cost per prisoner per day in Queensland (real net operating expenditure) was $189.87 (Australian Government Productivity Commission 2014) or approximately $69,302 per year.

Drug Court were health care treatment, court attendances and the cost of sanctions (particularly imprisonment) for non-compliance (Lind, Weatherburn & Chen 2002).

The NSW Drug Court was found to be more cost-effective than conventional court sanctions (mostly imprisonment) in reducing the risk of re-offending, while there was little difference between the two in delaying the time to the first offence. For example, it cost nearly $5,000 more for each shop stealing offence averted using conventional sanctions, and an additional $19,000 for each possess/use opiates offence averted, than it cost using the Drug Court program (Lind, Weatherburn & Chen 2002).

A second evaluation undertaken in 2008 estimated that the total cost of the program was estimated to be $32.752 million over two years (or $16.376 million per annum), giving an average (mean) cost of $114,119 per participant.[52] The analysis showed that the cost of the drug court participants if they had not participated in drug court would have been $36.268 million over two years (or $18.134 million per annum). The annual saving of the NSW Drug Court was thus estimated at $1.758 million (Goodall, Norman & Hass 2008).

The second evaluation concluded that the NSW Drug Court is cheaper and produces better outcomes than the alternative, leading to significant reductions and delay in recidivism and saving 'considerable resource use as a result of reduced incarceration'.

6.3.5 Drug Court of Victoria

The most recent evaluation of the Drug Court of Victoria found it to more cost-effective than imprisonment. The average cost of each drug court participant was $26,000, which compared favourably with the cost of a two year sentence of imprisonment ($197,000) (KPMG 2014)[53].

The reduction in the frequency and severity of offending achieved by the drug court cohort was estimated to result in 4,492 fewer days of imprisonment (6,125 versus 10,617). At $270 per day, this represented over $1.2 million in reduced costs of imprisonment over two years. The evaluators believed that this compared favourably with the costs of the court ($4.5 million over three years) especially given that the benefits to the community by way of reduced offending were not measured by the evaluation (KPMG 2014).

6.3.6 Perth Drug Court

A review of the Perth Drug Court considered its operational costs in relation to prison and a community order.

This review found that the offender management costs associated with the Perth Drug Court were higher than a community order (estimated to be $16,211 per participant verses $7,310 per offender), but lower than a prison sentence (estimated at $93,075).[54] However, when the different rates of recidivism were also considered, and the cost of just one of these recidivist episodes taken into account, the drug court became more cost effective in a global sense – while costing more per individual in direct correctional and court costs, the ongoing financial benefit of averted crime showed that the drug court had a much better social outcome (Department of the Attorney-General 2006).

The costs and cost-effectiveness of court-based interventions are summarised at Table 7. Although direct comparisons between programs should not be made due to differences in program design, evaluation methodology and evaluation periods, the information highlights the cost differences between high intensity

[52] These costs included the cost of final imprisonment following unsuccessful participation in the Drug Court program so cannot be compared with Queensland Drug Court costing information.

[53] The cost per participant is a straight average of operational costs for 2012-13 divided by the target number of participants at any given time (60 people).

[54] Cost determinations were based on an assumption employed in the 2003 evaluation that 70% of Perth Drug Court offenders would have received a 12-month imprisonment term if they had not appeared in drug court, while the remaining 30% would have received a 15-month community-based order (Department of the Attorney General 2006).

programs such as drug courts and more moderate interventions such as MERIT and CISP. Drug courts are more expensive than moderate interventions, however, the economic and social benefits of successfully implemented drug courts may be more substantial given that they target high risk, high need offenders who are generally responsible for committing a substantial share of overall offending.

The lack of reliable and consistent program cost-benefit information in Queensland (and other Australian jurisdictions) means that it is difficult to know whether it is more cost-effective to invest in moderate or high intensity programs.

Table 7: Summary of court program outcome and costing information

	Program costs ($)	Average number of people participating in program	Unit cost per participant ($)	Equivalent cost of imprisonment per offender ($)	Reductions in reoffending	Benefit/cost ratio ($)	Benefits
MERIT		55 people completed the program per year			program completers less likely than non-completers to re-offend	2.41 to 5.54	$914,214 for yearly average of 55 program completers
CISP	2,920,000 in 2008	2,004 referrals in 2008	4,080 to 7,268	34,000	50% (CISP completers) compared with 64% (control group)	1.7 to 5.9	
Perth Drug Court			16,211	93,075			
Victorian Drug Court	1,600,000/per year	130 accepted referrals between 2010-11 and 2012-13	26,000	197,000	31% lower rate of re-offending for drug cohort compared with control group		$1,200,000 reduced imprisonment costs over two years
NSW Drug Court	13,495,727 for 309 participants		24,000				$1,758,000 reduced costs per year
Former Queensland Drug Court	14,300,000 for 134 participants		59,000 (at full capacity); 107,000 per referral		59% (graduates) compared with 77% (terminates)		

6.4 SUMMARY

This chapter has shown that:

- the cost of crime to the community is significant (approximately $1.5 billion was spent in 2014–15 in Queensland on criminal justice administration costs alone);
- most evaluations of Australian drug court programs and other bail-based programs such QMERIT and CISP have demonstrated cost-effectiveness; and
- there is a paucity of reliable and consistent cost-benefit information relating to programs delivered across the different stages of the criminal justice system.

6.5 IMPLICATIONS

Along with increasing pressure on the criminal justice system, the growth of illegal drug use and drug-related offending in Queensland has led to substantial economic and social costs to the state. The evidence shows that interventions such as drug courts and other court-based programs can reduce drug-related offending in a cost-effective fashion. Given the high cost of drug use to the Queensland community, investing in such interventions is likely to produce significant cost savings into the future.

7 ASSESSMENT AND TREATMENT OF INDIVIDUALS WITH ALCOHOL AND OTHER DRUG USE ISSUES IN QUEENSLAND

7.1 INTRODUCTION

This chapter provides an overview of Queensland's current services for the assessment and treatment of offenders with alcohol and other drug issues. In particular, the chapter considers the supply of appropriate services to address alcohol and other drug use in both the general and offender populations.

The Queensland Alcohol and other Drug Treatment Service Framework released in March 2015 describes the 'common ground' underpinning alcohol and other drug (AOD) treatment service delivery in Queensland. The Framework was developed by a partnership of statewide AOD policy, sector and workforce development organisations.

In Queensland, AOD treatment is provided by:

- public health Mental Health and Alcohol and Other Drugs Services and public hospitals;
- NGOs, including Aboriginal and Torres Strait Islander community controlled organisations; and
- general practitioners and other private health care providers.

Individuals are able to self-refer to each of these service providers by personal presentation or by telephone contact. Once accepted for service, there is some crossover in referrals between government and NGO services.

With the exception of individuals who are referred to alcohol and other drug interventions as a condition of bail or a court order or via referral by QCS as part of their supervision case plan (mandatory), attendance at AOD services are voluntary. According to the Queensland Network of Alcohol and other Drug Agencies (QNADA), 50% of individuals presenting to AOD services are self-referrals.

7.2 ASSESSMENT PROCESS AND TOOLS

In the case of Queensland Health and NGOs, an initial intake assessment will be completed during which an individual's alcohol and other drug and general health history will be taken. This is sometimes undertaken by telephone. Each service provider may have its own way of conducting the assessment and own forms but the assessment generally covers all aspects of AOD use history, impacts, previous treatments and others.

If, as a result of this intake assessment, it is determined that the individual has problematic AOD use, an appointment or referral will be made.

7.3 TREATMENT

A wide range of treatment types is provided in Queensland's AOD services. These are detailed in the Queensland Alcohol and Other Drug Treatment Service Delivery Framework (Appendix D).

According to the Framework, effective AOD treatment services in Queensland are those that are:

- evidence-informed;
- targeted to the right clients;
- timely, responsive and comprehensive;
- safe, welcoming and non-stigmatising;
- accessible and easily contactable in terms of location and opening hours;
- accessible in relation to any physical, environmental or procedural barriers;
- culturally, religiously, gender, age and developmentally appropriate; and
- of adequate standard, staffed by appropriately trained and skilled staff.

Other features of effective AOD services identified in the Framework include the monitoring of progress of clients to ensure that the service is targeted, coordinated and efficient, and that the services provide continuity of care not only with other AOD services, but also with other health and welfare systems (e.g. mental health, disability, housing, homelessness and statutory care services).

Treatment types are categorised across a spectrum and broadly defined as:

- prevention and early intervention;
- intervention; and
- maintenance and aftercare.

Due to long waiting lists for most services, following initial contact, individuals are often referred to 'pre-care' groups (facilitated by ATODs or NGO staff) as a means of engaging the individual and maintaining their motivation to participate in treatment and to provide information around harm minimisation. The content of these groups is not standardised statewide and will be varied according to the needs of the participants in the program.

AOD services in Queensland are reported to be scarce, particularly in comparison to other larger jurisdictions in Australia. Waiting lists for services can range from two weeks to two months. For example, in Queensland, the only hospital-based medical detoxification program is located at the Royal Brisbane Hospital. Other residential withdrawal options are also available at Fairhaven (Salvation Army), Mt Tamborine, Moonyah (Salvation Army), Red Hill and Stagpole Street (Uniting Care), Townsville. Cairns ATODS also runs a detox service.

7.4 PUBLICLY FUNDED ALCOHOL AND OTHER DRUG TREATMENT SERVICES

This section provides information on treatment episodes finalised by publicly funded alcohol and other drug treatment services.[55] This information is collected by the Australian Institute of Health and Welfare (AIHW) as part of a national minimum data set.[56] The data show differences in the type of alcohol and other drug treatment services delivered and a high number of referrals from criminal justice agencies in Queensland compared with other jurisdictions.

7.4.1 Number and location of alcohol and other drug treatment services

In 2014–15, a total of 843 service providers assisted people seeking support for their alcohol and other drug use across Australia, with 181 (21%) of these providers based in Queensland.

Nationally, there was a 27% increase in the number of service providers between 2009–10 and 2014-15 (from 666 to 843) (AIHW 2016b). The number of providers in Queensland grew from 109 to 181 over the same time period (a percentage increase of 66%).[57]

In 2014–15, service providers were more likely to be non-government (66%) than government agencies (34%).

Figure 21 also shows that about half (51%) of alcohol and other drug treatment service providers were located in major cities and 38% were located in inner or outer regional locations.

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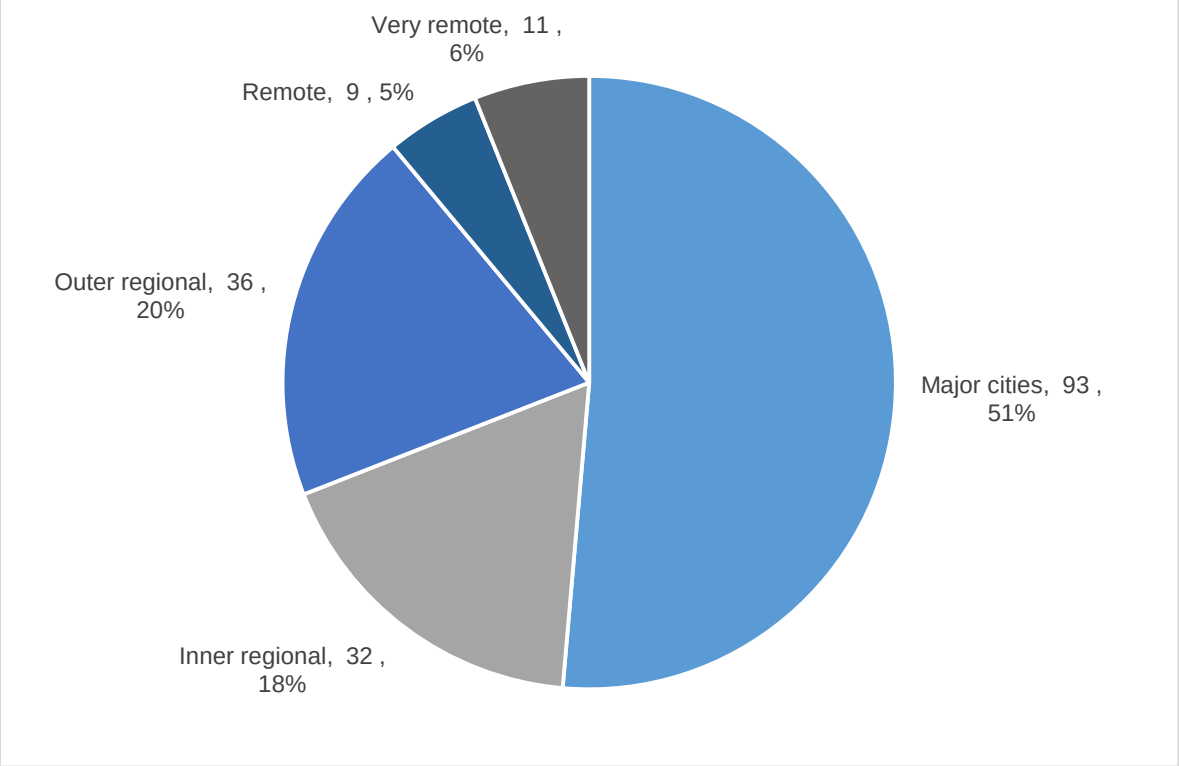
[55] All data reported in this section is from Australian Institute of Health and Welfare *Alcohol and other drug treatment services in Australia* national minimum data set.

[56] See *Data for drug and specialist courts review* at Appendix B for further information about the national minimum data set.

[57] It is noted that increases in the number of service providers does not necessarily equate to increases in service capacity. Increases may also reflect growing number of service providers contributing to national data set.

Figure 21: Number of alcohol and other drug treatment services by location, Queensland, 2014–15



Source: AIHW 2016 *Alcohol and other drug treatment services in Australia 2014–15: supplementary tables*

7.4.2 Number of treatment services provided

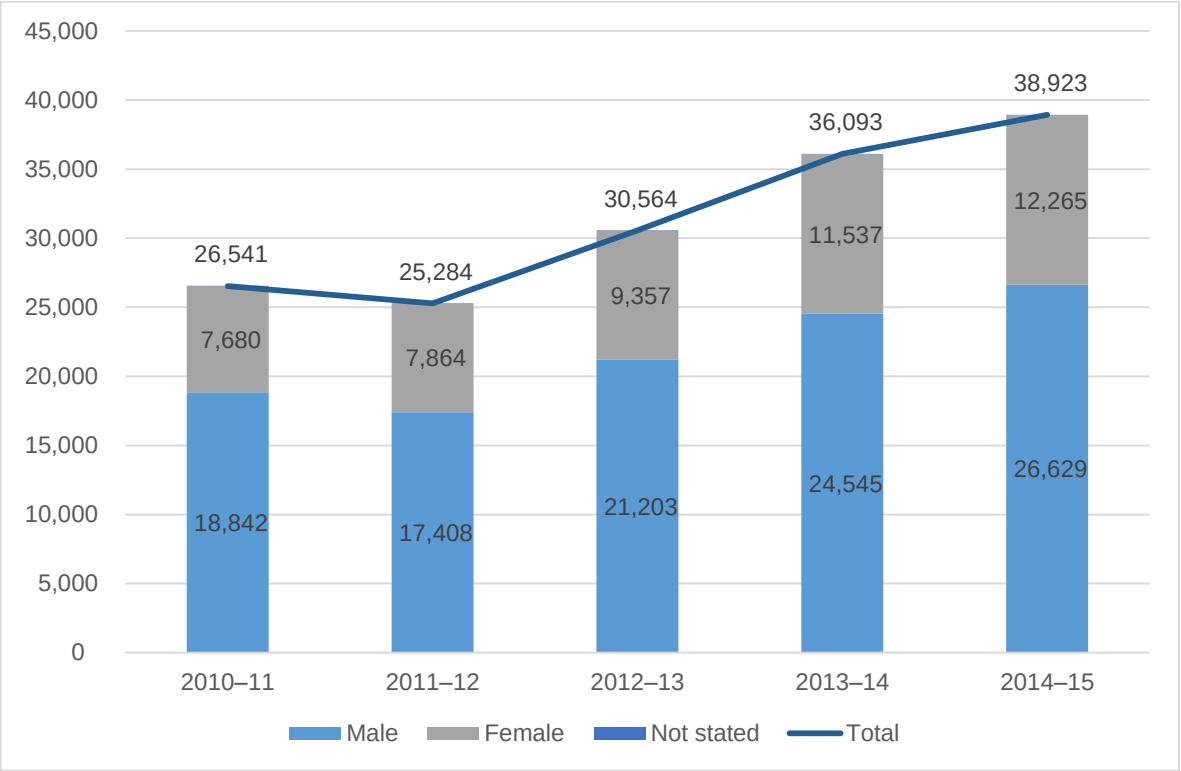
There has been an increase in the number of closed treatment episodes provided by Queensland-based alcohol and other drug services in recent years.[58]

Figure 22 shows that the number of closed treatment episodes increased from 26,541 in 2010–11 to 38,923 in 2014–15 (a percentage increase of 47%). Nationally, the number of closed treatment episodes increased by 13% between 2010–11 and 2014–15.

In 2014-15, 68% of Queensland's total closed treatment episodes related to male clients, 46% related to clients aged under 30 years and 16% related to Aboriginal and/or Torres Strait Islander clients.

[58] A closed treatment episode is defined as a period of contact between a client and a treatment provider that is closed when treatment is completed, has ceased or where there is no contact between the client and treatment provider for three months.

Figure 22: Number of closed treatment episodes by gender, Queensland, 2010–11 to 2014–15



Source: AIHW 2016 *Alcohol and other drug treatment services in Australia 2014–15: supplementary tables*

7.4.3 Main drugs of concern

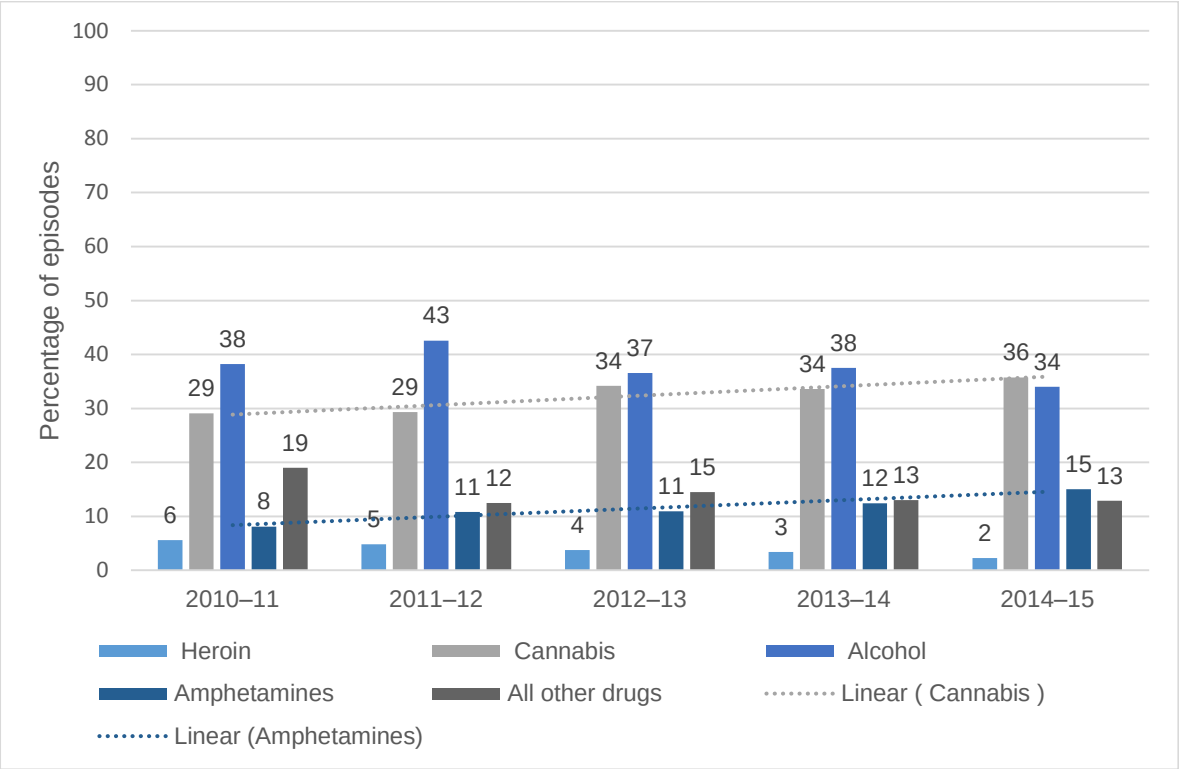
Alcohol and cannabis were the most common principal drugs of concern treated by Queensland alcohol and other drug treatment service providers.

Nationally, alcohol was the most common principal drug of concern in 2014–15 (38% of treatment episodes), followed by cannabis (24%), amphetamines (20%) and heroin (6%). However, cannabis became the most common principal drug of concern in Queensland in 2014–15 (36% of treatment episodes), followed by alcohol (34%) and amphetamines (15%).

The proportion of treatment episodes involving cannabis and amphetamines as the principal drugs of concern has been increasing over time in Queensland. Figure 23 shows that cannabis was a principal drug of concern for 29% of treatment episodes in 2010–11 compared with 36% in 2014–15; amphetamines were the principal drug of concern for 8% of treatment episodes in 2010–11 compared with 15% in 2014–15 (AIHW 2016b).

Alcohol and other drug treatment episodes were more likely to relate to cases where amphetamines or heroin were the principal drug of concern (26%) at the national level than in Queensland (17%) in 2014–15.

Figure 23: Closed alcohol and other drug treatment episodes for own drug use by principal drug of concern, Queensland 2010–11 to 2014–15



Source: AIHW 2016 *Alcohol and other drug treatment services in Australia 2014–15: supplementary tables*

7.4.4 Treatment modes

Treatment delivery differed in Queensland when compared with national patterns, with greater use of treatment interventions that involve the provision of information and education only.

While across Australia, counselling was the most common main treatment type (40% of treatment episodes in 2014–15), in Queensland interventions involving 'information and education only' were the most prevalent main treatment mode (33%).

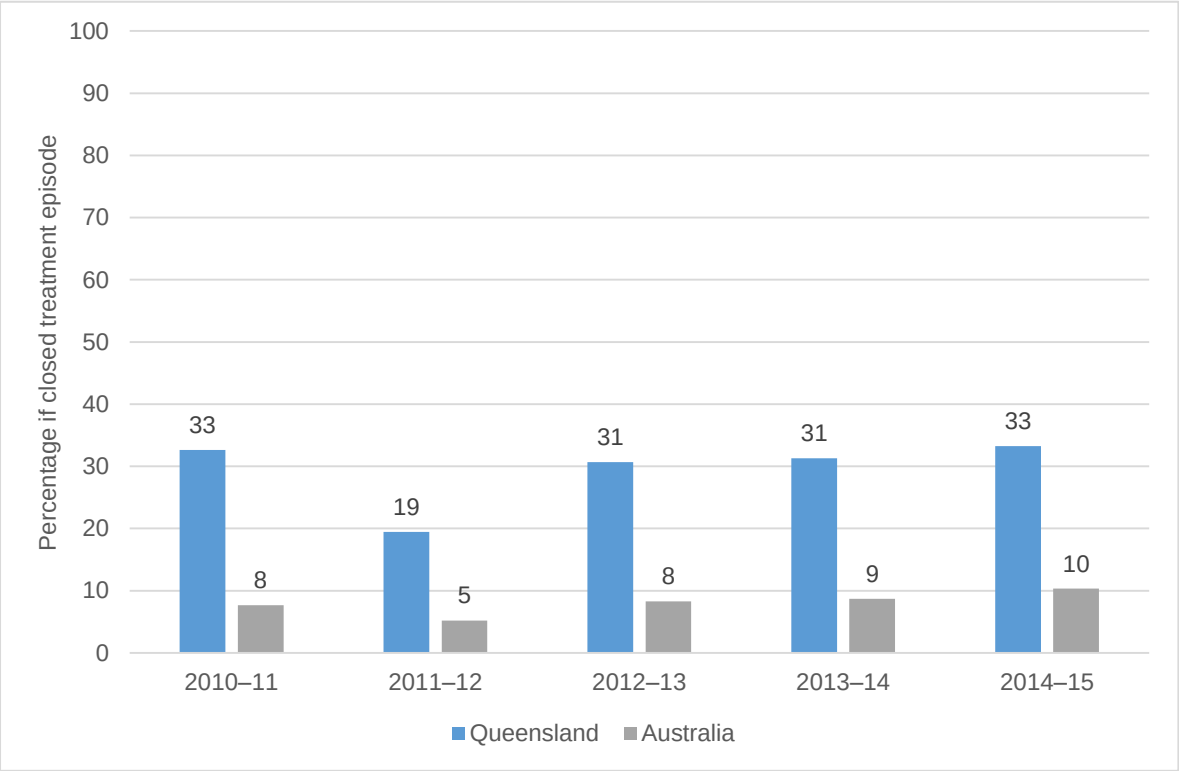
Figure 24 shows that the use of information and education only forms of treatment in Queensland was around three times higher than the national use of this type of treatment modality.

The relatively high use of information and education as a form of treatment is likely to reflect the operation of the Police Drug Diversion and the Court Diversion Program in Queensland during the reporting period. These programs aim to divert minor drug offenders from the criminal justice system to brief health interventions[59] and tend to focus on minor offences involving cannabis. This will partially explain why cannabis, rather than alcohol, is the most common principal drug of concern among Queensland's alcohol and other drug treatment services.

The potential use of information and education programs was further expanded on 1 December 2015 with the introduction of referral to a DAAR course under the *Bail Act 1980*.[42]

[59] These programs involve a two-hour treatment sessions that includes assessment (to determine drug dependency and risk-taking behaviours) and the provision of advice on reducing drug use and ways to minimise harm, motivational intervention, resources and referral (if assessed as appropriate).

Figure 24: Proportion of closed treatment episodes where information and education only was the main treatment type, Queensland, 2010–11 to 2014–15



Source: AIHW 2016 Alcohol *and other drug treatment services in Australia 2014–15: supplementary tables*

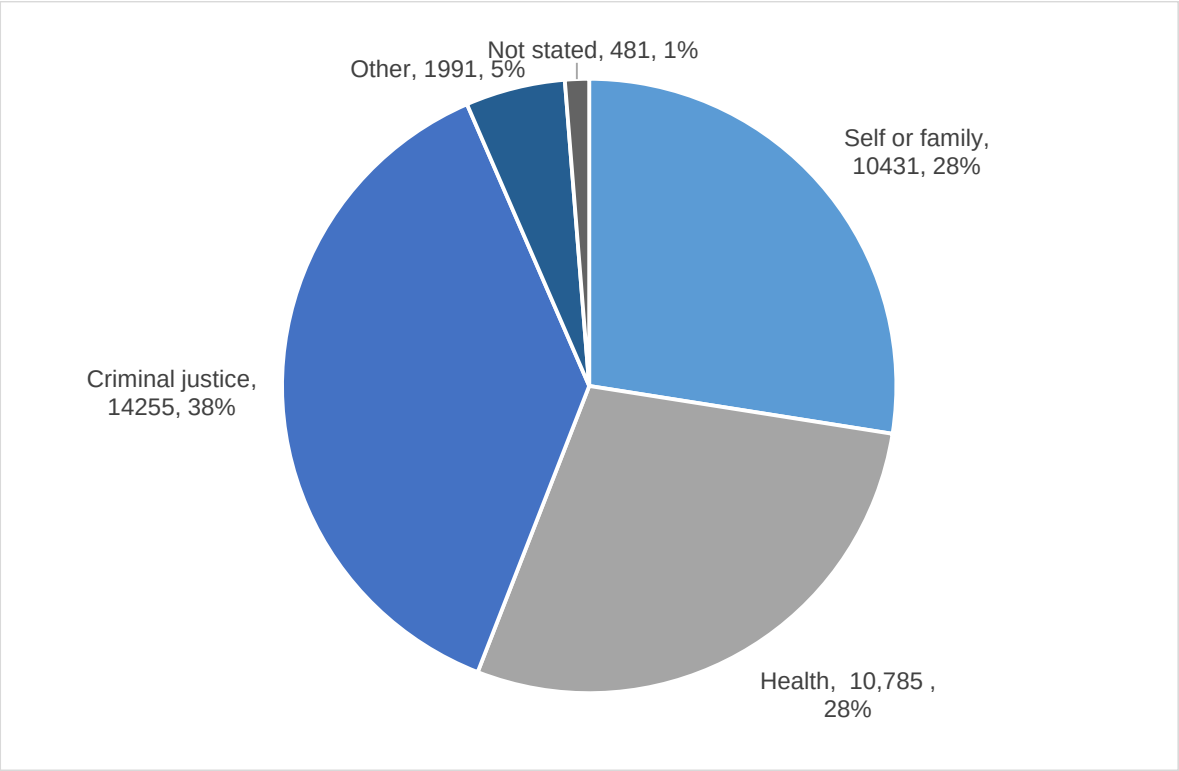
The high use of brief information and education treatment interventions will also partially explain why the proportion of treatment episodes finalised within one month in Queensland (66%) was higher than that found in other Australian jurisdictions.

7.4.5 Referral pathways to treatment

Queensland was characterised by a relatively high proportion of referrals to alcohol and other drug treatment services made by criminal justice agencies. The majority of these referrals related to cannabis use.

Figure 25 shows that criminal justice agencies (corrections, police and courts) accounted for 38% of referrals to treatment services in 2014–15, which was more than health (29%) or self/family referrals (28%). Among criminal justice agencies, the police (19%) were most likely to refer, followed by the courts (11%) and correctional services (8%). Nationally, criminal justice agencies accounted for 27% of referrals to alcohol and other drug treatment services.

Figure 25: Closed alcohol and other drug treatment episodes for own drug use by referral source, Queensland, 2014–15



Source: AIHW 2016 *Alcohol and other drug treatment services in Australia 2014–15: supplementary tables*

Note: These data relate to a person's own drug use only.

Further analyses show that treatment for different types of drug use was associated with different referral pathways. In 2014–15, the majority (70%) of closed treatment episodes where cannabis was the main drug of concern related to criminal justice referrals. Amphetamine-related episodes were driven by self and family referrals (39%), although health agencies (27%) and criminal justice agencies (28%) also made referrals relating to treatment for amphetamine use. Alcohol-related treatment episodes were driven by health agencies (43%) and self and family referrals (34%).

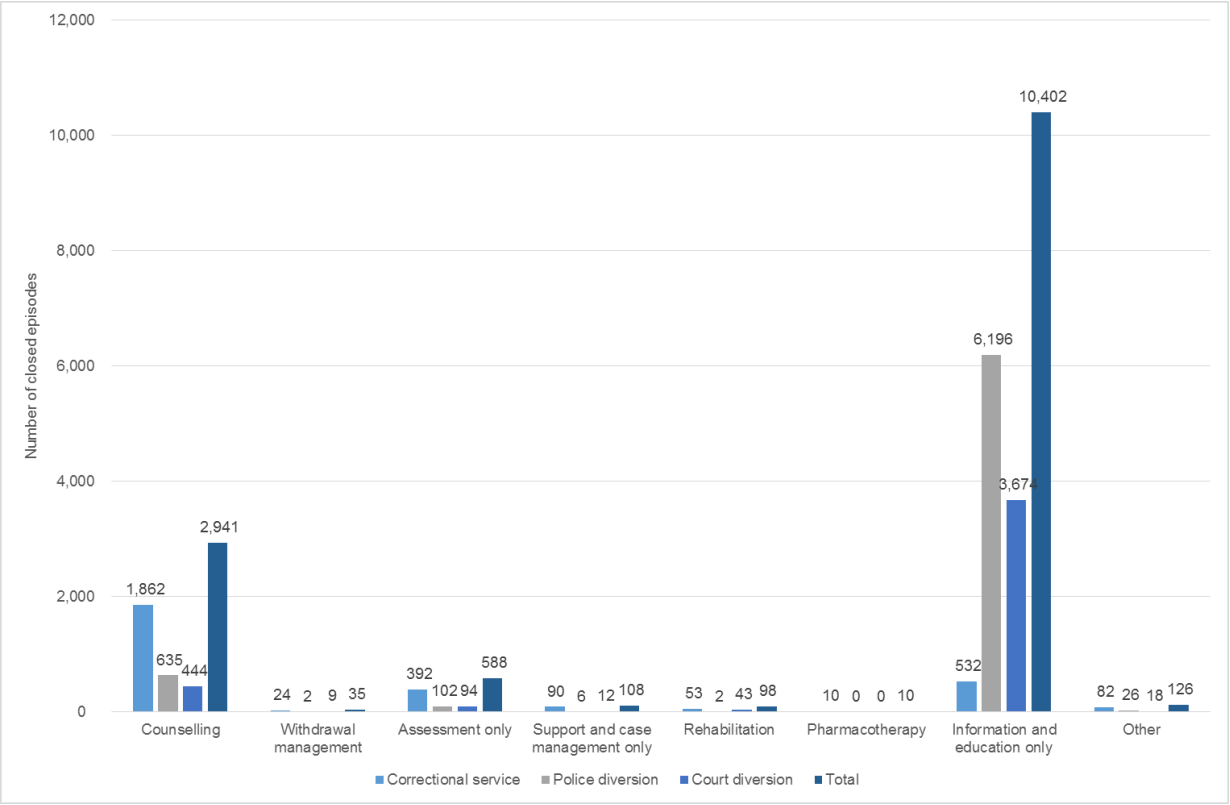
7.4.6 Criminal justice agency referrals to treatment

Criminal justice agencies tended to refer to information and education treatment services. There were indications of low utilisation of residential treatment facilities.

The treatment modalities associated with Queensland criminal justice agency referrals is shown in Figure 26. In 2014–15, there were 10,402 criminal justice referrals to information and education only treatment services. Police accounted for 60% (6,196) of these referrals, while the courts accounted for 35% (3,674).

Counselling was the second most common main treatment type among criminal justice referred episodes. In total, there were 2,941 treatment episodes involving counselling that were referred by criminal justice agencies. There were substantially fewer referrals to rehabilitation (98), withdrawal treatment (35) or pharmacotherapy (10) by criminal justice agencies. Other data show that rehabilitation and withdrawal services constituted the most common treatment type (88%) at Queensland-based residential treatment facilities in 2014–15. These data suggest very few criminal justice referrals to residential alcohol and other drug treatment facilities (at least as captured by the national minimum data set).

Figure 26: Number of closed treatment episodes, by main treatment type and criminal justice referral source, Queensland, 2014–15



Source: AIHW 2016 *Alcohol and other drug treatment services in Australia 2014–15: supplementary tables*

7.5 SUMMARY

This chapter has shown that:

- there has been an increase in the number of alcohol and other drug treatment service providers in recent years;
- alcohol and other drug treatment service providers in Queensland deliver a relatively high number of education and information treatment sessions when compared with other Australian jurisdictions – with the many of these sessions resulting from referrals by criminal justice agencies;
- the increasing number of people in contact with the criminal justice system is also apparent in the increasing number of people provided with alcohol and other drug treatment services in Queensland;
- cannabis is the main drug of concern (rather than alcohol as in other Australian jurisdictions) reflecting referrals made by criminal justice agencies as part of police and court diversionary programs; and
- amphetamine as a principal drug of concern has increased in recent years.

7.6 IMPLICATIONS

While there are now more service providers in Queensland to respond to drug- and alcohol-related offending, the demand for their services has also increased. Once again, the data show that a more effective and efficient response is required – one that provides a comprehensive model of integrated criminal justice interventions.

8 THE ASSESSMENT AND TREATMENT FRAMEWORK

8.1 INTRODUCTION

The previous two chapters have shown that, while there is a high demand for criminal justice interventions in response to drug- and alcohol-related offending in Queensland, an integrated, effective and efficient supply of interventions is lacking.

As part of its remit in developing a comprehensive criminal justice model to address this gap, this Review has considered the best-practice principles that have been developed in this area.

This chapter examines the evidence on assessment and treatment of drug users in the criminal justice system. It provides the underlying clinical framework for the recommendations developed throughout this report.

8.2 PRINCIPLES OF TREATING DRUG USERS IN THE CRIMINAL JUSTICE SYSTEM

Over the last two decades, there has been significant investment in research aimed at understanding what works in reducing reoffending. Specifically, systematic and expert reviews of the correctional literature have all largely concluded that the most effective interventions and programs are those that: (a) use identified and validated actuarial risk assessment tools; (b) employ cognitive-behavioural techniques and services as a foundation of treatment and intervention; and (c) match offenders to appropriate service levels and intervention types based on prognostic risk and criminogenic need (Andrews et al. 1990; MacKenzie 2006). These three principles now set the foundation for that which has become internationally recognised as best practice in community and custodial corrections.

Tackling the problem of high-volume drug-related offending requires the concerted and cooperative effort of criminal justice and health agencies to identify and implement programmatic elements that improve outcomes for drug using and drug-dependent offenders. This requires consideration of both the drug treatment and criminal justice intervention literature and, more importantly, research demonstrating the impact of specific drug-treatment interventions offered as a consequence of criminal justice interaction. At the same time, there is a significant body of evidence that has sought to identify effective practice in the treatment of drug using offenders. This research has shown that behavioural treatments and medications administered in both community and criminal justice settings can reduce substance abuse and drug-related criminal behaviour and is cost effective in doing so (Chandler, Fletcher & Volkow 2009).

Drawing on this large evidence-base, and to provide guidance to criminal justice and treatment professionals working with drug abusing offenders, the US National Institute of Drug Abuse (NIDA) has identified thirteen principles for effective drug addiction treatment for criminal justice populations (see Box 1). These principles should provide significant guidance to policy makers and practitioners in Australia, especially given the ubiquity of concern about the management of alcohol and other drug related offending. The remainder of this section examines the application of these principles within an Australian and, in particular, Queensland context.

Box 1: National Institute for Drug Abuse - Principles of Drug Addiction Treatment for Criminal Justice Populations (2014)

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 for criminal justice populations.
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.

8.3 A SHARED UNDERSTANDING OF DRUG DEPENDENCY

Engaging criminal justice clients in the process of drug treatment and rehabilitation is undoubtedly a challenging prospect that requires recognition on the part of treatment and criminal justice practitioners of the chronic and relapsing nature of drug dependency. Importantly, all practitioners should be educated on the neurophysiological consequences of drug use and adopt strategies that recognise dependency as a chronic relapsing condition. Drug dependency, for example, has well-recognised cognitive, behavioural, and physiological characteristics that contribute to habitual use despite the harmful consequences. Consistent with this, neurologists have also found that regular drug use almost invariably results in alterations to the brain's anatomy and chemistry that can then persist even after long periods of abstinence. These neurochemical changes are important for understanding why offenders, both during and after treatment, may persist in seeking drugs despite the consequences (Baler and Volkow 2006; Volkow et al. 2010; and Chandler et al. 2009). Of the 13 key principles identified by NIDA, system and community level recognition of drug addiction as a chronic disease is perhaps the most important. Without this, many or all of the remaining 12 principles would be difficult to achieve given the philosophical tensions between criminal justice and health practitioners on the question of how best to respond to drug dependent offenders.

According to the American Society of Addition Medicine (ASAM), a peak body for the conduct and dissemination of research on drug dependency, addiction is defined as a:

> "…primary, chronic disease of the brain reward, motivation, memory and related circuitry… characterised by inability to inability to consistently abstain, impairment in behavioural control, craving, … and a dysfunctional emotional response… which… without treatment or engagement in recovery activities, … is progressive and can result in disability or premature death."

Accordingly, to achieve drug abstinence requires much more than 'just saying no'. It requires 'treatment' as the primary response, recognising that (Kushner, Peters and Cooper 2014, p. 5):

- 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 thus there is a need for individualised treatment strategies that are flexible and responsive to individual and changing needs;
- incarceration without treatment will not have a measurable impact on reducing substance use or crime;
- 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.

8.4 CAUTIONING

For young people in particular, formal contact with the criminal justice system is likely more harmful than helpful. Decades of criminological research have demonstrated that formal criminal justice processing itself has the potential to increase significantly the likelihood of future criminal offending (Nagin, Cullen & Jonson 2009). The reasons given for this strong empirical relationship are many and varied. Some argue that labelling effects consequently foreclose opportunities for prosocial engagement (Bernburg & Krohn 2003; Bernburg, Krohn & Rivera 2006; Ward, Krohn & Gibson 2014), while others argue that early experience of the criminal justice system weakens perceived levels of deterrence. Whatever the cause, there is a general consensus that limiting a young person's contact with the criminal justice system is an appropriate goal, especially for non-serious status offences.

The use of cautioning, rather than apprehending, arresting and formally processing young people has been an important feature of the criminal justice system in all Australian jurisdictions (O'Connor & Cameron 2002; Polk 2003; Wundersitz 1997). In Queensland, the *Youth Justice Act 1992* requires that the primary criminal justice system response to young people (aged 10-16 years) should be diversion, which in this context includes being informally cautioned or warned, formally cautioned, or referred to a family conference. For individuals who are not juveniles at the time of their apprehension (including 17-year olds), the diversion options described above are not available.

For minor drug offences in Queensland, juvenile offenders are eligible for formal cautioning under the *Youth Justice Act 1992*, but only one such caution can be issued. Adult offenders (and juveniles previously cautioned) are not eligible for cautioning. Instead they must be referred to a drug diversion assessment. The opportunity for referral to a drug assessment is limited to one referral only.

There is unequivocal evidence that informal and formal cautioning yields more favourable long-term outcomes than formal processing (Payne and Weatherburn 2015). In Queensland specifically, the rate of recidivism (formal re-contact) is considerably lower for juveniles who are cautioned compared to those who are required to appear in court for their first offence, although these analyses do not control for the severity of the presenting offence (Dennison, Stewart and Hurren 2006). While it is not possible to conclude that cautioning reduces offending based on this analysis, it does suggest that cautioning does not appear to increase offending compared with those young people whose first contact is a court appearance, which is an important finding. For offenders appearing for drug offences, no disaggregated analyses exist in the Queensland context. However, in other jurisdictions where cautioning programs are available for adult first-time cannabis possession offenders (NSW), cautioned offenders have recidivism rates that are considerably lower than is estimated for general first-time offending populations (Payne, Kwaitkowski and Wundersitz 2008). In all, the analyses to date (although limited in number and methodological rigour) suggest that cautioning low-level drug offenders (both juveniles and adults) is likely to be a cheaper alternative to formal processing which doesn't worsen long-term criminal justice outcomes.

8.5 BRIEF INTERVENTIONS ARE PROMISING ALTERNATIVES

The emergence of brief interventions can be traced to the early 1980s, prompted by a call from the World Health Organisation to provide an evidence base for alcohol screening and brief intervention applications in the primary health care setting (Babor et al. 2007). Coupled with motivational interviewing techniques and un-invasive cognitive exercises, brief interventions emerged primarily in the United States as a strategy for engaging substance users at the point of clinical presentation. Their purpose is to encourage a reduction or cessation of use. Since then, the medical and drug treatment literature has seen a substantial body of research produced in favour of brief-interventions for clinical patients and clients presenting with mild to moderate substance use disorders (Roche and Freeman 2004). The vast majority of the 'what works' literature has thus been historically focused on brief interventions for alcohol and tobacco use (Roach and Freeman 2004), however a more recent literature has emerged testing the applicability of these strategies to other substances – specifically cannabis (Stephens et al. 2000; Copeland 2004; Copeland and Swift 2009), and, to a lesser extent, amphetamines (Baker et al., 2001; 2005), benzodiazepines (Bashir et al. 1994; Heather et al. 2004) opiates (Saunders et al. 1995) and cocaine (Stotts et al. 2001). For illicit substances, clinical trials and other research studies have overwhelmingly focused on juvenile or young-adult populations, while recent studies have begun to examine their utility for the prevention of violent offending and victimisation (Cheng et al. 2008; Walton et al. 2010).

According to the Australian Department of Health and Ageing, a brief intervention is one that 'takes very little time…[are] usually conducted in a one-on-one situation, and can be implemented anywhere on the intervention continuum' (Department of Health 2004). Consequently, brief interventions can last as little as 30 seconds (opportunistic) or can extend over several sessions of between five and 60 minutes in length. The most often cited aims of a brief intervention are: (a) to engage those not yet ready for change; (b) to increase the perception of real and potential risks and problems associated with substance use; and (c) to encourage change by helping individuals consider the reasons for change and the risks of not changing.

Brief interventions are generally underpinned by a Motivational Interviewing (MI) framework (Blonigen et al. 2015). The FRAMES model (see Hester and Miller 1995), for example, includes five elements that are considered common components of empirically supported brief interventions. These are:

- giving feedback on the risks and consequences of substance use;
- emphasising personal responsibility to change substance use;
- giving concrete advice on how to modify substance use;
- offering a menu of different change options; and
- increasing an individual's self-efficacy to change their patterns of use.

In terms of efficacy, randomised control trials have generally concluded that brief interventions are more effective than no treatment at all for individuals with mild or moderate substance use disorders (Blonigen et al. 2015). Further, many studies often conclude that brief interventions can be just as effective as more intensive treatments, although this conclusion is often complicated at the meta-analytic level because studies vary considerably in their definitions of what constitutes 'brief' (Blonigen et al. 2015). According to Jonas et al. (2012), it is likely that the efficacy of a brief intervention may have more to do with the number of multiple contacts than the length of each individual session. Similarly, it seems that multi-component interventions do not necessarily improve outcomes over simpler motivational interviewing or counselling sessions (see Kaner et al. 2013). Finally, a review of systematic reviews for alcohol-based brief interventions have found generally positive outcomes, but warns that these results tend to be inconsistent for different demographic groups, across different cultural settings and in different intervention contexts (O'Donnell et al. 2014).

For illicit substance use there is comparatively little evidence of effectiveness, although this is mostly because intervention adaptations for substances other than alcohol and tobacco are only relatively new. Nevertheless, the results so far appear promising.

In the Australian context, police drug diversion is a common form of brief intervention for minor drug offenders who have contact with the criminal justice system. The aim of these interventions is to reduce the

impost of large numbers of minor drug offenders on the criminal justice system by diverting them away from the system. A systematic review by Mazerolle et al. (2007) identified 14 studies relating to seven diversion interventions, all in Australia, the majority of which targeted minor cannabis offenders. Drug use outcomes were reported for five of the seven interventions, with three demonstrating reductions in use, one no change, and one mixed results. Reductions in self-reported offending were reported in two studies, a further two studies demonstrated reduced pressure on police resources, and improved police relations were reported in three studies.

Overall, brief interventions appear to be a promising option for mild-to-moderate drug users; however, in most of the applications reviewed here, more intensive interventions still yielded greater outcomes than brief interventions, albeit at higher cost. Further, brief interventions appear more effective for less serious or entrenched substance users, with those showing signs of dependence less likely to benefit from short, motivational interviewing programs (Blonigen et al. 2015). For these reasons, there is a growing consensus that brief interventions should be offered as part of a broader continuum of 'stepped care' that allows treatment and health practitioners to respond appropriately to clients who are not engaging or who are identified throughout the brief intervention as having more complex or significant treatment needs (Breslin et al. 1997; Sobell and Sobell 1999; 2000).

8.6 MANDATED TREATMENT WORKS

First and foremost, any review of what works in the drug treatment of criminal justice populations requires acknowledgement that those who are legally coerced to participate in treatment often perform as well as those who enter treatment voluntarily. There is a now large body of research that confirms that legally coerced clients do not underperform others who access treatment from outside the criminal justice sector (Kelly, Finney, & Moos 2005; McSweeney, Stevens, Hunt, & Turnbull 2007; Perron & Bright 2008; Young & Belenko 2002). Whereas during the early proliferation of drug courts there was concern that criminally mandated clients would monopolise to lesser effect the scarce resources of the health and treatment sectors, such fears have not been realised. To the contrary, the evidence supporting equality for legally-coerced clients is such that allocating treatment places and resources to criminal-justice led interventions is a worthwhile policy objective.

It is important to distinguish between compulsory drug treatment and coerced drug treatment, the latter including drug courts. Compulsory treatment refers to drug treatment program in which clients are mandated to enrol. It typically involves forced inpatient treatment, but can also involve outpatient treatment. Coerced treatment is different in that it provides individuals with a choice to avoid treatment (such as, in the case of drug courts, not consenting to participate in the program). A recent review of compulsory drug treatment by Werb et al. (2016) found nine studies that examined the impact of compulsory treatment. Results were mixed, with two studies showing a negative impact on recidivism, while another two showed a positive impact on recidivism and drug use.

8.7 TREATMENT AND SUPERVISION INTENSITY SHOULD BE GUIDED BY PRINCIPLES OF RISK AND NEED

Correctional practitioners, policy makers and researchers have long been concerned with the undoubtedly difficult task of identifying 'what works' in reducing reoffending. A cornerstone of this literature, developed over more than 50 years of research and practice, is that high-risk offenders are better suited to more intensive and structured interventions. Pioneering this philosophy, Andrews and Bonta (2010) dedicated their efforts in the *Psychology of Criminal Conduct* to a comprehensive examination and review of the literature, concluding that correctional agencies would be more effective if high-risk offenders could be more accurately identified and targeted with appropriate multi-dimensional desistence-based interventions.

Emerging from this paradigm is the treatment and intervention framework now commonly known as *Risk-Need-Responsivity* (RNR) – a theory founded in behavioral psychology and influenced heavily by the treatment classification literature of the 1960s and 1970s (Sechrest et al. 1979; Palmer 1978). In principle, RNR focuses

on the use of cognitive techniques and treatments for managing 'criminogenic' risk factors, defined broadly as individual, situational or environmental characteristics for which there is both empirical and statistical evidence of an association with future offending.

The three key principles of RNR are:

- the risk principle – that the level of program intensity be matched to offender risk level (defined as the risk of reoffending, absent intervention or treatment), and that intensive levels of intervention and treatment be reserved for offenders with the highest level of risk;
- the need principle – that criminogenic needs (i.e. those functionally related to persistence in offending) require commensurate and concurrent redress; and
- the responsivity principle – that the style and modes of intervention be matched or tailored to each individual offender's learning style and abilities and be responsive to individual strengths and levels of motivation (see Andrews, Bonta and Wormith 2006).

In the tradition of RNR, the most effective and cost-efficient interventions for drug using and drug dependent criminal justice populations are likely to be those where supervision intensity is tailored to the prognostic risk of reoffending and where drug treatment types and intensities are chosen cognisant of drug use as a key criminogenic need (Andrews and Bonta 2010; Taxman and Marlowe 2006). Therefore, 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 risk and need principles. Risk, in this case, refers to those individual offender characteristics that are nominally linked to less favourable recidivism outcomes. According to a review by Marlowe and colleagues (2003), these include age (younger), gender (male), onset of offending and substance use (younger), prior convictions, prior history of unsuccessful treatment, a diagnosis of antisocial personality disorder, and regular contact with other drug-using or anti-social peers. Conversely, criminogenic need refers to clinical disorders and functional impairments that increase the risk of future offending. Drug use is among the most common of criminogenic needs, together with mental illness, unemployment and lack of basic life-skills (Marlowe 2012). In their summary, Andrews and Bonta (2010) describe the "central eight" – eight domains through which the risk of reoffending can be energised if appropriate interventions are not utilised. These include:

1. Criminal History *(static)*
2. Antisocial Personality Pattern *(static/dynamic)*
3. Pro-criminal Attitudes *(dynamic)*
4. Social Supports for Crime *(dynamic)*
5. Substance Abuse (*dynamic)*
6. School/Work Failure (*dynamic*)
7. Family or Relationship Problems *(dynamic)*
8. Lack of Prosocial Activities *(dynamic)*

Ultimately, prognostic risk and criminogenic need should be used to determine the intensity of treatment and supervision, as well as the nature and type of response required for non-compliance. Importantly, low-risk offenders should not be over-treated or over-supervised. Not only is it potentially unethical and net-widening, but the over-treating of offenders who are low-risk and low-need has the potential to exacerbate drug use and worsen criminal justice outcomes (Lowenkamp and

QUEENSLAND CORRECTIVE SERVICES

Queensland Community Corrections assesses offenders based on the risk-needs-responsivity (RNR) model.

The Risk of Reoffending (RoR) is a validated, actuarial screening tool used to screen offenders sentenced to community orders (RoR-PPV) and custodial sentences (RoR-PV) for their risk of reoffending. The RoR informs decision making regarding the level of service provided to an offender.

The Benchmark Assessment may subsequently be conducted to identify risk factors, criminogenic and non-criminogenic needs and protective factors at the point of admission into a correctional episode. The Benchmark Assessment quantifies a risk level for each factor contained in the assessment.

The Dynamic Supervision Instrument also applies a scoring system for each factor allowing Probation and Parole officers to target case management efforts in response to changes in risk.

Latessa 2004; McCord 2003; Andrews & Dowden 1999; Bonta, Wallace-Capretta & Rooney 2000; Lowenkamp & Latessa 2004). Specifically, the research evidence indicates that high-intensity interventions for low-risk offenders can, in fact, interfere with an offender's existing strengths and turn moderate or mild criminogenic factors into significant criminogenic needs. By their very design, intensive interventions have the potential to:

- remove offenders from prosocial and productive activities such as work and school (Lowenkamp & Latessa 2004);
- replace potentially low-risk peers with high-risk peers; and
- deepen criminal justice involvement, having the potential for negative labeling and negative effects on self-concept.

Conversely, meta-analyses investigating the risk principle applied to juvenile and adult offenders in correctional programs or school-aged youth in school-based intervention programs have found that adhering to the risk principle produces effect sizes between two and six times as great (Lowenkamp & Latessa 2004). Accordingly, the level of supervision should be highest for offenders with the highest prognostic risk (Lowenkamp et al. 2006) while the intensity of the treatment services should be highest for offenders assessed as having high criminogenic need (Smith et al. 2009). For drug dependent offenders, this will almost invariably require some form of intensive drug treatment coupled with interventions targeting other concurrent criminogenic needs. To manage such a comprehensive and individualised system of intervention and treatment requires systems integration and a continuum of care as offenders move through different phases of the criminal justice system (Butzin et al. 2002; Taxman and Bouffard 2000).

8.7.1 Triaging by risk and need – a complex task

The fundamentals underlying the RNR framework have strong empirical support, however, the actual practice of triaging offenders into different treatment and supervision intensities is likely to be a challenging task. Marlowe, in his 2012 reflection on drug courts, sets out a case for the use of the risk and need principles when developing alternative options for the provision of drug treatment within the criminal justice system. Although framed as 'alternative tracks within a drug court', the framework is nevertheless useful for understanding how a continuum of criminal justice services could be designed. In it, Marlowe (2012) dichotomises prognostic risk and criminogenic need into categories of 'high' and 'low' which, when cross-classified, produces four intervention quadrants described as the 'risk and need matrix'. Each of the four quadrants then attracts a different intensity of supervision and treatment, coupled with different responses to non-compliance (see Table 8).

Table 8: Alternative tracks within an adult drug court

		Prognostic risk	
		High	**Low**
Criminogenic need	**High (substance dependence)**	Offenders require all the services typically provided under a drug court program	Offenders require drug treatment and cognitive behavioural interventions, but need only be required to appear before the court for matters of non-compliance (treatment emphasis)
	Low (substance abuse)	Offenders require the same level of supervision and compliance monitoring as would be provided under a drug court; however, drug treatment should be replaced with behavioural interventions that target other criminogenic needs and criminal thinking (accountability emphasis)	Offenders do not require drug treatment or cognitive behavioural interventions, and should only appear before the court for matters of non-compliance (diversion emphasis)

Source: Marlowe 2012.

Although a useful framework for conceptualising a whole-of-system approach to drug related offending, Marlowe (2012) nevertheless concedes that triaging offenders into four discrete 'tracks' is a complex process because:

> "[n]o assessment tool is perfectly reliable and valid. There will often be an appreciable number of false positives and false negatives…, meaning that assessment tools may overestimate or underestimate the level of risk and need in some cases. In addition, many drug-involved offenders may be poor informants and the information they provide may be erroneous, exaggerated or minimized"

In addition to this, there are a number of other practical and conceptual issues that makes the triaging of offenders into discrete categories a challenging prospect. First, the proportionality principle demands that the criminal justice system respond equitably and fairly to those matters presenting for adjudication.[60] The degree to which supervision and treatment can (or should) be enforced by a court will, therefore, depend considerably on the severity of the presenting offences and the nature of one's prior criminal history. In many cases, the initial phase of the triaging process occurs by default, with supervision intensities determined by proxy, based on some vague notion of proportional retribution. Consequently, the criminal justice system relies heavily on the severity or quantity of the presenting offences to implement a series of graduated sanctions and supervision intensities. Unfortunately, however, empirical criminological research (Makkai and Payne 2003) has shown that an offender's current offence/s are relatively poor indicators of prior offending and prospective risk, especially among early career criminals who are likely to be the most costly in the longer term. There is, therefore, a sizable number of offenders who are *qualitatively* at high-risk of reoffending but who, at the time of presenting to the court, may nevertheless only be eligible for interventions that carry supervision intensities consistent with a low-risk rating (Payne and Piquero 2016).

In addition, the drug-crime and criminal careers literature suggests that problematic drug use, including drug dependency in many cases, typically precedes the onset of serious regular offending (Makkai and Payne 2003a; 2003b). Consequently, there is likely to be a period of time for many offenders where criminogenic needs are high, but where the assessable risk of reoffending (based on official and static factors) is lower than would be otherwise indicated from self-reported histories. For this period, and in the interests of proportionality, the criminal justice system is likely to be significantly constrained in its ability to apply supervision and treatment intensities that exceed the justifiable limits of the presenting offences/criminal history.

Second, actuarial risk assessment tools are often calibrated to minimise the rate of false negative results. In other words, screening and assessment tools are often constructed with the view to limiting the number of high-risk offenders incorrectly classified as low-risk. Doing so requires a finite balance between sensitivity and specificity, though often in high-stakes situations the procedure is calibrated such that the incorrect classification of low-risk offenders is preferred over the incorrect classification of high-risk offenders. As a consequence, actuarial systems are often designed to prioritise the identification of high-risk offenders and the policy and program discussion about risk assessment is often limited to a high-risk / low-risk dichotomy. Those not assessed as 'high-risk' or 'high-priority for intervention' are subsequently aggregated together, often without any meaningful understanding or appreciation of the underlying heterogeneity. This is, in part, because scarce criminal justice resources limit the capacity to offer appropriate levels of supervision and treatment to those not deemed to be a high priority according to the risk principle. Unfortunately, therefore, a large proportion of drug dependent or drug using criminal offenders may not receive appropriate levels of treatment until such time as their official criminal careers demand a commensurate level of supervision.

[60] See section 2.6.1

8.7.2 Motivation and readiness to change – a vexed issue

Whichever intervention philosophy is ultimately selected, the issue of offender motivation and responsivity must be addressed. Several studies have explored the role of motivation in treatment and, specifically, the impact that motivation has on treatment retention and outcomes. An analysis of motivation among 500 drug court participants found that women, particularly women with mental health problems, exhibited the highest levels of motivation (Webster et al. 2006). This highlights the need to consider gender differences in planning interventions. The Treatment Needs/Motivation scales found within the TCU Criminal Justice Client Evaluation of Self and Treatment (CJ CEST) is one example of a freely available, evidence-based tool that can be used effectively to assess an offender's readiness for the drug court (Garner, Knight, Flynn, Morey & Simpson, 2007).

Clients who are internally motivated for treatment are the ones who are more likely to engage in the treatment process (e.g. attend sessions, develop rapport, and report satisfaction; Simpson & Joe 2004). Cosden et al. (2006) found that motivation for treatment—based on the client's reported need for treatment and acknowledgement of problem severity—was associated with the severity of drug use, and that client motivation (along with jail time) predicted program completion for drug court but not drug treatment court. Drug treatment clients who do not recognise that they have a drug use problem, do not want help, or simply believe they are not ready for treatment may require motivational enhancement services (e.g. Motivational Interviewing) before being mainstreamed into the drug court process.

However, the relationship between treatment motivation, program completion and recidivism is not as straightforward as might be expected. Cosden et al. (2006) also found that motivation was not a significant predictor of reoffending; rather, recidivism was predicted by program completion and problem severity.

To the extent that motivational change is acknowledged as a core objective of court-based intervention program, then all other aspects of the proposed model should be assessed and considered in light of their contribution and capacity to maintain this objective. This includes:

- the nature and composition of the intervention team – are the right agencies represented;
- the roles and responsibilities of key personnel;
- the nature of key program components and requirements (such as court appearances, compliance management and monitoring systems, the use of rewards and sanctions and graduated phasing); and
- the selection of treatment services.

Stakeholder views on motivation to change

Motivation for change was a topic often raised in the consultation sessions with stakeholders. The feedback received from stakeholders include:

- Motivation to change is an essential ingredient to an individual's success on an intensive drug treatment order.
- Offenders who are motivated solely by the desire to avoid harsh penalties (imprisonment) will be the most difficult to manage in a community corrections and intensive treatment context. Conversely, those offenders motivated by the desire to change their life or improve their life circumstances will have more favourable outcomes.
- However, for programs that target high-risk, high-need offenders, it may be unrealistic to expect anything other than purely instrumental motivations at the time of referral and entry.
- It is the role of case-workers (wherever situated) to help transition clients from instrumental (and largely external) motivators to internal and treatment focused motivators.
- Motivational interviewing, cognitive behavioural therapies and close case management programs are three key strategies for aiding motivational and attitudinal change.
- Motivational change can be difficult to achieve, if not a protracted process for high-risk and high-needs offenders.

Importantly, not only should treatment interventions be assessed for their ability to facilitate motivational change, but the practices and procedures of the intervention model must be assessed for their reverse potential – that is, the potential to diminish and demotivate clients.

The concept of motivation is different from the concepts of risk and responsivity — matching offenders to services based on their risk factors and delivery of services in a manner consistent with their learning styles. The research has provided preliminary empirical evidence that treatment outcomes can be improved if high-risk offenders are targeted for treatment services, regardless of their level of intrinsic motivation. It also implies that a cohesive treatment and supervision experience may impact the motivation of the offender (Thanner & Taxman 2003).

For information on the screening and assessment of an individual's motivation and readiness for treatment see section 8.8.4.

8.8 ASSESSMENT AS THE CORNERSTONE OF SUCCESS

At the cornerstone of any intervention, both reoffending risk and criminogenic needs should be determined using validated and standardised screening and assessment tools. Consistent with the broader correctional literature, drug treatment programs offered in concert with criminal justice orders are more effective when combined with appropriate levels of supervision and programmatic intensity. Ultimately, determining the optimal level of supervision and providing a seamless system of service provision requires a reliable assessment of risk (Thanner and Taxman 2003; Lowenkamp et al. 2006 Andrews and Bonta 2010; Taxman and Marlowe 2006). Similarly, criminal justice interventions are more effective when the level of drug treatment is suitably matched to the severity of drug dependency. Service-level matching therefore requires validated assessment and screening tools which limit over or under-treating individuals (Sacks et al. 2005), especially as the number and type of available treatment options increase (Carroll 2000). According to the American Society of Addiction Medicine, drug use and dependency assessment should include: aspects of the drug dependency and its severity, psychiatric problems and severity, medical conditions, substance withdrawal potential, legal pressures, family/social relationships, motivational factors, recovery and support environment, treatment history and behaviour, and cognitive capability.

8.8.1 Screening and assessment

Screening and assessment procedures are neither equivalent nor interchangeable processes. Rather, they exist as complementary systems designed to optimise efficiency in the allocation of scarce criminal justice and health resources. Screening, for example, is typically the process by which an offender's eligibility and suitability for treatment is first determined. Legal eligibility is often determined by a set of fixed criminal and circumstantial criteria not requiring further assessment, whereas program suitability is determined using brief probabilistic instruments which are indicative of treatment need requiring further and more detailed assessment. Screening, therefore, occurs soon after arrest/referral, and focuses only on those criteria required for eligibility and program placement determinations.

In principle, for screening to be effective the selected clinical criteria should be limited only to those factors considered important to the determination of an offender's suitability and eligibility, and may include: (1) drug use severity; (2) major mental health problems; (3) motivation for treatment; and (4) criminal thinking patterns. Importantly, clinical screening tools should be selected from a range of standardised instruments, these having been shown to be more reliable and valid than professional judgement alone for predicting success in correctional supervision (Andrews et al. 2006; Miller & Shutt 2001; Wormith & Goldstone 1984).

Assessment is differentiated from screening as a more comprehensive and thorough process used to determine an offender's suitability for specific types of treatment and levels of service intensity. In this case, assessment routinely occurs *after* an offender is deemed eligible for the relevant program or intervention. In some cases, offenders may be granted a position prior to the completion of a more comprehensive assessment, while in others the matter may be adjourned by the court for such a period of time that allows

for a detailed assessment to be conducted. Assessment in this context is intended to provide an in-depth dynamic picture of the client's prognostic risks and criminogenic needs, leading to the identification of appropriate levels and types of interventions. Again, validated and standardised assessment instruments have been shown to be more effective than professional judgement in the matching of offenders to appropriate levels and types of interventions.

8.8.2 Gender sensitive screening

The broader drug treatment literature has frequently identified less favorable outcomes for women in both coerced and voluntary treatment contexts. One method of redress for this issue is to ensure that the gender specific clinical needs of female offenders are adequately assessed. In a comprehensive review of drug court screening and assessment practices, Peters and Peyton (1998) argue that gender sensitive drug court screening processes should:

- ensure adequate identification of barriers to treatment participation, including responsibility for the care and support of minor children and other child custody issues;
- ensure adequate gender-sensitive assessment of relapse triggers is undertaken;
- consider carefully the circumstances related to housing and relationships, especially to ensure that women are safe in their current living situation and that there are no pressures from significant others to continue drug or alcohol use;
- where the risk of domestic violence is identified, appropriate steps should be taken by the court to develop a safety plan that prevents victimisation; and
- identify any current or prior mental health diagnoses and assess the need for medical intervention (for anxiety, depression, etc.).

8.8.3 Screening for mental health

Due to the high rates of mental health disorders among criminal justice populations, mental health symptoms and status should be routinely examined as part of a comprehensive screening and assessment procedure. Importantly, drug treatment interventions should not restrict admission solely based on mental health symptoms or a history of mental health treatment, but should instead consider the degree to which mental health or other disorders can lead to functional impairment that inhibits effective program participation. According to Peters and Peyton (1998) key mental health considerations should include:

- paranoia, hallucinations, delusions, severe depression, or mania (i.e. hyperactivity and agitation) that occurs frequently, is obvious to others, is disruptive to group activities, or otherwise prevents constructive interaction with drug court staff or participants;
- lack of stabilisation on psychotropic medication, or failure to follow medication regimes; and
- suicidal thoughts or other harmful behaviour.

In addition to the selection of appropriate tools, agencies responsible for the coordination of treatment services should evaluate those services and their capacity to work with participants with mental health problems. This includes program resources, the extent and availability of an allied treatment service, and the levels of functioning needed to participate effectively. Further, those undertaking the screening and assessment of mental health must be trained in the application of the relevant instruments, while the drug treatment and case management practitioners should be educated on the nature and course of mental health disorders, including the identification of signs and symptoms requiring referral. Among those items to be assessed, Peters and Peyton (1998) suggest a focus on:

- acute mental health symptoms (e.g. depression, hallucinations, delusions);
- suicidal thoughts and behaviour;
- other observable mental health symptoms;
- age at which mental health symptoms began;
- prior involvement in mental health treatment, and use of psychotropic medication;

- cognitive impairment;
- past or recent trauma such as sexual/ physical abuse;
- family history of mental illness; and
- social factors (e.g. primary responsibility for children, living with an abusive or substance-involved partner, sole economic provider responsibilities) that may present obstacles for treatment participation.

8.8.4 Screening for motivation and readiness for treatment

Drug court screening and assessment should also assess an individual's motivation and readiness for treatment. Motivation may be affected by perceived sanctions and incentives, and may increase when continued substance abuse threatens current housing, involvement in mental health treatment, vocational rehabilitation, family (including loss of children), or marriage. Apparent lack of motivation should not, as a singular factor, be used to disqualify candidates from admission to the drug treatment, unless the candidate specifically refuses to participate.

Research has shown that treatment outcomes for persons coerced or court-ordered to treatment are as good as or better than for participants in voluntary treatment (DeLeon, 1988; Hubbard et al. 1989; Leukefeld & Tims 1988). Although some offenders may initially agree to participate in treatment to reduce negative consequences, motivation for treatment is expected to become internalised over time. Individuals often cycle through a series of 'stages of change' during the treatment and recovery process (Prochaska et al. 1992), including:

- pre-contemplation (unawareness of problems);
- contemplation (awareness of problems);
- preparation (reached a decision point);
- action (actively changing behaviours); and
- maintenance (practices ongoing preventive behaviours).

Individuals in the earliest stages of change have little awareness of substance abuse (or other) problems, and no intentions of changing their behavior. Awareness of problems increases in later stages, as the individual begins to consider the goal of abstinence. Due to the chronic relapsing nature of substance abuse, movement through stages of change is not a linear process.

For individuals in the early stages of change, placement in treatment that is too advanced, and that does not address a participant's ambivalence regarding behavior change, may lead to drop out from treatment. For individuals in later stages of change, placement in services that focus primarily on early recovery issues may also lead to drop out from treatment. Assessment of stages of change is useful in treatment planning, and in matching the individual to different types of treatment. Several instruments have recently been developed to examine motivation and readiness for treatment.

8.8.5 Screening for substance use

The effectiveness of substance abuse assessment and screening instruments may vary according to the criminal justice setting and the goals of gathering information in that setting. In any case, it is important that screening processes adequately identify key issues that need to be addressed in treatment. Content domains may be singular or plural, including substance use, criminal, physical health, mental health, and special considerations.

According to Peters and Peyton (1998) in their review of drug court screening and assessment practices, practitioners should give consideration to the following issues:

- signs of acute drug or alcohol intoxication;
- acute signs of withdrawal from drugs or alcohol;
- drug tolerance effects;
- results of recent drug testing;

- self-reported substance abuse;
- age and pattern of first substance use;
- history of use;
- current pattern of use (e.g. quantity, frequency, method of use);
- 'drug(s) of choice'(including alcohol);
- motivation for using;
- negative consequences associated with substance use. For women, this may include changes in physical appearance;
- prior involvement in treatment;
- family history of substance abuse (include family of origin as well as current family); and
- other observable signs and symptoms of substance abuse (e.g. needle marks/ injection sites, impaired motor skills).

8.9 USING TREATMENTS THAT WORK TO REDUCE BOTH DRUG USE AND OFFENDING

Research and evaluation analyses have consistently shown that the most effective interventions are those that employ therapeutic community (TC), cognitive-behavioural and standardised behavioural techniques. Several large scale reviews (Pearson et al. 2002; Irvin et al. 1999; Dutra et al. 2008; Magill & Ray 2009) in addition to several randomised control trials (Siqueland & Crist-Christof 1999) have consistently demonstrated more favourable outcomes from treatment orientations that engage clients in cognitive-behavioural tasks and/or standardised behavioural modification techniques (see also Andrews et al. 1990; Sherman et al. 1997; Lowenkamp & Latessa 2004; Mackenzie 2006; McMurran & Preistley 2004; Budney, Moore, Rocha & Higgins 2006; Carroll et al. 2006; Easton et al. 2007; Kadden et al. 2007; Rawson et al. 2006). Therapeutic communities, especially in custodial environments and when coupled with cognitive-behavioural treatments (Pelissier et al. 2001; Mitchell, MacKenzie & Wilson 2012) and appropriate aftercare (Inciardi, Martin & Butzin 2004; Prendergast, Hall, Wexler, Melnick & Cao 2004), have also proven effective for reducing both drug use and reoffending (Hiller, Knight, & Simpson 1999; Knight, Simpson, & Hiller 1999;). Further, where other criminogenic needs are present, treatment programs should be augmented to include strategies that address criminal thinking (Bourgon & Armstrong 2005; Pearson & Lipton 1999; Peason et al. 2002).

The efficacy of behavioural treatments for drug use should be augmented, where applicable, with the use of pharmacotherapy. There is now a sizable evidence-base concerning the effectiveness of pharmacotherapy treatments in facilitating drug treatment, improving drug treatment retention and reducing reoffending – specifically methadone and buprenorphine for the treatment of opiate dependency – (Parker & Kirby 1996; Coid et al. 2000; Keen et al. 2000; Pearson & Lipton, 1999; Marsch et al. 2005; Schottenfeld, Chawarski, & Mazlan, 2008; Kinlock et al. 2009). Importantly, although pharmacotherapy is an effective treatment in its own right, research has shown that its positive impact is amplified when coupled with other psychosocial and cognitive-behavioural treatments (CBT). (Rohsenow et al. 2004; Montoya et al. 2005).

Although individuals should be provided with no more treatment that is required by their level of criminogenic need, where drug dependency is identified**,** programs should employ treatment services for a minimum duration of 90 days (three months). The length of time spent in treatment is universally acknowledged as an important predictor of drug treatment success. Spanning several decades of research (Simpson 1981; Simpson et al. 1982; Hubbard et al. 1989; Simpson et al. 1997), empirical analyses of treatment outcomes have found more favourable results for clients who spend at least 90 days engaged with treatment services.

To effectively employ standardised behavioural treatments, programs should, where possible, adopt a regimen of rewards and incentives in both the treatment and criminal justice settings. Rewarding treatment progress and compliance, otherwise known as Contingency Management (CM), has proven to be an effective strategy for treating the drug dependency of offenders in the criminal justice system. Contingency Management has been shown to be just as effective as CBT (Rawson et al. 2006), although the most favourable outcomes are typically found when CM and CBT are used in concert (Budney et al., 2006; Carroll et al., 2006;

Dutra et al., 2008; Kadden et al., 2007). Contingency Management has shown to be effective for the treatment of most drug types, including marijuana (Budney et al., 2006; Carroll et al., 2006; Kadden et al., 2007), methamphetamines (Rawson et al. 2006; Roll et al. 2006), cocaine and opiates (Budney et al. 2006; Gross, Marsch, Badger, & Bickel 2006; Olmstead & Petry 2009; Petry & Martin 2002; Prendergast, Podus, Finney, Greenwell & Roll 2006).

8.9.1 Treatment types and modalities

8.9.1.1 Cognitive Behavioural Therapy

Cognitive-Behavioural Therapy (CBT) was first developed as a treatment for alcoholism, focusing on the identification and development of behavioural strategies for managing relapse. It was adapted for cocaine-addicted individuals, and is now widely used for general substance use disorders (see Carroll and Onken 2005). Fundamental to CBT is the belief that maladaptive behavioural patterns (like substance abuse) are learned, and thus can be replaced with newly learned and reinforced behavioural repertories. Individuals undergoing CBT learn to identify problematic behaviours and their triggers, as well as behavioural contingency strategies for mitigating the risk of relapse (Carroll et al. 2006). Such triggers may be internal (physiological cravings or stress reactions) or external (such as seeing friends, or being at specific locations). According to Rounsaville and Carroll (1992), CBT addresses several critical tasks that are essential to successful substance abuse treatment, including:

- **Foster the motivation for abstinence**. An important technique used to enhance the patient's motivation to stop cocaine use is to do a decisional analysis which clarifies what the individual stands to lose or gain by continued cocaine use.
- **Teach coping skills**. This is the core of CBT – to help patients recognise the high-risk situations in which they are most likely to use substances and to develop other, more effective means of coping with them.
- **Change reinforcement contingencies**. By the time treatment is sought, many patients spend most of their time acquiring, using, and recovering from cocaine use to the exclusion of other experiences and rewards. In CBT, the focus is on identifying and reducing habits associated with a drug-using lifestyle by substituting more enduring, positive activities and rewards.
- **Foster management of painful affects**. Skills training also focuses on techniques to recognise and cope with urges to use cocaine; this is an excellent model for helping patients learn to tolerate other strong affects such as depression and anger.
- **Improve interpersonal functioning and enhance social supports**. CBT includes training in a number of important interpersonal skills and strategies to help patients expand their social support networks and build enduring, drug-free relationships.

A central component of CBT is the identification and anticipation of key triggers coupled with the development of trigger-avoidance and self-control strategies. Specific techniques include exploring the positive and negative consequences of continued drug use, self-monitoring to recognise cravings early and identify situations that might put one at risk of relapse, and developing strategies for coping with cravings and avoiding those high-risk situations. In more recent years, computer-assisted programing has been shown to be an effective tool for engaging clients in core CBT activities (Carroll et al. 2006). According to NIDA, the key active ingredients that distinguish CBT from other therapies and which must be delivered for adequate exposure to CBT include:

- functional analyses of substance abuse;
- individualised training in the recognition of and coping with craving, managing thoughts about substance use, problem solving, planning for emergencies, recognising seemingly irrelevant decisions, and refusal skills;
- examination of the patient's cognitive processes related to substance use;
- identification and debriefing of past and future high-risk situations;
- encouragement and review of extra-session implementation of skills; and
- practice of skills within sessions.

CBT has been evaluated extensively, including through randomised clinical trials and meta-studies (Dutra et al. 2008; Magill & Ray 2009; Carroll 1996; Hofmann et al. 2012). Notably, CBT has been shown to be more effective for the treatment of cannabis, cocaine and opioids, but less effective in the treatment of poly-drug use. Among the different types of CBT programming, the most favourable outcomes were found when CBT was coupled with contingency management programs. Further, CBT clients have more favourable long-term outcomes than those who receive minimal or no treatment at all (Rawson et al. 2006) and the intervention type has been found to be effective in addressing other problem behaviours, including criminal offending (Hofmann et al. 2012). Finally, from the perspective of tackling comorbidity, there is evidence that CBT can be effective in addressing a range of mental health conditions, including bipolar disorder, anxiety disorders and personality disorders (Hofmann et al. 2012).

8.9.1.2 Moral Reconation Therapy

Moral Reconation Therapy (MRT) is a systematic cognitive-behavioural counselling program developed by Little and Robinson (1988) with demonstrated capacity for treating drug use (Bahr et al. 2012; Wanberg & Milkman, 2006) and reducing reoffending (Ferguson & Wormith 2012), including as part of a drug court program (Cheesman et al, 2012; Heck et al. 2008; Kirchner and Goodman 2007). MRT operates as an open-ended, workbook-based program conducted as a series of group-work and homework exercises, each aimed at reducing drug use and challenging criminal thinking. The program is run across 16 steps (or units), 12 of which are completed in a group counselling environment, while the remaining four steps are completed individually. The 16 steps are clustered into four phases: engagement; creating change; reinforcing permanent change; and transitioning to the future (optional and individual).

Underpinned by a cognitive-behavioural philosophy, MRT addresses beliefs and reasoning, in an effort to restructure a participant's cognitive scripts about both drug use and crime. Central to the program is an attempt to address moral reasoning and improve decision making skills, thereby fostering more prosocial activity and community-minded engagement. MRT is indicated for offenders who meet the DSM-V diagnostic criterial for one or more substance use disorders (Ferguson and Wormith 2012). Importantly, new clients can enter the program at any time and can be incorporated into the cohort of existing clients who are at the more advanced stages of their treatment.

8.9.1.3 Therapeutic Communities

A therapeutic community (TC) is a treatment facility in which the community itself, through self-help and mutual support, is the principal means for promoting personal change. In a TC, residents and staff participate in the management and operation of the community, contributing to a psychologically and physically safe learning environment where change can occur. In a TC there is a focus on social, psychological and behavioural dimensions of substance use, with the use of the community to heal individuals emotionally, and support the development of behaviours, attitudes and values of healthy living. Importantly, therapeutic communities can also target the psychological and social factors that influence drug abuse, through CBT, CM, counselling, relapse prevention and motivational interviewing (Holloway & Bennett 2016).

Therapeutic communities may be prison-based or they may be located in community-based treatment centres. Meta-analytic reviews have concluded that therapeutic communities have some of the strongest positive evidence of any prison-based substance abuse programs (Wilson, 2016). The results in terms of substance use are not as strong, with a recent systematic review finding that substance use decreases during the program, but that relapse was common (Malivert et al. 2012).

8.9.1.4 Motivational Interviewing / Motivational Enhancement Therapy

Motivational Interviewing (MI) as a form of drug treatment was first described by Miller and Rollnick (2002) in response to Prochaska and DiClemente's (1984) stages of change model. MI, or Motivational Enhancement Therapy (MET), is described as a client-centred, empathic, but directive counselling strategy designed to explore and reduce a person's ambivalence about engaging in treatment and stopping their drug use.

The MI/MET approach aims to induce rapid and internally motivated change through counselling sessions where empathic listening and skillful interviewing techniques are used. The four basic principles of MI are (Centre for Substance Abuse Treatment 1999):

- express empathy – the counsellor communicates that the client always is responsible for change and respects the client's decision on this issue;
- identify discrepancies – the counsellor encourages the client to focus on how current behaviour differs from his/her ideals and goals;
- roll with resistance and avoid arguing – rather than resist client resistance, the counsellor uses strategies to reduce resistance; and
- support self-efficacy – the counsellor recognises client strengths and encourages him or her to believe that change is possible.

Research on MI and MET suggests that its effects may depend on the type of drug used and the goal of the intervention. These approaches have been used successfully for alcohol and marijuana-dependency in adults, especially when combined with other CBT techniques; however, the results of MET appear mixed for people abusing other drugs (e.g., heroin, cocaine, nicotine) and for adolescents who tend to use multiple drugs. In general, MET seems to be more effective for engaging drug abusers in treatment than for producing changes in drug use.

8.9.1.5 Contingency Management Interventions

Contingency management (CM) principles have been shown to be effective in the treatment of substance abuse disorders. CM involves the use of tangible rewards to reinforce positive abstinence and other positive behaviours. Studies have demonstrated that incentive-based interventions can increase treatment retention and promote both temporary and longer term abstinence from drugs (Petry et al. 2000; Higgins et al. 2000; Petry et al. 2002), including opiate and cocaine use disorders (Silverman et al. 1996) alcohol use disorders (Petry et al. 2000), and marijuana use disorders (Budney et al. 2000). CM programs are typically delivered in one of two different models:

- Voucher-Based Reinforcement (VBR) which augments other community-based treatments where the treatment client receives a voucher with monetary value that can be exchanged for food items, movie passes, or other goods or services that are consistent with a drug-free lifestyle.
- Prize Incentives (PI) offers treatment clients the chance to win prizes (typically cash) instead of vouchers. Compared with standard VBR techniques, the prizes are not automatically offered at each stage of success.

8.9.1.6 The Matrix Model

The Matrix Model is not a specialised treatment modality, but a holistic and intensive framework for engaging, primarily stimulant (e.g. methamphetamine and cocaine) abusers in treatment. Originally known as neurobehavioral treatment, the Matrix Model integrates several evidence-based treatment techniques into a comprehensive and individualised treatment plan targeting the participant's behavioural, emotional, cognitive and relationship issues. Participants learn about issues critical to addiction and relapse (CBT), receive direction and support from a trained therapist (MI/MET), and become familiar with 12-step and self-help programs. Patients are often monitored for drug use through urine testing.

In the Matrix model, the counsellor/therapist functions simultaneously as teacher and coach, fostering a positive, encouraging relationship with the participant and using that relationship to reinforce positive behaviour change (Obert et al. 2000). The interaction between the therapist and the patient is authentic and direct but not confrontational or parental (Rawson et al. 1995). Importantly, therapists must be trained to conduct treatment sessions in a way that promotes the patient's self-esteem, dignity, and self-worth. A positive relationship between patient and therapist is critical to patient retention, though once established the Matrix Model should:

- maintain a strong therapeutic relationship between the client and the counsellor;

- teach clients how to structure time and initiate an orderly and healthy lifestyle;
- impart accurate, comprehensive and comprehensible information about acute and subacute withdrawal effects and cravings for substances;
- provide opportunities to learn and practice relapse prevention and coping techniques;
- involve family and significant others in the therapeutic and educational process to gain their support for – and prevent their sabotaging of – treatment;
- encourage clients to participate in community-based mutual-help programs; and
- monitor treatment effectiveness by conducting random urinalysis testing.

A number of studies have demonstrated that participants treated using the Matrix Model show statistically significant reductions in alcohol and other drug use and improvements in psychological indicators (Rawson et al. 1986; Rawson et al. 2002). Some research, however, has shown that as a consequence of the Matrix model's intensity, the program may not be suited to all clients (Obert et al. 2000) and may not allow sufficient time for other treatment needs to be addressed.

8.9.1.7 Family Behaviour Therapy

Where appropriate, interventions should encourage family involvement in treatment. There is some evidence in support of Family Behaviour Therapy (FBT) for both adults and adolescents (Azrin et al, 1994; Carroll & Onken 2005; Donohue et al. 2009; LaPota et al. 2011). FBT aims to reduce substance use problems along with a range of other co-occurring problems, such as conduct disorders, child mistreatment, depression, family conflict, and unemployment.

FBT combines behavioural contracting with CM. Working with the client and at least one other family member, therapists aim to encourage families to apply the behavioural strategies taught in therapy to help contribute to an improved home environment. Behavioural goals are developed by the client, based on a CM system, and may relate to aspects of family functioning such as effective parenting. They are then regularly reviewed by the client and significant other. Treatment interventions are chosen by the client, who is engaged in treatment planning, from a menu of options supported by evidence.

Similarly, since its first use in 1985, behavioural couples therapy (see O'Farrell et al., 1985) has been shown to be an effective means of encouraging abstinence and decreasing drug-related family conflict, including domestic and family violence (Fals-Stewart et al. 2001; O'Farrell and Fals-Stewart 2000; O'Farrell and Fals-Stewart 2002).

8.10 TACKLING COMORBIDITY AND CO-OCCURRING DISORDERS

Responsivity to treatment and supervision is critical to program and intervention success (Andrews and Bonta 2010; Simpson & Joe 2004). In part, this requires the tailoring of treatment and intervention regimens to meet the diversity of cognitive and psychosocial comorbidities within the criminal justice population. The high prevalence of mental health problems among criminal justice populations requires the coordination of comprehensive services that address co-occurring medical, mental health and psychosocial disorders. Research has consistently shown that drug treatment outcomes, including those provided in concert with criminal justice interventions, can be improved considerably where co-occurring disorders and comorbidities can be treated concurrently and seamlessly with drug dependency (McLellan et al. 1993).

8.11 MONITORING INDIVIDUAL SUCCESS

Individual level progress in treatment should be monitored for signs of disengagement and relapse. Specifically, routine drug testing has been shown to be an effective tool for the treatment of drug dependency, especially among criminal justice populations (Matrix Research and Consultancy & NACRO, 2004; Sherman et al. 1997). Drug testing programs, coupled with contingency management systems for rewarding treatment progress, are important tools for maintaining treatment retention and thereby maximising treatment duration.

8.12 COMMITMENT TO EVALUATION

Interventions in the criminal justice system should be subject to governance, ongoing performance monitoring and systematic, independent evaluation. Public sector governance encompasses a set of responsibilities exercised by an agency to provide strategic direction, to ensure that objectives are achieved, risks are managed and resources are used responsibly and with accountability.

Particularly, in view of the complexity of Queensland's court diversion programs and the need to ensure adherence to program objectives and issues of efficiency and effectiveness, a governance structure should be established to collectively oversee all court based programs. This would involve the creation of a reference group comprised of representatives from all key agencies, service providers and academics.

Ongoing program monitoring, in particular when conducted against performance benchmarks and known performance indicators, is beneficial to ensure that program outcomes are achieved in the longer term. Performance monitoring in this context refers to the process of regularly collecting and monitoring performance information, reviewing program performance (i.e. using this information to assess whether a project is being implemented as planned and is meeting stated objectives), and using this information to identify where improvements might be made. The distinction between performance monitoring and evaluation is that, while monitoring key indicators of performance may help provide some evidence that certain outcomes are being delivered, it does not provide immediate evidence as to the contribution of a program to those outcomes.

Evaluation is best conducted using a systematic approach, which involves planning evaluation early in the process—ideally during the initial stages of planning the program—and starts with the development of a program logic model and evaluation framework (Morgan & Homel 2013). This can then form the basis for decisions about the most appropriate evaluation design and methods. Unfortunately, it is common for evaluation to be an afterthought, which poses numerous challenges for the measurement of key outcomes, such as the lack of appropriate baseline measures. Irrespective of whether a process and/or outcome evaluation is being undertaken, it is important for the evaluation design and research methods to be determined early in the life of the program (Weatherburn 2009).

For more information on governance, monitoring and evaluation refer to Chapter 36**Error! Reference source not found.** in Part C of this report.

8.13 IMPLICATIONS

This chapter has presented the evidence on best practice in the assessment and treatment of offenders with alcohol and other drug issues, in order to provide an understanding of what works in reducing reoffending. Based on this evidence, a set of criteria has been developed that provides principles for effective alcohol and other drug treatment for criminal justice populations.

8.14 RECOMMENDATIONS

Recommendation 3	**Criteria for alcohol and other drug interventions in a criminal justice framework**
3.1	**Alcohol and other drug treatment should be underpinned by a shared understanding across government 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'.**
3.2	**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. Accordingly:**
	(a) the level of program intensity should be matched to offender risk level (the risk of reoffending principle);

(b) criminogenic needs (i.e. those functionally related to persistence in offending, including drug use and co-occurring needs such as mental illness, unemployment and accommodation) should be addressed concurrently; (the need principle); and

(c) the style and modes of intervention, wherever possible, should be matched or tailored to each individual offender's learning style and abilities and be responsive to individual strengths and levels of motivation (the responsivity principle).

3.3 More intensive (and more costly) interventions should be reserved for high-need, high-risk offenders, while briefer (and cheaper) interventions, should be provided to low-risk or first time offenders.

3.4 Low risk offenders should not be over-treated or over-supervised because, notwithstanding ethical considerations, there is a potential for net-widening, to exacerbate drug use, and to worsen criminal justice outcomes.

3.5 Intensive interventions delivered in a criminal justice setting and targeting high risk offenders should operate on the basis that most clients are not, at the time of referral, motivated to change their lifestyle or address their criminogenic needs. The goal should therefore not be to target those already motivated to change, but in implementing strategies proven to facilitate the transition of unmotivated offenders into a position of contemplation and action (e.g. as is provided under a drug court model).

3.6 Treatment programs should use validated and standardised screening and assessment tools that match offenders to appropriate service levels and intervention types based on risk and need. The following key practice principles should be followed:

(a) Eligibility screening should be based on established written criteria. Criminal justice officials or others are designated to screen cases and identify potential drug court participants.

(b) As part of the screening and assessment process, eligible participants should be promptly advised about program requirements and the relative merits of participating.

(c) Instruments should be selected on the basis that they will actually be used in the decision making process.

(d) Screening tools should be used that can be easily administered and scored, as well as that provide clinically meaningful results based on comparisons with normative data.

(e) Instruments should be selected that have good overall classification accuracy and psychometric properties, particularly reliability and validity.

(f) Trained professionals should screen drug court-eligible individuals for alcohol and other drug problems and suitability for treatment as well as risk screening for withdrawal, self-harming and suicidal ideation, aggression and violence, and mental health concerns. Staff should be appropriately qualified and trained for administering the selected instruments.

3.7 In the case of offenders with a drug dependency, the following additional principles apply:

(a) Effective interventions are those that employ evidence based and endorsed psychotherapeutic therapies and techniques such as therapeutic community, cognitive-behavioural and standardised behavioural techniques which should be augmented, where applicable, with the use of medication-assisted treatment including pharmacotherapy.

(b) Although individuals should be provided with no more treatment that is required by their level of criminogenic need, where drug dependency is identified, programs should employ treatment services for a minimum duration of 90 days.

(c) To effectively employ standardised behavioural treatments, programs should, where possible, adopt a regimen of rewards and incentives in both the treatment and criminal justice settings. Rewarding treatment progress and compliance has proven to be an effective strategy for treating the drug dependency of offenders in the criminal justice system.

(d) Individual progress in treatment should be monitored for signs of disengagement and relapse. Specifically, routine drug testing has been shown to be an effective tool for the treatment of drug dependency, especially among criminal justice populations. Drug testing programs, coupled contingency management systems for rewarding treatment progress, are important tools for maintaining treatment retention and thereby maximising treatment duration.