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**The illicit drug problem: drug
courts and other alternative
approaches**

by

Marie Swain

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EXECUTIVE SUMMARY

The **impact** of illicit drug use on individuals and the community at large is great, and shows no sign of diminishing (pp2-3). Since the early 1980s the approach by Australian governments to the problem, at both a state and federal level, has been aimed at reducing the supply of and demand for illicit drugs and minimising the harm they cause. Recent **funding allocations** indicate an ongoing commitment to this approach (pp4-6). As part of the attempt to reduce the demand side of the equation a **new measure**, a dedicated **drug court**, is being trialled in New South Wales to give eligible offenders the opportunity to participate in treatment programs to overcome their drug dependence. It is hoped that a reduction in the level of criminal activity resulting from illicit drug dependency will also be achieved (pp45-47). **Diversionsary schemes**, such as the drug court program, provide an alternative option to the traditional path through the criminal justice system (pp7-8). Other schemes which exist or have existed in the Australian context are discussed at pages 8 to 13.

The **model** for the drug court is that which has been in operation in the United States for approximately a decade (pp25-27). A number of positive **benefits** are said to have flowed from the use of these courts including: a reduction in the rate of recidivism and drug usage by participants in the drug court program; increased likelihood of participants obtaining or holding jobs; improvement in family relationships; and cost savings to the justice system (pp27-37). Despite many studies and reports on the position in the United States which claim some or all of the positive outcomes referred to above, a number of influential commentators have stated that the **evaluations** conducted to date are not conclusive (pp37-40).

Issues relevant to the **implementation** of the drug court in New South Wales include: the provision of adequate resources to ensure sufficient treatment places are available; the provision of other support services to assist drug court participants in their daily lives; equity issues to ensure all eligible offenders are able to participate; and the impact on other voluntary drug treatment services currently in existence (pp40-45).

A special panel comprising: the drug court judge and officers from the Office of the Director of Public Prosecutions; Legal Aid Commission of NSW; Attorney General's Department; Department of Corrective Services (Probation and Parole); Department of Health (Corrections Health Service); and the NSW Police Service, will assess each participant to determine the most appropriate treatment program. As no single treatment option is suitable across the board, a number of **treatment options** ranging from detoxification to maintenance to behavioural modification will need to be made available (pp13-24).

The Bureau of Crime Statistics and Research has been given the responsibility of conducting a comprehensive and ongoing evaluation of the Parramatta drug court. At the end of the two year trial period, decisions can then be made as to the success or otherwise of the initiative.

1 INTRODUCTION

In September 1998 the NSW government announced that it was going to introduce a two year trial of a 'drug court' as another means of addressing the illicit drug problem, and on 9 February 1999 the first drug court in Australia commenced operations in Parramatta under Judge Murrell. Drug courts have been in operation in the United States for a decade and are to be trialled in a number of jurisdictions such as Canada and Ireland in the near future. Although there is no standard definition, the National Association of Drug Court Professionals¹ in the United States defines them as follows:

A drug court is a special court given the responsibility to handle cases involving less serious drug using offenders through a supervision and treatment program. These programs include frequent drug testing, judicial and probation supervision, drug counselling, treatment, educational opportunities and the use of sanctions and incentives.

Inciardi et al² define them as:

Courts specifically designated to administer cases referred for judicially supervised drug treatment and rehabilitation within a jurisdiction or court-enforced drug treatment program.

The introduction of this novel approach does not detract from the adopted strategy of all Australian State and Federal governments which aims to reduce the supply of and demand for illicit drugs and to minimise the harms they cause. It is, however, an acknowledgement that other means need to be trialled to break the cycle of illicit drug use and crime.

The first section of this Briefing Paper presents a snapshot of the illicit drug problem facing our community today, and in the second section various approaches and available treatment options are discussed. In section three a description of the United States drug court experience to date is given, and the major achievements highlighted. Issues raised in relation to the establishment of a drug court in New South Wales are also presented.

¹ This is the principal organisation of professionals involved in the development of treatment oriented drug courts. Its members include judges, prosecutors, defence attorneys, treatment service providers, educators, researchers and community leaders.

² Inciardi J, McBride D, Rivers J, *Drug Control and the Courts*, Drugs, Health and Social Policy Series, Vol 3, Sage Publications, 1996, p69.

2 THE ILLICIT DRUG PROBLEM

A snapshot of illicit drug use is provided in *The National Drug Strategy: Mapping the Future*:³

- Cannabis is the most frequently used illicit drug in Australia. Almost one third of Australians (31%) have used marijuana at some time in their lives, and more than 1 in 8 (13%) reported using marijuana in the 12 months prior to the 1995 NDS Household Survey.⁴
- Approximately 2 out of every 5 marijuana consumers (42%) use it very infrequently - once or a few times a year. Approximately one third (31%) of users consume marijuana at least once a week.
- Lifetime and current use of other illicit drugs are significantly lower than those for marijuana. Less than 1 in 10 Australians have ever used hallucinogens or amphetamines and considerably fewer have ever used other illicit drugs, particularly heroin or cocaine.
- 1 in 20 Australians report having been offered ecstasy or other designer drugs, 2% have used these drugs and current consumption is estimated at 1%.
- The demographic portrait of an Australian likely to use illicit drugs is that of a young, unattached male who is more likely to be unemployed than his non-using contemporaries. Age and gender are strongly associated with illicit drug use. Illicit drug use is highest among persons aged less than 35 years and males are more likely than females to experiment and/or continue using illicit drugs.
- Whereas 42% of those with a tertiary education have used marijuana, only 28% of persons without formal qualifications have done so. Education is not a factor in the use of illicit drugs other than marijuana.
- Unemployed persons have higher prevalence rates for marijuana (55%), heroin (5%), amphetamines (18%), cocaine (7%), hallucinogens (8%) and ecstasy or other designer drugs (7%) compared with employed Australians.
- It is estimated that 778 Australians died from conditions associated with illicit drug

³ Single E and Rohl T, *The National Drug Strategy: mapping the future An evaluation of the National Drug Strategy 1993-97*, A report commissioned by the Ministerial Council on Drug Strategy, Canberra, April, 1997, pp35-38.

⁴ A household survey undertaken to monitor and evaluate issues relevant to the National Drug Strategy concerning both licit and illicit drugs. A total of 3,850 face to face interviews were conducted with people 14 years and over, Australia-wide during the period May to June 1995.

use in 1995.⁵ There were 4 times as many deaths in males than females. While illicit drugs account for many fewer deaths than tobacco or alcohol, those who die as the result of illicit drug use tend to be much younger. On average each death results in 36.7 years of potential life lost, compared with 4.7 years for tobacco.

- In 1995/96, 61 Australians were diagnosed with HIV where injecting drug use was a reported risk factor. For about one half of these persons (29) there was no other reported risk factor (eg homosexuality, bisexuality, or heterosexual contact with an injecting drug user). Up to June 30 1995, 1,126 Australians had been diagnosed with HIV infection where injecting drug use was a factor.
- The economic cost of illicit drug use, including lost productivity, treatment and law enforcement was estimated at \$1.68 billion for 1992.⁶ This is likely to be a conservative estimate as there is insufficient data to quantify the cost of property crimes committed by addicts to support their dependency. A relatively large proportion of the costs associated with illicit drugs goes to law enforcement, the courts and corrections systems of Australia.
- In 1994, 1,721 persons were imprisoned for: possession of an illicit drug (144); dealing or trafficking (1,304); or manufacturing or growing illicit drugs (273). Drug offenders represented 11% of all prisoners. An unknown proportion of the other 89% of prisoners were convicted for offences committed to support addictive habits, or whilst under the influence of illicit drugs.

According to a more recent study by the National Drug and Alcohol Research Centre the number of people dying from heroin overdoses has risen to its highest level in Australia, increasing 10% in a year to 600 deaths. In NSW, which accounts for half the nation's deaths from opiate overdoses, deaths rose by 13% between 1996 and 1997. A comparison of such deaths over the last decade is presented in the table below.⁷

Heroin deaths: Overdoses in NSW among those aged 15 to 44 years

1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
201	154	193	142	178	177	201	251	244	292

⁵ The Australian Institute of Health and Welfare, unpublished data, 1997 cited in *The National Drug Strategy: mapping the future*.

⁶ Collins DJ and Lapsley HM, *The Social Costs of Drug Abuse in Australia in 1988 and 1992*, Monograph No 30, National Drug Strategy, AGPS, 1996.

⁷ 'Heroin overdose deaths hit a record 600', *Sydney Morning Herald*, 9 February 1999.

3 APPROACHES TO THE ILLICIT DRUG PROBLEM

To date the National Drug Strategy adopted in Australia primarily as a response to the HIV/AIDS epidemic has been a three pronged approach which aims to reduce the supply of and demand for illicit drugs and minimise the harm they cause. Governments at both the State and Federal level have made funds available to achieve these objectives. This section examines: the allocation of funds made by the Federal and the New South Wales governments in recent times, various diversionary schemes used to deal with offenders who have a substance abuse problem; and the range of treatment options available.

(i) Funding Allocations

Federal: In November 1997 the Federal Government announced the first instalment of its *Tough on Drugs* initiative under which approximately \$87 million is to be spent on law enforcement (\$43.9 million); prevention and education(\$19.3 million); and drug treatment (\$24.5 million) over a three year period.⁸ The specific allocation of these funds is as follows:

- \$7.5 million will be spent increasing the capacity of the customs cargo profiling system and examination facilities in Sydney
- \$6.7 million will go to: improve coastal surveillance in the Torres Strait by increasing night and marine surveillance and helicopter flying hours; establish a Federal Police presence on Thursday Island; provide a secure communications network in the Torres Strait; and purchase three small, high speed vessels for the Customs Service
- \$1.5 million will be spent to employ additional customs intelligence analysts
- \$15.5 million will be spent to provide 54 more officers for the Australian Federal Police to ensure a prompt response to major drug trafficking operations. This will see the establishment of 3 'strike teams' whose job will be to dismantle drug syndicates wherever they operate in Australia
- \$7.3 million will be spent to improve the communication and information technology capabilities of Commonwealth law enforcement agencies
- \$3.9 million will go towards a National Heroin Signature Program which will identify the trafficking patterns for heroin. This money will also be used to improve research into drug crime links and increase Federal Police funding for informant handling and witness protection
- \$1.5 million will be used to enhance the Australian Transaction Reports and Analysis

⁸ *Tough on Drugs* pamphlet located on the Internet at: <http://www.adca.org.au/toughondrugs/whatis.htm>

Centre's capacity to monitor suspicious financial transactions

- \$7.4 million will be spent by the Commonwealth on a Schools Drug Strategy with the aim of achieving a 'zero tolerance' of drugs in schools. This important initiative will be developed in consultation with State and Territory Education Ministers, non-government school authorities as well as health professionals and community organisations
- \$4.8 million has been set aside for a community grants programme for local drug prevention and education projects. Funding will be conditional on how projects can help equip those on the front line, such as parents, to play their part against illicit drugs
- \$1.8 million will be allocated for a national 'one stop shop' to provide information to the community including parents, schools and health care facilities, which will be run by a non-government organisation with real experience in the field
- \$21.5 million will go towards establishing and operating new non-government treatment facilities
- \$3 million will also be spent in consultation with the States, training front-line professionals including doctors, hospital staff and police officers, as these people are well placed to provide practical advice and information about counselling and treatment
- \$5.3 million will be provided to support practical, new research and ways to reduce the harm that drugs cause. \$4 million of this will be spent to enable the National Health and Medical Research Council to undertake an expanded program of research to achieve new ways to prevent and treat illicit drug use. This will give a stronger focus to abstinence based treatments and accelerate the eventual re-integration of drug users into the community. \$1.3 million will be spent on the non-heroin trials⁹ agreed to by the Ministerial Council on Drug Strategy in July 1997

In March 1998 the Prime Minister announced the second instalment of the *Tough on Drugs* strategy worth in excess of \$100 million over four years. This money is additional to the original \$87 million and targets each step in the drug chain from its importation and distribution to its consumption. The main features of this second package are:¹⁰

- \$23.4 million over four years to the Australian Federal Police for another four mobile strike teams to strengthen the fight against international drug trafficking in

⁹ In July 1997 approval was given by the Ministerial Council on Drugs Strategy for trials of the following alternative pharmacotherapies to proceed: naltrexone, LAAM, buprenorphine, slow release oral morphine and tincture of opium.

¹⁰ *Tough on Drugs: Strengthening the Fight* located on the Internet at: <http://www.ozemail.com.au/~npafed/drugs2.htm>

Sydney, Perth, Adelaide and northern Australia, based in Cairns;

- an additional \$10 million over four years for school drug education programmes to further educate children on the dangers of taking drugs;
- \$18.4 million over four years for state of the art mobile x-ray search equipment to enhance capacity for drug interception at our borders;
- \$9.5 million over four years for new ship and aircraft search teams to improve drug detection and seizure at Australian ports and airports;
- \$3.75 million over three years to crew an additional vessel to patrol the Torres Strait Islands; and
- a further \$10 million over four years to support more proven, effective treatment programmes.

New South Wales: In November 1998 the Minister for Health announced increased funding for drug treatment services in New South Wales.¹¹ An additional \$5.6 million would be made available over two years to expand drug treatment services particularly in Sydney's Greater West and South-West regions. This money is to be spent on expanded facilities including: increased residential rehabilitation facilities; detoxification services; maintenance programs; and counselling and other treatment services.

Other drug initiatives of the Carr Government referred to in this announcement include:

- \$5 million in school drug education programs;
- Parent Education Nights;
- a \$3.3 million, 20 bed detoxification unit at Fairfield;
- a \$2.6 million, 20 bed detoxification unit at Lismore;
- a Youth Treatment Service in Cabramatta worth nearly \$1 million;
- trials of new drug treatments including naltrexone and buprenorphine; and
- increased policing and law enforcement

¹¹ Media Release, Hon A Refshauge MP, Minister for Health, 'Increased funding for extra drug treatment services', 11 November 1998.

(ii) Diversionary Schemes

Diversionary schemes provide an alternative option to the traditional path through the criminal justice system, and have been described as: ‘a procedure for social/therapeutic intervention at any of a number of stages of the judicial process, and diverting an offender away from prosecution, sentencing or incarceration to some other activity which may have a more positive result both for the offender and society.’¹² Proponents of such schemes argue that they offer an opportunity to: reduce court backlogs; provide early intervention before the development of fully-fledged criminal careers; reduce the costs of criminal processing; and enhance offenders’ chances for community reintegration.¹³

Diversion can take place at different points in time: before arrest; before trial; before sentence; and after sentence. In 1994 the Alcohol and Other Drugs Council of Australia was commissioned by the National Drug Crime Prevention Fund to conduct a study of diversion practices in Australia.¹⁴ This study identified five distinct diversion types:

Informal police diversion: where individual officers exercise their discretionary powers not to proceed against offenders.

Formal police diversion: where programs are in place which involve formal cautioning of offenders by senior police.

Statutory diversion: where programs are in place which aim to avoid the progression of offenders into the criminal justice system by directing them to other kinds of intervention. Some examples of statutory diversions are the drug assessment panels or counselling services which exist in South Australia and the Australian Capital Territory (discussed at pages 8 and 9 below).

Prosecutorial diversion: where prosecutors intervene and direct offenders away from the court system if they believe the community is best served by treating the offender rather than by court action which may involve sanctions such as fines, bonds or imprisonment; and

Judicial diversion: which is based on the discretionary power of magistrates and judges. Courts may order a range of dispositions and interventions, for example, assessment and treatment orders in the Australian Capital Territory and court diversions to treatment in Western Australia (discussed at pages 9 and 10 below).

¹² Meadows G, *Diversion Programs*, Discussion Paper prepared for the Committee of Review, Drug and Alcohol Authority, 1985 referred to in the *Final Report of the Committee of Review into Drug and Alcohol Services in New South Wales*, Department of Health, August 1985, p217.

¹³ Inciardi J, McBride D, Rivers J, *Drug Control and the Courts*, op cit, p26.

¹⁴ Australian Bureau of Criminal Intelligence, *Australian Illicit Drug Report 1996/97*, December 1997, p10.

For diversion programs to work effectively, however, there needs to be sufficient facilities to which offenders can be diverted. The Alcohol and Other Drugs Council's diversion study found that funding arrangements for existing programs were inadequate and that there were not enough places to accommodate the large number of offenders who might be eligible for diversion.

In the United States 'diversion' is the term used to describe the approach taken when prosecution of a matter is deferred because an offender has entered a treatment program after being charged with an offence. Those who fail to complete the treatment program have their charges brought back before the court and determined. Those who successfully complete the treatment program are either not prosecuted further or have their charges dismissed. The other main approach taken in the United States' drug courts is for the court to defer sentencing a person, who has either entered a guilty plea or been found guilty, if that person has entered a treatment program until he or she has successfully completed the program requirements. In a 1997 study of 97 drug courts in the United States, 30% had in place schemes which came into effect at the pre-trial/pre-plea stage; 16% at the pre-trial/post-plea stage ; 12% at the post-conviction stage; and 42% combined two or more of the preceding options.¹⁵

Some of the diversionary schemes which exist or have existed in Australia include:

a. South Australia

There are special provisions in the South Australian *Controlled Substances Act* 1984 to deal with people alleged to be in possession of specified drugs of dependence. Such people must be referred to a Drug Assessment and Aid Panel (DAAP) panel. Either the Panel or the person concerned can decide that the matter should be dealt with by proceedings in court. Otherwise, the Panel carries out an assessment, which can include requiring the person concerned to be examined to assess any physical, psychological and social problems connected with drug use. Following this, the Panel can require the person to enter into a written undertaking, effective for up to six months. This can involve treatment, participation in an educative, preventative or rehabilitative programme, or any other steps that will assist them to overcome any personal problems that may tend to lead, or may have led, to the misuse of drugs. Non co-operation can lead to prosecution.¹⁶

Each Drug Assessment and Aid Panel is made up of one legal practitioner and two other members with extensive knowledge of 'the physical, psychological and social problems connected with the misuse of drugs' or 'the treatment of persons experiencing such problems', who are appointed for a three year renewable term. It is supported by an administrative officer and a social worker.

¹⁵ Makkai T, 'Drug Courts: Issues and Perspectives', *Trends and Issues*, Australian Institute of Criminology, No 95, September 1998, p3.

¹⁶ Brown D, Farrier D, Neal D, and Weisbrot D, *Criminal Laws*, The Federation Press, 2nd Edition, 1996, p1099.

The Panels deal with a wide diversity of clients who are individually assessed before they give an undertaking to co-operate with the Panel and to follow all reasonable directions. The exact nature of involvement varies considerably from client to client, and the *Controlled Substances Act 1984* permits undertakings to cover a broad range of issues, from specific treatment programs for the illicit drug use that brought the client to the Panel, to a range of broader programs, including those that may be associated with the client's drug use but not necessarily a direct product of it.

The DAAP was established in 1985 following the proclamation of the *Controlled Substances Act 1984*, and is a genuine pre-court drug diversionary program. The Act allows for the referral to the DAAP of those alleged to have committed 'simple possession' charges. These matters are referred to the Panel rather than the courts in the first instance, and unless an offender wishes to defend the matters in court, fails to adhere to the requirements of the Panel, or is found unsuitable by the Panel, the matters are never referred to the courts and no conviction is recorded.¹⁷

b. Australian Capital Territory

In matters where an offender comes before the ACT courts, and the offending behaviour is related to dependence on an illicit substance, the magistrate may order that the offender be referred for assessment and possibly treatment managed by a panel of experts in the field. Once a finding has been made by the courts against an offender, the issue of drug use may be considered. A magistrate may order that the offender be referred for an assessment, in which case the offender makes contact with the Drugs of Dependence Assessment (DODA) Panel. An intake worker takes a full history of the offender's drug use and related matters, and the case then comes before the DODA panel, which is made up of a legal representative and two drug treatment experts. After assessment, recommendations may be made for treatment and the offender is required to make contact with the appropriate agencies (which have been recommended by the DODA panel). Once contact has been made, a treatment strategy is developed and approved by the court. Progress through treatment is then reviewed by the DODA panel and by the court, which may deal with breaches of undertakings and non-attendance at treatment.

The ACT panels are enabled by the *Drugs of Dependence Act 1989*. This Act targets drug offenders in general rather than targeting a particular category of drug related offences, as is the case with the South Australian Drug Assessment and Aid Panels.¹⁸

c. Western Australia

The West Australian Court Diversion Service (CDS) has been in operation since 1988, and operates as a supervising agency given authority by the courts under the *Bail Act 1982*. The

¹⁷ *Best practice in the diversion of alcohol and other drug offenders*, Proceedings of the Alcohol and Other Drugs Council of Australia Diversion Forum, October 1996, pp12-14.

¹⁸ *Best practice in the diversion of alcohol and other drug offenders*, *ibid*, p14.

development of the CDS has been described as: ‘a process which attempted to formalise an informal practice whereby offenders self referred themselves to drug agencies whilst on bail and then asked the agencies to report to the courts at sentencing time (or not to report if the treatment had not gone well)’. The program, which is funded jointly by the Alcohol and Drug Service of the Health Department and the Department of Corrections, provides an assessment, testing and referral service to those alleged offenders who admit to the use of illicit substances other than cannabis.

The CDS assesses defendants while they are on remand or bail, and makes a recommendation to the court regarding the suitability of the individual to participate in the program. The defendant is then placed on bail with a condition that they obey the legal directions of the CDS. This condition provides a possible trigger for the matter to be brought back to court if compliance becomes a problem. Following assessment, the defendant is given a range of treatment options to choose from, and his or her progress through treatment is monitored closely by the CDS officer, including thrice weekly urinalysis, with all participants’ progress being reported to the courts.¹⁹

According to Rigg and Indermaur²⁰ the courts use the CDS to purposely delay sentencing thereby using the anxiety associated with the period preceding the sentence to encourage drug users to engage in treatment. The overall objective of the program is to decrease the number of people in custody with serious drug problems by allowing sentencers to be assured that offenders with serious drug problems have engaged in treatment and are suitable for and willing to participate in community based treatment.

d. Victoria

Until recent amendments made to the *Sentencing Act* 1991 magistrates and judges had the option of making a specific order under section 28 of the Act, when an offender was found guilty of an offence, where there was some evidence that drugs could be considered to be partly responsible for the offending behaviour. A section 28 order required the offender to undergo compulsory treatment for his or her drug problem. In keeping with the spirit of the Act it was intended that a section 28 order was the most serious disposition preceding a prison sentence. The program operated in a similar manner to the West Australian CDS in so far as assessment and administration was conducted through a government service but ongoing treatment was provided through a range of funded services.²¹

e. New South Wales

It should be pointed out that magistrates and judges already have the power to refer people

¹⁹ *Best practice in the diversion of alcohol and other drug offenders*, op cit, pp14-15.

²⁰ Rigg J and Indermaur D, ‘Issues in Drug Offender Diversion: A Review of the Court Diversion Service in West Australia’, *Australian and New Zealand Journal of Criminology*, Vol 29 No 3, December 1996, pp247-264.

²¹ *Best practice in the diversion of alcohol and other drug offenders*, op cit, p15.

appearing before them to drug treatment programs and to take successful completion of this treatment into account at the sentencing stage by imposing more lenient sentences or by finding the offence proved but not recording a conviction against the person. However, certain ‘diversionary’ schemes for offenders with a substance abuse problem have been in place in New South Wales since the late 1970s and 1980s.²²

The first of these schemes, the Drug Diversionary Program was set up in 1977 at the request of the Attorney General and the Premier. It was introduced in a few specific local courts and aimed to ‘divert’ certain drug offenders into a ‘treatment’ stream. An eight week remand period was allowed, during which time the offender attended a drug treatment centre, and was also referred to the Probation and Parole Service for a pre-sentence report. It would appear that the Drug Diversionary Program did not meet the expectations envisaged by the legal, health and welfare professions. According to Bush, some of the major problems encountered were: misinterpretations of the roles of Probation Officers, health workers and the legal profession; outcomes were often no better for ‘divertees’ than ‘non-divertees’; the ineffectiveness in reporting to courts on treatments frustrated the sentencing process; and the eight week remand period proved to be impractical.

Following on from the Drug Diversionary Program, a second scheme, the Drug and Alcohol Court Assessment Program (DACAP), was introduced in a limited fashion in December 1979. This scheme took the form of ‘pre-sentence’ diversion, and provided two main services: the first was to prepare a pre-sentence assessment of the offender for use by the court; and the second was to present to the court referral recommendations when it was thought that placing a person in a particular treatment program may be a suitable sentencing option, if the offender him or herself was in agreement.

Initially, DACAP was to be a pilot research study confined to the Central Court of Petty Sessions and the Bourke Street Drug Advisory Service. However, before evaluation took place, the scheme was expanded in 1981 and became policy.²³ Despite the recommendation by a majority of the Drug and Alcohol Authority Standing Committee on Drug Diversion against the further expansion of the program in early 1985, an ad hoc committee was established (the DACAP Review Committee) which was in favour of expansion. In 1985 a Committee of Review into Drug and Alcohol Services in New South Wales was established at the request of the Premier. In considering whether to recommend the continuance and expansion of the DACAP scheme, the Committee examined the stated objectives of DACAP and the degree to which these had been met. The stated objectives of DACAP were:²⁴

- to provide relevant and reliable information to assist the magistrate in delivering

²² Bush R, *Drug and Alcohol Court Assessment Program (DACAP): Progress Report on Initial Year of Operation*, A81/1, NSW Drug and Alcohol Authority, 1981.

²³ *Final Report of the Committee of Review into Drug and Alcohol Services in New South Wales*, August 1985, op cit, p218.

²⁴ Ibid, pp219-220.

appropriate sentences;

- to assist individuals to make reasonable and informed choices about treatment options; and
- to provide information and make recommendations in the area of diversion programs.

The Committee concluded that:

The first objective derives from the complaints of magistrates in the 1970s that they were obliged to sentence drug users without any advice or information to assist them in knowing what would be appropriate for each offender. DACAP seems to have succeeded in satisfying this need.

The second objective is somewhat misleading in that it implied that DACAP is in some way designed to divert offenders into treatment. The only 'treatment' which was planned to form a part of the DACAP scheme is detoxification which necessarily takes place before assessment and sentence. Diversion in DACAP is not to treatment, but to assessment during the three week remand period between conviction and sentencing. Following conviction, should it be required by a judge or magistrate, an offender can be diverted for the purpose of an assessment, both to enable the client to make an informed decision about treatment options and provide independent information to the Court as an aid to appropriate sentencing. It requires a short remand on bail to allow the assessment to be completed and a report to the Court to be prepared. This is the model of diversion embodied in DACAP.

The literature reports very little success for treatment imposed by law ... The Committee was informed by a probation officer working in DACAP that probation and parole officers usually find difficulty in reconciling the conflict of their dual role as administrators of punishment (legal enforcement) and of help (treatment). Confidentiality is traditionally respected in a counselling situation or when private information is given by a client to an assessor. In DACAP the assessor writes a pre-sentence report for the Court using any information given in confidence.

It is unclear whether benefit is derived by offenders through DACAP. The remand period and the assessment add to the social control exerted on the individual. On the other hand, they may give the offender an opportunity to become more self-aware and to learn about what treatment programs exist, although this knowledge may be of little benefit if she or he must then pass several years in gaol.

The Committee ultimately recommended that DACAP be expanded and continue as a joint

program of the Department of Corrective Services and the Department of Health.

In 1992 the DACAP scheme was reviewed along with a number of other programs receiving funds from the Federal Government as part of the National Campaign Against Drug Abuse. One of the findings of this review was that as the Probation and Parole Service was doing more detailed pre-sentence reports, one of the original objectives of the DACAP program, namely the preparation of pre-sentence assessments had been supplanted. It was therefore considered the funding could be used more beneficially by introducing a program which would have a greater emphasis on treatment of the substance abuse problem. This program, the Drug and Alcohol Intervention Program (DAIP), was developed by the Probation and Parole Service in conjunction with the Department of Health and commenced in late 1995.

²⁵

The DAIP is an early intervention program which aims to educate offenders in minimising harm from alcohol and other drugs and to offer strategies for dealing with drug and/or alcohol related problems. It targets offenders who do not have a lengthy criminal history and who are not compulsive users of alcohol and other drugs. Offenders are assessed as to their suitability to participate in the program at the pre-sentence stage, and if deemed suitable, are placed on a recognizance which requires them: to be of good behaviour; to accept the supervision and guidance of the Probation and Parole Service; to attend and participate in DAIP and/or other such programs as deemed necessary; and to report within seven days. It is a short-term intensive program consisting of an eighteen hour, skills-based group work component followed by an intensive, short period of one to one supervision. Most offenders complete the entire program within a maximum of six months. According to the Department of Corrective Services 1996/97 Annual Report, the program now operates at nine locations throughout the State, and when it is fully developed there will be between six and eight program intakes of 30 to 40 offenders at each location every year.²⁶

A new diversionary approach is now being examined with the introduction of the first drug court at Parramatta (see pages 45-47 below).

(iii) Treatment Options

In this section of the paper the various treatment options available to the drug court when dealing with eligible offenders are discussed.²⁷ No attempt is made to suggest that one treatment is better than another, and it should be noted that as no single option will suit everyone, it is essential that a range of options be available. This point is made by Maguire

²⁵ Department of Corrective Services, *Annual Report 1994/95*, p25.

²⁶ Department of Corrective Services, *Annual Report 1996/97*, pp28-29.

²⁷ Unless otherwise indicated the details on the treatment options are taken from Heather N, Batey R, Saunders JB, and Wodak AD, *The Effectiveness of Treatment for Drug and Alcohol Problems: An Overview*, National Campaign Against Drug Abuse, Monograph Series No 11, AGPS, 1989, Chapter 4 - Treatment Approaches, pp47-85.

et al:²⁸

Fazey's 1992 study of a 'flexible' drug treatment regime suggests that certain approaches to treatment can retain patients and reduce criminal activity. She concludes that: As long as patients stay in treatment their criminal behaviour reduces, but whether they stay in treatment or not seems strongly related to the type of treatment they receive. If they do not see it as meeting their needs - even if the medical practitioner thinks that it does - then they vote with their feet, and go back to committing more crime to finance their street habit. Jarvis and Parker similarly suggest that 'the more flexible and 'user-friendly' the treatments offered are, the more likely it seems to be that young heroin users will come forward'.

The assumption that there is an automatic correlation between drug users receiving treatment and a reduction in crime, is also examined by Maguire et al through the presentation of findings from various studies on this relationship. They conclude:

If studies clearly and unequivocally showed that treatment results in decline in criminal activity, then the case for compulsory treatment would, no doubt, be put forward more frequently, and with more force. However the evidence does not provide such certainty. For example, in the Jarvis and Parker study, many users felt they were 'growing out of drugs' or were weary of 'hassle' from the police. Hence the reasons users were receiving treatment and the success of treatment outcomes (measured as less likelihood of using illicit sources of drugs or committing offences) may have less to do with treatment per se and more to do with personal biography and situation.

In summary, studies are by no means unanimous in their conclusions about the impact of treatment upon crime behaviour, suggesting that abstinence (generally the medically desired outcome) is achievable by some users while others find acceptance of such medical regimens to be too difficult, resulting in rejection of the 'therapeutic goals', possibly increased involvement in crime and a 'chaotic' lifestyle. Neither treatment per SE nor participation (voluntary or otherwise) in it is guaranteed to reduce criminal activity, although other studies offer more optimistic conclusions, albeit tentatively so, and some reviews offer strong support for methadone maintenance as effective in helping to reduce drug related crime and injecting.²⁹

However, it has become apparent from the research that: treatment can work as long as it is sustained and intensive; the most important factor in how successful the treatment will be

²⁸ Maguire M, Morgan R and Reiner R (eds), *Oxford Handbook of Criminology*, Clarendon Press, 1994, p416.

²⁹ *Oxford Handbook of Criminology*, ibid, p416.

is the length of time the offender remains in treatment; and the overall success rates of those voluntarily participating in a treatment programme as opposed to those whose participation was compulsory are not significantly different.³⁰

It is important to recognise that the treatment option chosen may be influenced by a person's particular philosophical approach. Essentially there are two dominant philosophies which underlie most forms of treatment: the first is the belief that the ultimate outcome is to achieve abstinence, and the second is that while abstinence is a desirable goal it may not be possible to achieve, therefore the aim should be to reduce or minimise the risk associated with illicit drug use. Bull describes the situation thus:³¹

The goals of treatment can be conceived of as a hierarchy of desirable outcomes with abstinence from illicit drug use at the top followed by a number of less desirable outcomes. In other words, if total abstinence is not feasible then a range of other options is possible ... For example, drug replacement therapies such as methadone maintenance programs have always seen safer, prescribed drug use as the less harmful alternative to illicit drug use.

a. Detoxification

Detoxification describes the physiological process of 'withdrawing' from the effects of a particular drug. It is not, in itself, a treatment option and without additional measures such as counselling, there is great degree of likelihood that relapse will occur. Detoxification may take place at home, in a detoxification unit or in a hospital ward. It may be undertaken either without any medication to assist the process; or with the aid of drugs which have similar actions to the substance to which dependence has developed. The detoxification process is described in *A Background Report on Heroin Use in Australia* as follows:

Withdrawal treatment (or 'detoxification') uses drugs to reduce the severity of these [withdrawal] symptoms by giving decreasing doses of methadone or other drugs over two weeks. Heroin dependent persons who abruptly stop using heroin experience distressing withdrawal symptoms. Withdrawal treatment does not produce enduring abstinence from heroin. Psychosocial interventions (eg support, counselling, crisis management, skills training) or maintenance drugs are usually necessary to assist a heroin dependent person to remain abstinent after withdrawal.³²

Detoxification can take from several hours to more than a week, and the length and severity

³⁰ Makkai T, 'Drug Courts: Issues and Perspectives', op cit, p2.

³¹ Bull M, *Comparative Analysis of Illicit Drug Strategy*, National Campaign Against Drug Abuse, Monograph Series No 18, AGPS, 1992, Chapter 3 - Treatment, p65.

³² Crosbie D, *A Background Report on Heroin Use in Australia*, Alcohol and other Drugs Council of Australia, October 1997, p11.

of the withdrawal syndrome cannot be predicted precisely since this is dependent on many factors such as the level and duration of use; the drug taken; the general health of the user; concomitant illness or traumatic conditions; and the environment in which the detoxification takes place.

b. Maintenance approaches

Substitution or maintenance approaches aim to stabilise a heroin dependent person by providing daily doses of a long acting, orally administered opioid drug such as methadone, to replace heroin which is injected, illegal and shorter acting. It provides the person with an opportunity to disengage from illicit heroin use and the drug subculture and to use other rehabilitation services such as counselling. Methadone and levo-alpha-acetylmethadol (LAAM) belong to the 'agonist' category of drugs, that is, they act at opiate receptor sites in the brain to induce a change in body function.

• Heroin maintenance

The question of providing heroin as a form of maintenance treatment has been widely debated, particularly in light of the proposal for a controlled trial by the ACT government, which was ultimately rejected by the Federal government in August 1997. Since this time calls for re-consideration of such a trial have come from various quarters including: the ACT Health Minister, Mr Moore; the Lord Mayors of Australia's capital cities; the NSW Director of Public Prosecutions, Mr Cowdrey QC; the Premier of Victoria, Mr Kennett; the South Australian Minister for Human Services, Mr Brown; the Victorian Commissioner of Police, Mr Comrie; the Australian Medical Association; and the West Australian branch of the National Party voted at its annual state conference in August 1998 to support a controlled trial of prescription heroin;³³. However, many people and organisations including: the Prime Minister, Mr Howard; both New South Wales Government and Opposition leaders, and the Salvation Army remain opposed. Underlying their concern is the belief that a more permissive approach 'may produce a worse outcome'³⁴ and that 'the introduction of a heroin trial would not send the right signal'.³⁵

There is some limited overseas experience of heroin maintenance.³⁶ In Britain up to the late 1960s heroin prescription was standard treatment for heroin dependence, however, a

³³ Mackey P, 'Alternative treatments for heroin addiction', *Current Issues Brief*, No 3, 1998/99, Commonwealth Parliamentary Library Information and Research Services, p14.

³⁴ 'Drug reformers lashed: Trial would put more heroin on streets, says Howard', *Sydney Morning Herald*, 13 February 1999.

³⁵ 'Howard lifts profile with drugs offensive', *The Australian*, 22 February 1999.

³⁶ In an article written for the *Sydney Morning Herald*, Dr Gabrielle Bammer, a senior fellow at the National Centre for Epidemiology and Population Health at the Australian National University, provides details from those countries examined as part of the four-year investigation culminating in the feasibility study for the controlled heroin trial. 'The jury is still out on the benefits of heroin trials', 23 February 1999.

number of doctors over-prescribed and a substantial black market was created. In an attempt to curb this, restrictions were introduced so that doctors had to be specially licensed to prescribe heroin. This situation continues in Britain, although methadone has become the treatment of choice following its introduction in the mid-60s. In Britain there are 109 doctors with licences to prescribe heroin, of whom 50 use those licences and about 20 account for the bulk of prescriptions. About 300 people receive heroin on prescription. In a survey of addiction specialists, half of the 105 respondents thought heroin prescription was justified sometimes or often.

Trials have been conducted in Switzerland where more than 1,000 dependent heroin users have received heroin prescriptions since 1994. The findings of these trials showed:³⁷

- before being prescribed heroin, 69% were earning money through illegal means but this dropped to 10% after 18 months of heroin prescription;
- participants' use of illegally obtained heroin also dropped substantially, as did their use of cocaine;
- there were marked improvements in overall physical and psychiatric health;
- employment rose from 14% to 32%;
- it cost about 50 Swiss francs (about \$50) a person a day to provide the treatment and it is estimated that 95 Swiss francs a day were saved by reducing crime and improving health, a net saving of 45 Swiss francs; and
- supervised heroin administration at clinics with restricted opening hours was feasible, as well as politically and socially acceptable. This result was replicated in 17 centres, and concerns about doses escalating out of control were not substantiated.

Despite the above, Dr Bammer outlines five reasons why the Swiss results are criticised: (i) not everyone was helped; (ii) heroin prescription was provided along with considerable social and psychological support and it is not possible to disentangle the benefits due to heroin prescription and those due to counselling and social assistance; (iii) the treatment is expensive; (iv) except for one small study in Geneva, there was no comparison group; and (v) only 8% of those participating had stopped using all forms of heroin (prescribed and illegal) after 18 months.

In relation to this last point Dr Bammer writes:

This final criticism warrants more discussion. Some would argue that achieving stability through heroin prescription should be the prime aim and

³⁷ Bammer G, 'The jury is still out on the benefits of heroin trials', *Sydney Morning Herald*, 23 February 1999.

that abstinence is less important. In this argument, heroin dependence is similar to diabetes where a cure is not possible, but maintenance treatment permits a fulfilling normal life. The problem with focusing on abstinence is that we have no good comparison figures, so we do not know whether the 8% should be a cause for celebration or dismay. There have been no well-designed independent evaluations of how many move to abstinence from other forms of treatment or for heroin users not in treatment.³⁸

Trials of legal prescription heroin have also received attention in other countries such as the Netherlands, Denmark, Luxembourg and Canada.

- **Methadone**

In 1985 the Australian Health Ministers Conference endorsed the development of national guidelines for methadone treatment, and in 1993 the Commonwealth, State and Territory Governments agreed that these guidelines should take the form of a National Policy. This policy promotes methadone maintenance, as distinct from methadone withdrawal, because it does not believe that a strategy based on withdrawal is likely to achieve the stated objectives of methadone treatment, namely the reduction of unsanctioned opioid and other drug use, improvement in the health of clients, reduction in the spread of infectious diseases such as HIV/AIDS and hepatitis B and C, reduction in deaths and in crime associated with illegal opioid use, and improvements in social functioning.³⁹ Research data suggests that methadone maintenance treatment results in a reduction of heroin use, crime and overdose deaths among treated heroin users.⁴⁰ The number of clients in methadone maintenance treatment has continued to rise in recent years and there remains a substantial unmet demand. In 1997 there were 11,400 people in methadone treatment in New South Wales, of whom approximately 30% were enrolled in public programs and 70% were treated by private prescribers.⁴¹

Although methadone maintenance is currently the most significant treatment program in New South Wales there are certain negative factors associated with it, not least of which has been the recent assertion that heroin addicts who undergo methadone treatment are almost seven times more likely to die during the first two weeks on it than those who do not take methadone.⁴² The explanation given for this is the difficulty in determining a safe and

³⁸ Bammer G, 'The jury is still out on the benefits of heroin trials', *Sydney Morning Herald*, 23 February 1999.

³⁹ Brown D et al, *Criminal Laws*, op cit, pp1097-98.

⁴⁰ Hall W, 'Methadone Maintenance Treatment as a Crime Control Measure', *Crime and Justice Bulletin*, No 29, NSW Bureau of Crime Statistics and Research, 1996.

⁴¹ Information provided by the NSW Health Department to the Joint Select Committee into Safe Injecting Rooms, referred to in the Committee's Report at p46.

⁴² Caplehorn J and Drummer O, 'Mortality associated with New South Wales methadone programs in 1994: lives lost and saved', *Medical Journal of Australia*, Vol 170 No 3, February 1999, pp104-108.

effective starting dose. The authors of the study of the 67 methadone-related deaths recommended that prescribers be made aware of the risks, signs and symptoms of methadone toxicity and be required to examine newly admitted patients every day for the first one to two weeks of maintenance.

- **LAAM**

The rationale behind LAAM therapy is similar to that for methadone treatment of opiate dependence, with LAAM having the advantage of being a longer acting substance (it lasts 48 to 72 hours) and therefore it needs to be given on a less frequent basis (three times a week). Two positive consequences of this are: that take-away doses are not required which means the risk of diversion to the street market can be prevented, and those receiving LAAM are afforded a greater degree of freedom to pursue non-drug related activities as they do not need the drug on a daily basis.

- **Naltrexone**

Naltrexone is an opioid ‘antagonist’ which means it severely attenuates or completely blocks the effects of heroin or other opioids by occupying the receptor site without producing a physiological effect. Tolerance does not develop to the opioid blocking effect of naltrexone, and no physical dependence is observed after repeated doses. The most commonly reported side effects are mild withdrawal like symptoms that typically occur during the first one to two weeks of treatment.

It is generally accepted that opioid antagonist therapy is most effective with those who are highly motivated and have a substantial amount of social stability. Several studies suggest that patients who are ‘successful’ in naltrexone treatment are those who are: involved in a meaningful relationship with a non-addict partner; employed full-time or attending a learning institution; and living with family members rather than with friends or alone.

The general consensus is that pharmacotherapy alone cannot be considered sufficient as a treatment. Opioid dependence is a complex phenomenon in which the actual pharmacological effect of the drug is only one component. Life style, psychological status and social stability are other important factors which must also be addressed. Naltrexone in combination with psychotherapy, family therapy or behaviour therapy may provide a useful adjunct to these other forms of treatment.

Given that the impact of naltrexone is almost immediate, to alleviate the unpleasant and painful symptoms commonly experienced during withdrawal such as nausea, diarrhoea, joint pain, and headaches, some doctors put the patient under general anaesthetic, or at least heavy sedation. The rationale is to get addicts through the worst of the withdrawal process (6 to 8 hours is usually enough) leaving them theoretically clean, with the naltrexone in place blocking both the effects of heroin and the patient’s craving for that drug. While the use of naltrexone in treatment addiction is not new, there has been a degree of controversy over its administration under anaesthetic or sedation to achieve ultra-rapid opiate detoxification (UROD). This is explained partly by the fact that while remote, there is always a risk

associated with anaesthesia, which means it should not be used lightly. More importantly UROD is a definite move away from accepted heroin treatments, which focusses more on the notion that heroin addiction is a medication condition, and not a behavioural problem. There are experts in the drug and alcohol field on both sides of this debate. Proponents of the treatment see it as offering addicts the possibility of getting through the unpleasant initial withdrawal stage and giving them control and choice. Those opposed accept that naltrexone used in this way accelerates withdrawal and prevents the physical side effects. However, they are more concerned with the long term effect as there is no firm evidence to suggest that used in this manner it keeps people off heroin in the long term. There is also a concern that if a patient stops using naltrexone and begins to use heroin again, there is an increased risk of a fatal heroin overdose because of a lower tolerance to opiates after treatment.

To help answer some of these questions, the New South Wales Government announced that a clinical trial of naltrexone in rapid-opiate detoxification would be undertaken⁴³ and two pilot studies were conducted in 1998 as the first stage of a two part trial. 40 patients at Sydney Hospital received naltrexone under sedation and 80 patients at Westmead Hospital were treated under anaesthetic. Data from this first stage of both trials will be compared before the government proceeds with the second stage of the trial, which involves a full randomised clinical trial of naltrexone among 560 drug addicts at Westmead Hospital. Preliminary data from stage one of the Sydney Hospital trial have been described as 'encouraging' by the NSW Minister for Health with 50% of heroin addicts off the drug after three months, and a further 40% of methadone users taking part in the trial abstaining after naltrexone treatment. The media accounts of the Westmead Hospital trial were not as encouraging. In November 1998 it was reported that an unreleased report prepared by the Department of Health showed that 36% of heroin addicts taking part in that trial had started using heroin again within 18 weeks. However, only 10% of methadone users taking part in the same program relapsed after 18 weeks.⁴⁴

Although the Federal Government announced recently that naltrexone would be available for general prescription by doctors, there still appears to be a division of opinion in the medical community as to its usefulness in treating opiate users as distinct from alcoholics.⁴⁵

- **Buprenorphine**

This drug has both agonist and antagonist properties, which means that while it has some

⁴³ Media Release, Hon R Carr MP, 'NSW Government to permit clinical trial of rapid-opiate detox - Naltrexone', 18 January 1998.

⁴⁴ 'Cure fails in 36% of drug cases', *Sydney Morning Herald*, 13 November 1998.

⁴⁵ Dr John Saunders, Professor of Alcohol and Drug Studies at the University of Queensland was reported as saying that naltrexone could potentially be suitable for 30% to 40% of alcoholics as opposed to 5% to 15% of heroin users. Dr Andrew Byrne, a general practitioner in Redfern who specialises in the treatment of addiction is reported as saying that his estimate is that naltrexone would be useful in only about 1% to 2% of opiate users. 'Drug 'cures some addicts': But naltrexone works better for alcoholics than those on opiates', *Sydney Morning Herald*, 5 February 1999.

of the effect of opiates, it also acts as a block, in a similar fashion to naltrexone. A recent study by the National Drug and Alcohol Research Centre found it to be as effective as methadone in suppressing heroin use and in keeping patients in treatment.⁴⁶ Moreover it has several advantages over methadone: it is safer, with no deaths from overdose recorded anywhere in the world; it can be taken every two days rather than daily like methadone; and withdrawing from buprenorphine is relatively easy. By comparison methadone is considered more addictive than heroin, making methadone withdrawal difficult.

At the Ministerial Council on Drugs Strategy meeting on 31 July 1997 approval was given for trials of naltrexone; LAAM; buprenorphine; slow release oral morphine; and tincture of opium to go ahead to determine their possible use in treatment for those addicted to heroin. According to Crosbie:

The trials of these agents will examine the comparative effectiveness and cost-effectiveness of the new and existing agents, and the best way to deliver these treatments in general practice and specialist clinics. If successful, these agents would expand the range of options from which doctors and patients could choose, thereby increasing the chances of success ... LAAM is a long acting form of methadone (opioid agonist) that can be taken three times per week instead of daily. It reduces the need for daily attendance [at a clinic], enabling the person to lead a more normal life. Buprenorphine is safer than methadone in terms of overdose risk, it produces fewer withdrawal symptoms and like LAAM, it can be given three times a week. Slow release morphine and tincture of opium may appeal to patient groups who find existing maintenance options unattractive. Oral morphine is widely used to manage chronic pain and may also be of use for heroin dependence. Tincture of opium is used in Asia for withdrawal and maintenance. It may appeal to heroin dependent persons from an Indo-Chinese background.⁴⁷

The table below⁴⁸ gives an overview of recent developments in each State and Territory, indicating which trials have received or are expected to receive funding, and indicating where other initiatives such as drug courts or safe injecting rooms are under consideration. A national evaluation of the trials is to be undertaken by the National Drug and Alcohol Research Centre which is expected to report in 2001.

⁴⁶ 'Drug simplifies heroin therapy', *The Australian*, 9 November 1998.

⁴⁷ Crosbie D, *A Background Report on Heroin Use in Australia*, op cit, p12.

⁴⁸ Mackey P, 'Alternative treatments for heroin addiction', op cit, p7.

	NSW	VIC	SA	QLD	WA	ACT	TAS	NT
Naltrexone	✓	✓	✓	✓	✓	✓		
Buprenorphine	✓	✓	✓			✓		
LAAM		✓	✓					
Slow Release Oral Morphine		✓						
Tincture of opium			✓					
Methadone	✓	✓	✓	✓	✓	✓	✓	
Drug Court	✓							
Legal Injecting Rooms	Rejected by State Govt - under consideration by South Sydney Council	Under consideration by councils				Proposal put forward by the Minister for Health		

c. Other treatment options

• Behavioural treatments

The behavioural approach aims to bring about a change in a person's drug taking behaviour which can be maintained. Various treatment methods that have been shown to be effective include aversion therapy, covert sensitisation, contingency management, relaxation training, systematic desensitisation, social skills training, and relapse prevention. However, the application of cognitive behavioural methods tends to be used more in treating alcohol addiction rather than other addictive disorders.

• Psychotherapeutic approaches

The literature on the psychological treatment of opiate dependence is fraught with controversy and contradiction and suffers from a dearth of carefully designed clinical trials. However, some argue that psychotherapy may be an important adjunct to pharmacological treatment, and for people for whom pharmacological treatments are not suitable it provides an alternative treatment option.

Therapeutic community programs are designed to restructure an individual's approach to life and to alter attitudes towards drug taking. Therapeutic communities are based on the belief that drug users have a disordered life style which needs to be addressed in a formal way and they direct particular attention towards re-socialising the individual. Theoretically, therapeutic communities provide an ideal approach to the management of the disorganised

lifestyle of the dependent individual. However, practically, therapeutic communities are often unattractive to many individuals who have become dependent on drugs because of the seemingly extreme necessity of removing oneself from the larger community environment. Within a program there is always a daily regime designed to direct the individual in ways quite different from the usual daily activities involved in drug seeking. The elements of the regime include: community enhancement; therapeutic educative activities; counselling; community clinical management; and activities based on privileges which reward adaptive behaviours with sanctions to correct continuing abnormal behaviour. Treatment in a therapeutic community does not include any chemical agents except when medically or psychiatrically prescribed.

Studies have shown that the outcome in therapeutic communities is directly related to the length of stay and that a person with a shorter drug using history and family or social support mechanisms is more likely to do well in a therapeutic community.

- **Self-help groups**

A number of self help groups have developed in recent years in the drug and alcohol field, for example Narcotics Anonymous (NA), which are derived from the original model of Alcoholics Anonymous (AA) and apply the same philosophical approaches to particular populations. It is probably more accurate to describe what these groups have to offer as a new way of life rather than treatment, and a source of help which is continuous over time and far more readily accessible. However, conducting research on the effectiveness of these groups is difficult because the anonymity factor prevents the keeping of records.

Conclusion

In general all of the major treatment options discussed above can be shown to have some positive effects on clients in terms of drug use, criminality, employment and other aspects of social functioning. Programs with flexible policies and a case-management approach that includes provisions of social psychological services are usually found to be more effective than more rigid approaches, and for most types of programs, time spent in treatment increases the likelihood of positive long term outcomes.

One thing is clear, however, that regardless of the treatment option chosen, a place and/or a service needs to be available. A survey conducted in 1998 of the major non-government drug treatment centres found that approximately 11,680 people would seek admission to drug and alcohol clinics in the year. Of these, 3392 would be admitted to treatment, while 4796 people who need treatment would be turned away, mainly because of a severe shortage of places. The balance of cases are not considered serious enough to warrant admission for treatment.⁴⁹ And the Chair of the Prime Minister's Australian National Council on Drugs,

⁴⁹ The survey was carried out by the Council of Social Service of New South Wales (NCOSS) and sought comment on unmet need for alcohol and other drug services from a broad cross-section of community organisations in NSW, the majority of whom receive government funding from either the Department of Community Services, the Ageing and Disability

Major Brian Watters, said the Salvation Army turned more than 25 addicts away from the 120 bed William Booth Drug and Alcohol Rehabilitation Centre in Surry Hills every week because there was no room.⁵⁰

(iv) Safe injecting rooms

One of the recommendations made by Commissioner Wood in the Final Report on the Royal Commission into the New South Wales Police Service was that ‘consideration be given to the establishment of safe, sanitary injecting rooms under the licence or supervision of the Department of Health, and to amendment of the *Drug Misuse and Trafficking Act 1985* accordingly’.⁵¹ The New South Wales Parliament responded by establishing a Joint Select Committee to examine the issue. In its Report tabled in February 1998, the six members of the Committee in the majority recommended that the establishment or trial not proceed.⁵² Reasons for this recommendation included: safety concerns associated with administering and operating injecting rooms; the impact on the local community; increased crime risks associated with injecting rooms; the impact on attitudes to drug use; and the question of resource allocation.

The arguments in favour of holding a trial held by the four members of the Committee who were in the minority included: the potential to reduce fatal overdoses and the transmission of blood-borne viral infections; the possible reduction in the public nuisance aspects of injecting drug use such as the discarding of needles and syringes in public places; the potential to reduce the social and economic costs to the community of injecting drug use; the reduction in opportunities for police corruption; and the provision of a valuable point of contact with the most marginalised of drug users.

Since the tabling of the New South Wales Joint Select Committee Report, the question of trialling safe injecting rooms has been mooted by a diverse range of people: a group of 10 Melbourne city mayors, including Melbourne’s Lord Mayor, have signed a co-operative plan of action to combat illegal drugs in their cities and communities, the Inaugural Metropolitan Mayors Statement on Drugs,⁵³ the New South Wales Director of Public Prosecutions, Mr

Department of NSW Health. ‘Drug centres overwhelmed by demand’, *Sydney Morning Herald*, 8 October 1998.

⁵⁰ ‘Full house: Salvos turn away needy’, *Daily Telegraph*, 28 October 1998.

⁵¹ The Royal Commission into the New South Wales Police Service, *Final Report, Vol II: Reform*, p226.

⁵² *Report on the Establishment or Trial of Safe Injecting Rooms*, Joint Select Committee into Safe Injecting Rooms, New South Wales Parliament, February 1998.

⁵³ ‘Mayors back heroin trial and injecting rooms’, *Connexions*, Vol 19 No 1, February/March 1999, p30.

Cowdrey QC;⁵⁴ the Mayor of South Sydney council, Mr Smith,⁵⁵ the charity Open Family Australia;⁵⁶ and the Premier of Victoria, Mr Kennett.⁵⁷

4 DESCRIPTION OF THE DRUG COURT

The drug courts in the United States provide the model for the New South Wales drug court.

(i) United States experience to date⁵⁸

Background: The focus of the first US drug courts established in the 1970s was on case management, with felony drug cases being assigned to separate courts to facilitate the processing of these matters and to free up judges in other courts to deal with non-drug related offences. The aim of the drug courts was to deal promptly with such cases, and to ensure punishment was handed down more quickly. In the 1980s a number of factors combined to bring about a change in the focus of the drug courts to concentrate more on altering an offender's behaviour through means such as including treatment for the addiction problem, drug testing, community supervision and traditional sanctions for non-compliance. These factors included:

- Unprecedented levels of drug-related crime;
- Increasing numbers of drug users;
- Increasing rates of incarceration;
- Prison overcrowding;
- High recidivism rates among drug abusers;
- Increasing workloads on the courts; and
- Continued public pressure to do something

The first drug court to adopt the new approach commenced in Dade County, Miami, Florida in 1989. Two important differences from the earlier 'case processing' drug courts were that

⁵⁴ 'Chief prosecutor blasts MPs' zeal for law and order', *Sydney Morning Herald*, 24 February 1999.

⁵⁵ 'Campaign for legal heroin injecting rooms', *Sydney Morning Herald*, 25 June 1998.

⁵⁶ 'Kennett supports shooting galleries', *Sydney Morning Herald*, 26 February 1999.

⁵⁷ *Ibid.*

⁵⁸ The information in this section is taken from Makkai T, 'Drug Courts: Issues and Perspectives', *op cit.*

the sentencing judge, rather than a probation officer monitored the offender's progress; and offenders could stay in the program even if they violated its conditions of participation. By 1997 there were over 200 drug courts operating in the United States, and 11 of the 52 states had enacted or had under consideration legislation to enable the establishment of such facilities.

Objectives: The goals of drug courts can be divided into treatment goals and criminal justice goals. The most important treatment goals are:⁵⁹

- to improve the rate of abstinence among drug abusers compared with traditional approaches;
- to improve the capabilities of drug court clients to function in society;
- to create the situation in which, when relapses occur, they occur with less frequency and with longer periods of sobriety; and
- to provide clients with employment, education and life skills.

If the treatment goals outlined above are able to be realized, it is more likely that the general goals of the criminal justice system will be met. These goals are:

- to reduce the level of criminal activity related to drug abuse;
- to reduce recidivism rates of drug offenders;
- to reduce the impact on jails by reducing the percentage of non-violent drug offenders who are incarcerated;
- to reduce the number of offenders failing to appear for trials, sentencing and probation supervision;
- to improve the caseload of the trial courts; and
- to achieve meaningful cost savings within the entire criminal justice system.

Key components: As no two drug courts are alike the National Association of Drug Court Professionals Drug Court Standards Committee has identified ten key components 'for developing effective drug courts in vastly different jurisdictions and to provide a structure for conducting research and evaluation for program accountability.'⁶⁰ These are"

⁵⁹ Brown J, 'Drug diversion courts: Are they needed and will they succeed in breaking the cycle of drug-related crime?', *New England Journal on Criminal and Civil Confinement*, Vol 23 No 1, Winter 1997, pp63-99.

⁶⁰ Makkai T, 'Drug Courts: Issues and Perspectives', op cit.

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- Alcohol and other drug treatment services need to be integrated with the justice system case processing.
 - Prosecution and defence counsel need to work together to promote public safety while safeguarding the participant's due process rights.
 - Participants are identified early and promptly placed in a treatment program.
 - There needs to be access to a continuum of alcohol, drug and other related treatment and rehabilitation services.
 - Abstinence should be monitored by frequent drug testing.
 - Co-ordinated strategy governs drug court responses to participant's compliance.
 - Ongoing judicial interaction with each drug court participant is essential.
 - Monitoring and evaluation to measure the achievement of program goals and assess effectiveness.
 - Continuing interdisciplinary education promotes effective drug court planning, implementation and operations; and
 - Partnerships between drug courts, public agencies and community based organisations is essential for generating local support and enhancing drug court effectiveness.

(ii) Achievements of United States drug courts ⁶¹

In this section outcomes under the traditional adjudication process (court conviction and jail sentence) and those under the drug court system are compared.

- **Reduction in drug use**

Traditional Adjudication Process: Drug Use Forecasting data collected on defendants in 23 cities in the United States in 1996 indicated that 51% to 83% of arrested males and 41% to 84% of arrested females were under the influence of at least one illicit drug at the time of arrest. ⁶² Under the traditional adjudication process, defendants convicted of drug offences are either sentenced to a period of incarceration or referred for probation supervision, with

⁶¹ The information in the following section is taken from *Looking at a Decade of Drug Courts* prepared by the Drug Court Clearinghouse and Technical Assistance Project, American University, 1 May 1998, attached as an Appendix to a paper entitled 'Drug Courts: A proven success' prepared by Ross Goodridge for a conference in July 1998.

⁶² *Drug Use Forecasting: Annual Report on Adult and Juvenile Arrestees*, US Department of Justice, National Institute of Justice, 1996 referred to in *Looking at a Decade of Drug Courts*.

few jurisdictions requiring frequent drug testing to monitor drug use after conviction. Jurisdictions that do have the capacity to monitor find significant drug usage rates, but are not able to respond promptly to a positive test.

Few jails or prisons provide any comprehensive treatment services for inmates, and none provide any long-term rehabilitation support once the defendant is released. In jurisdictions that require, as a condition of probation, completion of a treatment program, there is generally no monitoring of whether defendants who complete such programs actually cease or reduce their use of drugs. This situation, coupled with available recidivism data, has led many justice system officials to conclude that the traditional case disposition process lacks the capacity to bring about any significant reduction in drug usage by persons convicted of drug offences.

Drug Court Experience: Because drug court programs test defendants for drug use on a regular basis (usually at least weekly), information regarding drug use by defendants under drug court supervision is available and known to the court on an ongoing basis, and is responded to with appropriate sanctions. Consequently, the drug use of defendants participating in drug court programs is substantially reduced and significantly lower than that reported for non-drug court defendants, and for participants who graduate from the programs (ranging from 50% to 65%) is eliminated altogether.

- **Reduction in Recidivism**

Traditional Adjudication Process: It has been estimated that at least 45% of defendants convicted of drug possession will recidivate with a similar offence within 2 to 3 years. The more frequently a defendant has been arrested for a drug offence, the more likely he or she is to recidivate. A high percentage of defendants convicted of drug possession are also arrested for property offences during the period when they are using illicit substances, and a substantial percentage have either committed violent offences or are considered likely to do so particularly as their addiction progresses.

Drug Court Experience: In comparison, drug court programs are experiencing a significant reduction in recidivism among participants. Depending upon the characteristics of the population targeted and the degree of social dysfunction (employment status, family situation, medical condition etc), recidivism among all drug court participants has ranged between 5% and 28% and less than 4% for graduates. The drastic reduction in drug use by drug court participants, and the consequent reduction in criminal activity associated with drug use, is confirmed by urinalysis reports for drug court defendants that are usually well over 90% negative.

- **Intensive supervision**

Traditional Adjudication Process: The supervision of defendants released before trial usually consists of a weekly call-in and periodic reporting period (usually 60 to 120 or more days following arrest); after conviction, supervision usually consists of monthly reporting to a probation officer. Urinalysis is generally conducted only periodically and treatment

services provided only if available. The court's involvement occurs only when probation violations are reported, generally when new crimes are committed. Bench warrants may be issued for defendants who fail to appear for court hearings, but their actual execution (eg the defendant's arrest) may not occur for months, and is often triggered only by a new arrest.

Drug Court Experience: Defendant supervision and monitoring, as well as treatment services, in all of the drug court programs are significantly more immediate and intensive than would have been provided to the typical drug court defendant before the program began. Drug court defendants come under the court's supervision very shortly after arrest, and throughout a typical 12 to 15 month period are required to attend treatment sessions, undergo frequent and random urinalysis, and appear before the drug court judge on a regular and frequent basis. Almost all of the drug courts have instituted procedures for immediate execution of bench warrants (often within hours) for defendants who fail to appear at any court hearing.

- **Capacity to Promptly Address Relapse and Its Consequences**

Traditional Adjudication Process: It is particularly common for defendants on probation for drug offences to fail to comply with probation conditions entailing attendance at treatment programs or abstinence from drug use. Frequently, their failure to comply is evidenced by a new arrest for a drug or drug related offence, generally becoming known to the justice system months after the defendant's drug use has resumed, if it has ever ceased in the first place. This new arrest usually triggers: a probation violation hearing, which generally results in imposition of the original sentence suspended when the defendant was placed on probation; and conviction for the new offence, often resulting in an additional sentence of incarceration. It is common for this cycle to continue indefinitely once the defendant is released, with an enhanced incarceration sentence imposed each time to reflect the defendant's lengthening criminal history. At least 40% of offenders incarcerated in 1995 were imprisoned for drug or drug related offences and more than 60% of the correctional population had substance abuse problems.⁶³

Drug Court Experience: Recognizing that substance addiction is a chronic and recurring disorder, the drug court program maintains continuous supervision over the recovery process of each participant, through frequent court status hearings, urinalysis, and reports from the treatment providers to the supervising judge. Drug usage or failures to comply with other conditions of the drug court program are detected and responded to promptly.

Immediate responses, such as enhanced treatment services, more frequent urinalysis (daily, if necessary), imposition of community service requirements and 'shock' incarceration, are some of the options drug court judges use to respond to program noncompliance. In appropriate situations particularly where public safety is at issue or participants wilfully fail to comply with program conditions, they are terminated from the drug court and referred

⁶³ *A National Report: Drugs, Crime and the Justice System*, US Department of Justice, Bureau of Justice Statistics, 1995, referred to in *Looking at a Decade of Drug Courts*.

for traditional adjudication, and standard penalties are applied.

- **Integration of Drug Treatment with Other Rehabilitation Services**

Traditional Adjudication Process: Although there are strong correlations between drug abuse and other attributes of social dysfunction exhibited by drug users, such as poor reading skills, dysfunctional family relationships, and low self esteem, most courts do not address these problems when sentencing drug using offenders. At best they *refer* them to a treatment program and/or a special skills class, with no regular monitoring of their participation or its results.

Drug Court Experience: In contrast, a fundamental premise of the drug court approach is that cessation of drug abuse requires not only well structured treatment services but co-ordinated and comprehensive programs of other rehabilitation services to address the underlying personal problems of the drug user, and promote his or her long-term re-entry into society. While sobriety is a primary objective of the drug court program, no participant can successfully complete the program without also addressing needs relating to his/her long-term rehabilitation. As noted earlier, in addition to sobriety, most drug courts require participants to obtain a high school or equivalent certificate; obtain or maintain employment; and develop mentor relationships within the community to sustain them after they leave the drug court program.

Summary results: the first decade ⁶⁴

The following section outlines a summary of results observed over the first decade of drug court operations in the United States.

- **Retention rates**

‘Completion rates’ and ‘retention rates’ are indicators commonly used to measure the impact of drug court programs. ‘Completion rates’ refer to individuals who completed, or were favourably discharged from, a drug court program as a percentage of the total number admitted and not still enrolled. This measure is an indicator of the extent to which offenders successfully complete their drug court program requirements. ‘Retention rates’ refer to individuals who are currently active participants in, or have successfully completed, a drug court program as a percentage of the total number admitted. This measure is an indicator of the extent to which a program has been successful at graduating or retaining offenders as active program participants in the program. Although inter-related both measures are helpful in assessing program performance. A program that had been operating consistently over a longer period of time would be expected to have similar completion and retention

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Looking at a Decade of Drug Courts, op cit.

rates.⁶⁵

Programs report high participant retention rates. Despite their rigorous requirements drug court programs are retaining a significant percentage of the defendants enrolled, and consequently, are having a more significant impact on participants' lives than traditional pre-trial and/or probation supervision. Data from the 200 oldest drug courts reflect an average retention rate of more than 70% (the total graduates plus active participants), despite the difficult populations that most programs target. These retention rates can be contrasted with the significantly lower rates generally acknowledged for traditional drug treatment programs dealing with criminal defendants, with slightly higher rates for individuals not involved with the criminal justice process.

It has also been noted that in many cases, defendants may be terminated from a drug court program because they fail to meet the stringent requirements imposed by the court but, have nevertheless made significant progress in terms of reducing drug use and improving their employment status, educational development, and family relationships.

- **The Nature and Extent of Addiction**

The nature and extent of addiction among drug court participants varies widely but generally tends to be severe. Most drug court participants, even first offenders, appear to have significant histories of substance addiction, frequently 15 or more years.

- **Judicial Supervision**

Participants note judges' supervision, coupled with drug court treatment services and strict monitoring, is the key to their success. More than 25% of the respondents had been in at least one treatment program during the previous 3 years which they had left unsuccessfully.

- **Cost-Effectiveness**

The average cost for the treatment component of a drug court program ranges between \$US1200 and \$US3000 per participant, depending upon the range of services provided. Savings in jail bed days alone have been estimated to be at least \$US5000 per defendant, which does not factor in the value of the added capability to incarcerate the more serious offenders that many jurisdictions are also deriving from these programs.

Similarly prosecutors are reporting that the drug court programs have reduced police overtime and other witness costs, as well as grand jury expenses for those jurisdictions with an indictment process, that would otherwise be required if these cases proceeded in the traditional manner. Most programs also report that a substantial percentage of the

⁶⁵ *Drug Courts: Overview of Growth, Characteristics and Results*, Report to the Committee on the Judiciary, US Senate and the Committee on the Judiciary, House of Representatives, United States General Accounting Office, July 1997, p50 found on the Internet at: <http://www.gao.gov/AIndexFY97/abstracts/gg97106.htm>.

participants who came into the program unemployed and on public assistance have become employed while in the program and are now self-supporting. In addition, many participants who are employed at the time of program entry are able to maintain their employment, despite their arrest because of their program participation.

- **Benefits for Families and Children**

Approximately 2/3 of the drug court participants are parents of minor children. Many of these parents have lost or are in danger of losing custody of their children because of their drug use. Drug court participation has resulted in many of these litigants' retaining or regaining custody upon completing the drug court. More than 500 drug free babies have been reported born to female drug court participants while enrolled in drug court programs, thus obviating the substantial medical and social service costs (estimated at a minimum of \$US250,000 per baby) required to care for a drug-addicted infant, let alone the resultant societal impact. Almost all drug courts provide family counselling and at least half provide aid with housing, food, and clothing. Most also provide day care while participants attend treatment.

- **Criminal Justice Resources**

Criminal justice resources are freed up for violent and other serious criminal cases. Staff and services, which have up to now been consumed by the less serious but time consuming drug cases now targeted for drug court assignment, can be directed to more serious cases and to those offenders who present greater risks to community safety. The caseloads assumed by the drug court judges have also freed up other judges' docket time for other criminal matters as well as civil cases which, in many jurisdictions, have been given second priority because of the drug caseload. In jurisdictions where jail space has been freed up, this space is now being used to house more serious offenders or to assure that they serve their full sentences.

- **Benefits to Prosecutors and Police**

Prosecutors and police in many jurisdictions report that the drug court has significantly enhanced the credibility of the law enforcement function, provided their agencies with a more effective response to substance abuse and is a significant alternative to the 'revolving door' syndrome which frequently results from the traditional case process. Defendants are no longer released back into the community, and back to using drugs, shortly after arrest but, rather, placed in a rigorous, court supervised treatment program that carries an important message to the community regarding the seriousness of illegal drug use. A recent poll of 318 police chiefs found that almost 60% advocate court supervised treatment programs over other justice system options for drug users.⁶⁶ In a number of jurisdictions, prosecutor and/or police agencies have contributed asset forfeiture funds to the local drug court and have campaigned with the judiciary for community support.

⁶⁶ *Drugs and Crime Across America: Police Chiefs Speak Out*, Police Foundation and Drug Strategies, 1996, referred to in *Looking at a Decade of Drug Courts*.

Highlights of National Drug Court Survey Findings

The 1997 Drug Court Survey Report recently published by the Office of Justice Programs Drug Court Clearinghouse and Technical Assistance Project at American University provides a comparative profile of the 95 oldest drug court programs. The following are the most salient observations that emerge from that survey:

- **Program growth**

The number of drug courts, in both the planning and operational stages of development, tripled during 1997.

- **Primary services being provided**

Physical and Mental Health Services: Drug courts are providing a range of physical and mental health services to participants, as well as substance-abuse treatment. Almost all of the drug courts provide public health services including HIV and TB screening and referral. Many programs provide special services for dually diagnosed participants who have mental health problems, frequently as a result of their substance abuse. A number of drug courts routinely utilize the services of a physician and/or nurse.

Education, Job Training, Employment, and Other Rehabilitation Services: The range of treatment and rehabilitation services being delivered by drug courts is expanding significantly. Many of the early drug courts focused primarily upon treatment services, with ancillary support for education, job training and placement. Most of these early drug courts, and their numerous progeny, have expanded their treatment and rehabilitation services significantly, recognizing the diversity of both treatment and other needs presented by the drug court populations. The expanded services being developed also reflect, in large part, a growing recognition that the drug court must treat not only the participants' addiction but the numerous associated personal problems most participants encounter, (physical, mental, housing, family, employment, self-esteem etc) if long term sobriety and rehabilitation is to be achieved and future criminal activity is to be significantly reduced. Many of the treatment program components, for example, are developing differentiated 'tracks' to address the diversity of drug court clients' treatment needs. Special components are also being developed for the specific ethnic and/or cultural groups represented and other 'special populations' including pregnant women, mothers, fathers, persons who have been sexually abused and others.

- **Offenders Targeted: Focus on Long-Term Drug Users**

Drug courts are increasingly targeting the chronic recidivists as well as first offenders. Many drug courts that began as pre-trial diversion programs are expanding their focus to target individuals with more extensive criminal histories who require the rigid supervision and monitoring of the drug court and can benefit from the treatment and rehabilitation services provided. Less than 20% of presently operating drug courts restrict their services to first offenders. Although generally not eligible for diversion because of their more extensive

criminal history, defendants with more extensive criminal histories are generally offered some incentive to complete the drug court, such as suspension of a jail term, or a reduction in the period of their probation. Most programs report that participants are presenting moderate to severe crack/cocaine addiction with other drug usage and alcohol addiction as well. Approximately 60% of the programs routinely test for alcohol consumption as well as illegal drug use. All of the drug courts either prohibit or strongly discourage the use of alcohol by drug court participants.

- **Who is the Drug Court Client ?**

More than 90,000 individuals have enrolled in drug courts to date and approximately 70% have graduated or are still participating. A profile of 256 drug court participants in the final phase of 55 drug courts in 23 states and other data reported by operating programs indicated the following:

Participant enrolment and performance: significantly more males than females are enrolling in drug court programs; where day care, special women's groups and other special services are offered, females are graduating at a higher rate than their male counterparts; and for voluntary programs, a high percentage of defendants offered the opportunity to participate in the drug court accept it despite its more rigorous requirements compared with the traditional sanction to which they are exposed.

Participant demographics: the average age of drug court participants is generally over 30; the average age of graduates in individual programs is often older than the average age for all participants in the program. The majority of participants both male (56%) and female (41%) are single.

Drug usage of participants: Most drug court participants have been using drugs for at least 15 years, and generally much longer. Most are using multiple illegal drugs at the time of program entry, and are also using alcohol. Some have also abused prescription drugs. Approximately 1/4 of drug court participants have participated unsuccessfully in at least one, and often more, prior treatment programs, and many drug court participants have served time in prison for prior drug offences.

Educational status of participants: Almost all of the drug court programs require a high school certificate or equivalent in order to graduate.

Children of participants: Many drug court participants are parents. About 60% of the 256 drug court participants surveyed were parents of minor children, many of whom were in foster care at the time the parent entered the drug court.

- **Participant Retention**

The retention rates for drug courts remain high, generally between 65% and 85%, despite: the difficult populations most programs are targeting; the rigid participation requirements of these programs; the recent proliferation of drug court programs; and their expansion to

more complex caseloads.

The proliferation of drug courts also does not appear to have had any negative impact on the high retention rates (total graduates plus active participants divided by total number ever enrolled) experienced by early programs. Moreover, retention rates do not appear to decrease as the period of program operation lengthens.

The retention rates also do not appear to be influenced by the population size of the jurisdiction served. Drug courts in large metropolitan areas appear to retain participants at a rate similar to drug courts in smaller jurisdictions with populations under 200,000 and in rural areas.

- **Impacts being achieved**

Recidivism: Recidivism rates continue to be significantly reduced for graduates as well as for individuals who do not complete the program. These rates continue to range between 2% and 20%, depending upon the characteristics of the population targeted. Most of the recidivism reported involves new drug possession charges or traffic violations arising out of driving licence suspensions resulting from the initial drug court charge.

Drug use: Drug usage, as measured by the percent of negative urine samples for drug court participants during frequent, random urinalyses, is being reduced for most participants, not just graduates, despite the substantial drug usage of these defendants when entering the drug court.

Justice System Cost Savings: Drug courts are continuing to achieve cost savings for the justice system, particularly in the use of jail space and probation services. A number of jurisdictions report reducing and/or more efficiently using jail space and probation services as a result of the drug court, which frees up these resources so that they can focus on other offenders who present greater public safety risks. Savings are also reported in prosecutor and law enforcement functions, particularly in regard to court appearance costs. All sectors of the justice system have also noted 'cost avoidance' results from the reduced recidivism of drug court participants and graduates.

Employment for Participants: Many individuals participating in the drug court are able either to retain their jobs or to obtain employment as a result of drug court participation. While a small percentage of drug court participants have steady jobs at the time of program entry, a substantial number (generally more than 65%) are unemployed or employed on a sporadic basis. Many of the individuals who are employed at the time of program entry report that they were able to retain employment by demonstrating participation in the drug court, and a high proportion of unemployed individuals obtain employment while enrolled. A number of drug courts have a job counsellor on site dedicated to working with drug court participants. Almost all of the drug courts provide vocational training and job development services. Many judges also work with local employers to personally guarantee daily supervision of persons they employ in order for them to either retain or obtain employment.

Long Term Sobriety: Drug courts are developing close working relationships with a broad base of community organisations to promote the long term sobriety and rehabilitation of participants. Through both community networks and involvement with the local Alcohol Anonymous and Narcotics Anonymous groups, participants are often linked with community mentors shortly after entering the drug court. Drug courts are also developing close working relationships with local chambers of commerce, medical providers, community service organisations, the local educational system, the religious community, and other local institutions to provide a broad-based network of essential services that can be drawn upon to serve the needs of drug court participants.

Alumni Groups: Drug court graduates are forming alumni groups and serving as mentors for new participants in many jurisdictions.

Family Reunification and Other Family Services: Drug courts are resulting in family reunification in many instances. In many programs, parents who have lost custody or may lose custody of their children because of their drug use have regained it upon completion of the drug court program. Drug courts are providing a wide array of family services. Almost all of the drug courts provide family counselling and at least half provide assistance with housing, food and clothing. Most of the programs also provide parenting classes, including special segments on stress and anger management

Birth of Drug Free Babies: Birth of drug free babies is an unplanned program impact

- **Other Justice System Benefits**

Support from Law Enforcement Agencies: Increased collaboration is developing among drug courts and law enforcement agencies. Many drug courts are developing close relationships with local law enforcement agencies and community policing activities. Much effort is being made by drug court judges to explain the drug court process to line officers who are generally the arresting officers in many drug court cases. The police department in one drug court jurisdiction (New Haven), for example, has assigned an officer full-time to the drug court to assist with monitoring and supervising participants and to immediately execute bench warrants for any participants who fail to appear in court or are otherwise in non-compliance with drug court orders. A number of drug courts provide arresting officers with updated information on the progress of their arrestees in the drug court, and many drug courts invite the arresting officer to participants' graduation ceremonies.

Adaptation of the Drug Court Model to Other Justice System Initiatives: Many jurisdictions are adapting the adult drug court model to juvenile populations and family matters. Using the adult drug court model of intensive, ongoing judicial supervision and the development of a structured system of sanctions and rewards, juvenile and family drug courts are focusing on both delinquency cases and dependency matters. There is also increasing recognition among the adult drug court judges that children and other family members who live with an adult substance abuser are at particular risk of becoming substance involved. Consequently a number of adult drug courts are developing special prevention oriented components for children and other family members of adult drug court participants, whether or not they are

already involved with the adult or juvenile justice system.

Evaluation

The question of evaluation is critical. Despite many studies and reports on the position in the United States which claim some or all of the positive outcomes referred to above, a number of influential commentators have stated that the thoroughness of the evaluations is questionable.

Under the *Violent Crime Control and Law Enforcement Act* of 1994, which authorizes the award of federal grants for drug court programs in the United States, the General Accounting Office (GAO) is required to assess the effectiveness and impact of these grants and report to Congress. To assist Congress in its deliberations on whether to fund drug court programs, the GAO provided a preliminary report in May 1995.⁶⁷ In response to the legislative mandate and discussions with the Senate and House Judiciary Committees a further report was prepared in July 1997 which examined: (i) the funding for drug courts; (2) their approaches, characteristics and completion and retention rates; (3) the extent to which program and participant data are maintained and used to manage and evaluate drug courts; and (4) the results of their review and synthesis of existing published and unpublished evaluations or assessments of drug court programs regarding the impact of such programs.⁶⁸

One of the findings of the 1997 report was that existing evaluations provide some limited information but do not permit firm conclusions regarding drug court impact to be drawn. The report states on page 15 that:

... the GAO continues to believe it is essential to emphasize that there are shortcomings associated with many of the evaluations of drug court programs that have been done, and thus there are good reasons for withholding final judgement until more and better data are collected and additional studies are completed.

And concludes that:

A substantial number of evaluation studies of drug court programs have been done. However, due to the newness of the programs at the time of the evaluations; the diversity in the programs at the time of the evaluations; the diversity in the programs; and the differences and limitations in the objectives, scopes and methodologies of these studies, we cannot draw any firm conclusions from our evaluation synthesis on the overall impact/effectiveness of drug courts. For the same reasons, we cannot reach

⁶⁷ *Drug Courts: Information on a New Approach to Address Drug-Related Crime*, GAO/GGD-95--159BR, May 22, 1995 found on the Internet via the Government Accounting Office archival catalogue's access search page at: <http://www.gao.gov/reports.htm>.

⁶⁸ *Drug Courts: Overview of Growth, Characteristics and Results*, op cit.

firm conclusions about specific aspects of drug court programs or specific questions about program participants. The studies ... showed varied results about the impact of drug court programs ... some studies showed positive effects of the drug court programs during the period offenders participated in them, while others showed no effects, or effects that were mixed, and difficult to interpret. Similarly some programs showed positive effects for offenders after completing the programs, while others showed no effects, or small and insignificant effects. Drug relapse was less frequently evaluated in these studies than rearrests, and estimates of relapse rates varied substantially. None of the studies, however, showed any adverse effect from participation in the drug treatment program.

... some variation in the results of these studies might be due to the differences in how the studies were conducted. It is also possible, however, that variation in results across different drug court programs may result from the fact that drug court programs target different populations, operate differently, and some are more successful in producing positive outcomes than others. We believe, that until follow-up data on relapse and criminal recidivism for participants and non-participants are collected across a broad range of programs, it will not be possible to respond to issues raised by Congress and others or to reach firm conclusions about whether drug court programs work, or whether some work better than others. With such data, and additional data on program operations and treatment characteristics, researchers would be in a better position to rigorously analyse how drug court program outcomes are affected by participant and program characteristics.

... we recognize the difficulties inherent in collecting follow-up data on criminal recidivism and particularly drug relapse, as well as comparable data on non-participants. Drug court program participants and comparable non-participants, may move to other jurisdictions following the completion of the program, or after completing their sentence, and may be difficult to follow. Neither group can be expected to volunteer for drug tests to determine relapse after they have left the court's purview, and arrests for new drug offenses are fallible measures of drug relapse (since not all drug offenses or criminal offenses generally result in arrests) just as arrests are fallible indicators of criminal recidivism in general.⁶⁹

The impact on recidivism rates in those appearing before drug courts was a feature of a study conducted by Belenko et al in 1993, which found that:⁷⁰

⁶⁹ *Drug Courts: Overview of Growth, Characteristics and Results*, op cit, pp85-86.

⁷⁰ Belenko S, Fagan J, and Dumanovsky T, 'The Effects of Legal Sanctions on Recidivism in Special Drug Courts', *The Justice System Journal*, Vol 17 No 1, 1994, pp53-81.

While a number of special drug courts have emerged over the past three years, little is known about their long-term effects on defendant behaviour. Whatever the primary objective of a specific drug court, however, recidivism is an important measure of program effect. This is especially true if drug court cases receive shorter incarceration or more probation sentences, thereby increasing time at risk. Recidivism rates for drug offences and other offences over a two year period were compared for offenders adjudicated in New York City's fast-track drug courts and those processed through standard means, controlling for sanction severity and offence and offender characteristics. Few significant differences in recidivism prevalence or rates, or reconviction or reincarceration rates, were found.

Similar concerns have been expressed by Australian experts working in the drug and alcohol field. Peter Connie, the Executive Director of the NSW Network of Alcohol and other Drugs Agencies commented: ⁷¹

Of some surprise to me when I commenced looking at the US information is the lack of evaluation of that country's programs. While the Australian media reports phenomenal success rates by the American programs their official reports indicate that little or no formal evaluation exists ... Certainly any initiative commenced in NSW will need to have a rigorous evaluation component.

It would appear from the Debate on the Drug Court Bill that the question of evaluation has been considered in some detail.

... this pilot project will have a comprehensive and ongoing evaluation by the New South Wales Bureau of Crime Statistics and Research and it will consist of three separate and combined studies, the first of which will be a comparison of the treatment and control groups and their cost effectiveness in reducing re-offending. The second will be a monitoring study whereby data on the operation of the program will be collected on an ongoing basis and quarterly reports will be produced. A third study will measure changes in indicators of health and social functioning over the course of the program for a sample of 150 drug court participants. ⁷²

(iii) Implementation issues in the New South Wales context

Despite the positive outcomes said to have been achieved in the United States, and the bipartisan support for the drug court initiative when the Bill was introduced in the New South Wales Parliament, a number of implementation issues remain to be clarified. Makkai

⁷¹ Connie P, 'Innovative Drug Courts still face some hurdles', *Connexions*, Oct/Nov 1998, p27.

⁷² Hon A Corbett MLC, *NSWPD*, Legislative Council, 25 November 1998, p10595.

refers to the following potential problems in establishing drug courts to which policy makers should pay attention:⁷³

- The drug court needs to be integrated into a range of government and non-government agencies in order to provide treatment and other support services such as employment, training, counselling and mental health services.
- The role of the judge, magistrate or presiding officer needs to be reassessed as they can no longer remain a neutral arbiter of the legal process given their aim is to cure the offender. In addition the judge, the prosecutor and the defence lawyer need to work together to achieve the best outcome for the client's and the community's wellbeing.
- The drug court will occasionally impose a tougher sentence on the offender than if they had progressed through the traditional court process. The prosecutor and the defence need to collaborate to ensure that both the community's and the individual's wellbeing takes primacy.
- Treatment oriented courts signal a radical shift in the role of courts. No longer are they simply adjudicative institutions but they also have a legitimate role in shaping policy with respect to social problems that impact on the court's effectiveness as an institution.
- Treatment agencies traditionally were only concerned with reducing drug dependence, while the court is concerned to reduce criminal behaviour that is often driven by drug dependence. The court needs to be sensitive to the tensions between these outcomes.
- The means used to select clients will differ between treatment agencies and the court. The court will use the type of offence and prior record in making a decision, this is irrelevant to treatment agencies.
- There is also a practical problem in making the distinction between users and dealers. Often users will deal in drugs as a way of making enough money to purchase more drugs, and by excluding dealers, many users will be excluded from the drug court. Given the real world of drug users, those who are eligible for drug courts must include all offenders who are also drug dependent that the courts are prepared to divert
- If the court focus is on 'first time drug offenders', it is more likely that such offenders would tend to be marijuana users. Given the community's ambivalent view on marijuana, namely that it is seen by some as a 'soft' drug and in a different light to 'hard' drugs like heroin or cocaine, offenders, particularly young persons are less likely to participate in diversionary programs or be willing to enter

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Makkai T, 'Drug Courts: Issues and Perspectives', op cit, p7.

treatment.

- There is a possibility of net-widening with changes in police practices. Focusing on repeat offenders rather than first time offenders will diminish greatly this possibility.
- The question arises as to whether non-drug using offenders would have lower recidivism rates if placed in a structured and intensive style of court that provides the same support services. If the answer is yes, the issue of equity arises.
- Alcohol related disorder is a significant problem in Australia. Illicit drugs cannot be considered without including alcohol in the treatment regime. Two-thirds of drug courts surveyed in the US reported 'moderate to severe alcoholism' amongst their clients.
- Given that many offenders begin their criminal and drug using careers at a relatively young age, drug courts need to incorporate juveniles into the program; and
- To enable proper evaluation of drug courts to be carried out, policy makers need to be clear about what is being measured, and what research measures are being employed, before the drug court begins operation.

General concerns: In relation to the treatment options available to the drug courts Mr Connie raised the following: ⁷⁴

- The question of informed consent in relation to a court determining that a person be put into a methadone maintenance program and the associated legal and ethical issues about mandating people to ingest a psychotropic substance.
- In many areas methadone capacity is saturated, thus access is also an issue.
- Surveys of residential services reveal minimal capacity and the move to primary health care models means area health services now provide little extended case work services.
- Feedback from non-government treatment providers indicates they have difficulty engaging mandated clients, with many reporting retention rates as low as 10% of referrals from probation and corrections services.
- A number of providers have commented that they are reluctant to displace voluntary clients, who are likely to be motivated for treatment, for people who are mandated to attend.
- Non-government organisation managers fear that a rapid, non-consultative and under resourced implementation of the drug courts initiative will lead to further

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Connie P, 'Innovative Drug Courts still face some hurdles', op cit.

pressure on already insufficient treatment resources.

- Assessment and referral of offenders to treatment is a concern for them. Managers cite the difficulty they have experienced in the past accepting people that have been assessed externally to their program. It is unlikely that many providers will be prepared to take clients based on an assessment by the drug court staff, unless some agency assessment is in place.

Redfern Legal Centre commented on several aspects of the proposed drug court's operations. These included:⁷⁵

- The interference in the therapeutic alliance between treating practitioner and patient.
- Not all people who use drugs are 'dependent'.⁷⁶ However, non-dependent drug users will be encouraged to plead dependence or to 'get a habit' in order to gain access to what some may believe to be a more enlightened review of their case by the drug court.
- There is already an existing shortage of services for people with drug and alcohol problems and the drug courts will be in competition for these places. This may have the effect of encouraging people to commit crimes to gain access to limited treatment places through the drug court or denying access to people who seek therapeutic assistance but are not criminals.
- The judiciary requires extensive education in the area of drug use, dependency, treatment and harm reduction but they do not require a new court to enable them to separate out illicit drug dependence issues from the other areas of their social and community responsibility.
- The proposal has particular risks of increasing the amount of coercion and compulsion in the health system rather than increasing the amount of health considerations in the criminal justice system.

The following points emerged during the Debate on the Drug Court Bill:

- Given that it is already possible in New South Wales for the courts to divert people with substance abuse problems who appear before them, it could be argued that it is a waste of valuable resources to set up a new court when the money could be channelled into expanding treatment services. Similarly Dr Wodak, the Director of

⁷⁵ Information provided by the Redfern Legal Centre to Hon R Jones MLC, *NSWPD*, Legislative Council, 25 November 1998, p10585.

⁷⁶ 'Dependent' use is defined as: 'Where use is persistent, frequent and involves high doses, producing psychological and physiological dependence such that the user cannot discontinue without experiencing significant mental or physical distress' Schafer R, *Drug Use in America: Second Report of the National Commission on Marijuana and Drug Use*, US Government Printing Office, Washington DC, 1979.

the Drug and Alcohol Service at St Vincent's Hospital, stated:⁷⁷

There are many warnings that drug courts may not turn out to be the long desired leap forward. There have been previous attempts in Australia to blend drug treatment with law enforcement. The NSW Drug and Alcohol Court Assessment Program in the 1980s was one of many less than successful attempts. Any 'success' of the drug courts in the United States is a direct result of closer supervision of drug treatment and related services. We could provide this closer supervision in Australia without the expense of setting up the new court system.

- The drug court will only be successful if an adequate treatment program is available and there is already evidence to suggest that funding of drug and alcohol treatment services is falling. In its August 1998 Report, *Drugs, Money and Governments 1996/97*, the Alcohol and Other Drugs Council of Australia stated that the New South Wales government cut spending on drug and alcohol services by \$2.13 million from 1995/96 to 1996/97, with funding per head dropping from \$7.06 to \$6.60. Reference to the requirement for sufficient resources was made by many speakers during the Debate including the following comment by Mr A Fraser MP, the Chairman of the National Party committee on drug issues: 'I support the Drug Court Bill but I do so cautiously because I do not believe the necessary resources are in place to provide the rehabilitation and detoxification programs needed to make the project work'.⁷⁸
- The apparent success of the drug court program in many places in the United States may have been attributable to the fact that informal diversionary schemes were not available in the traditional courts. Speaking in the Debate the Hon J Ryan MLC said:

I wish to raise a matter which is not dealt with in the Bill but which I believe should be. As I understand it, there are already facilities to divert people from the courts. Many people addicted to drugs and alcohol present in court, usually through an advocate, asking to be bailed to a detoxification or rehabilitation facility before returning to the magistrate or judge for appropriate action. To some extent what the bill formally sets in train is already operating informally. Many places in the United States where drug courts were seen to be useful did not previously have an informal scheme in place. I do not expect a dramatic reduction in drug crimes, because the bill will only formalise something that already informally operates fairly

⁷⁷ 'Let's learn from the Swiss on drugs', Dr A Wodak, *Sydney Morning Herald*, 8 September 1998.

⁷⁸ NSWPD, Legislative Assembly, 10 November 1998, p9540.

extensively.⁷⁹

- A recent survey by NCOSS⁸⁰ showed that there is already a large gap in the availability of specialist drug and alcohol services across the State. Approximately one third of those seeking access to residential alcohol and other drug facilities gain entry, the remaining two-thirds are declined admission. Given the paucity of treatment programs and services, the Drug Court may impact greatly on the voluntary treatment sector.
- Thought has to be given to what arrangements will be made for people originally from rural and regional New South Wales, who wish to leave Sydney to return to their family support networks in light of the lack of drug treatment services in these areas. Although the drug court is located in Parramatta, it would be inappropriate for offenders to stay in the western Sydney region if their family and friends are elsewhere.
- The issue of accreditation of drug treatment programs and facilities to ensure an appropriate standard is met.

Makkai concludes in her paper that drug courts:⁸¹

- have had successes but will not produce a success every time and careful judgements need to be made about acceptable failure rates;
- are more intrusive for offenders than a conviction or short sentence;
- are more expensive than traditional courts but when all the related costs (imprisonment and the cost of re-offending) are taken into consideration they could ultimately be much cheaper;⁸² and
- face implementation challenges integrating criminal justice and treatment agencies, co-operative arrangements between judge, prosecutor and defence, and achieving objectives broader than those of the criminal justice system

⁷⁹ NSWPD, Legislative Council, 26 November 1998, p10814.

⁸⁰ *Survey on unmet need for alcohol and other drug related services*, op cit.

⁸¹ Makkai T, 'Drug Courts: Issues and Perspectives', op cit.

⁸² The cost to society of law enforcement related to illicit drugs was estimated at more than \$450.6 million. Of this, \$156 million was for State and Territory police, the National Crime Authority, the Australian Federal Police and the Australian Customs Service. \$230.5 million was for the prison system and \$64.1 million was funding for the court system. Thus more than half the tangible costs related to administering and operating the prison and court systems. Collins DJ and Lapsley HM, *The Social Costs of Drug Abuse in Australia in 1988 and 1992*, Monograph No 30, National Drug Strategy, AGPS, 1996.

(iv) The New South Wales Drug Court⁸³

A dedicated drug court has been established at the Parramatta District Court to handle only cases involving non-violent offenders over the age of 18, who are dependent on illicit drugs, and are most likely to be facing a prison sentence. Potential candidates for the program are referred to this court as quickly as possible after first appearing before any court on a charge. The eligibility of these offenders is then assessed by a specially constituted drug court screening team, made up of the drug court judge and officers from the Office of the Director of Public Prosecutions; Legal Aid Commission of NSW; Attorney General's Department; Department of Corrective Services (Probation and Parole); Department of Health (Corrections Health Service); and the NSW Police Service and an appropriate treatment program is determined.

To be accepted into the program offenders must plead guilty and meet certain other criteria over and above eligibility. For example, a person needs to be allocated a treatment place and agree to abide by the program conditions including the possibility of imprisonment as a sanction for breaches. If accepted into the program, an offender's sentence is suspended for the duration of his or her compliance with the program. The drug court judge has been given considerable discretion in dealing with the sentence of offenders on the basis of their progression through the program. For example, where the offender has made little effort towards rehabilitation, an offender's sentence may be fully reinstated upon the person being thrown off the program. At the other extreme, a sentence may be wiped clean if a person graduates after successful completion of the demanding rehabilitation program. Between these extremes, the judge may also adjust the sentence as appropriate. If not accepted into the program, the drug court may deal with a person if he or she consents. Otherwise, the drug court must refer the person back to the referring court.

The drug court will have an unfettered discretion whether to accept persons into the program. No appeal will lie against a decision not to accept a person, who might otherwise be eligible. The program will also provide a range of treatment options and support services for drug-dependent offenders.

The drug court program aims to: reduce the level of criminal activity resulting from illicit drug dependency; improve the health and social functioning of the offender; and stop the offender from using illicit drugs while participating in the program. To achieve these aims a range of treatment options including detoxification, residential rehabilitation, outpatient counselling, methadone and naltrexone will be made available. Supervision will be provided by officers of the Probation and Parole Service, who will play a key role in taking offenders through the program. This will involve, where appropriate, organising for the offender to attend educational, vocational, counselling and developmental programs. Probation and parole officers will liaise with registered employment agencies to broker access to jobs or job start programs for offenders where possible.

⁸³

Details in this section are taken from the Second Reading speech to the Drug Court Bill given by the Hon R Dyer MLC on behalf of the Attorney General, *NSWPD*, Legislative Council, 25 November 1998, p10575.

An offender's progress through the program will largely be evaluated by objective criteria, such as attendance at court and drug testing. The frequency of appearance before the Court will vary across phases and according to an offender's progression through the program. Similarly urine tests will be carried out to detect illicit drug use, this will decrease in regularity as a person progresses through the program. Participants' progress will be monitored by the drug court team, and regular appearances before the drug court judge will be required. Breaches of the program will be met with immediate sanctions including the possibility of imprisonment.

The program, which commenced on 9 February at Parramatta District Court, is to run as a two year pilot and will be thoroughly evaluated by the Bureau of Crime Statistics and Research to determine the cost effectiveness of this approach compared with other more traditional sentencing options.

It is clear from the second reading speech to the drug court bill that the program as currently laid out is not immutable but capable of expansion, fine-tuning and improvement in light of the day to day experience, and the evaluation of the trial period:⁸⁴

The bill can best be described as framework legislation. It sets out the broad parameters within which the drug court program will operate. In such an innovative and untried program, this approach allows for maximum flexibility and the ongoing refinement of the program as necessary.

The New South Wales Coalition is reported as planning to trial three drug rehabilitation jails in Sydney, the Hunter region and country New South Wales in spare prisons or 'secure hospital settings' if it wins the upcoming State election.⁸⁵ Convicted non-violent prisoners would volunteer for the scheme and courts could use the Custodial Drug Treatment Programs as a sentencing option. However, methadone maintenance would not be a treatment option. In making the announcement the Opposition's spokeswoman on Health, Mrs J Skinner MP, is reported as saying:

This is about making people drug-free, so methadone will not be included. It will be run as a medical model with a comprehensive range of services including drug rehabilitation, other healthcare, counselling and support, programs to develop life skills and with access to education and training.⁸⁶

5 CONCLUSION

The extent of the illicit drug problem confronting our community necessitates, it could be

⁸⁴ Hon R Dyer MLC, *NSWPD*, Legislative Council, 25 November 1998, p10576.

⁸⁵ 'Liberals' cold-turkey jail for addicts', *Sydney Morning Herald*, 19 February 1999.

⁸⁶ 'Drug offenders could be sentenced to hospital ward', *The Australian*, 19 February 1999.

argued, experimentation with innovative approaches such as the dedicated drug court at Parramatta. It is by investigating the utility of such alternative measures that possible gains and benefits may be identified. This point was made by the Reverend the Hon F Nile MLC during the debate on the drug court Bill:

The drug court program will be introduced over a trial period. It is difficult to assess a program unless it undergoes a trial. I do not believe the establishment of a drug court program is making any concessions to the drug problems we have in our State. It is an honest attempt to determine if it is a viable way to deal with them. If the program does not succeed, if it does not achieve its objectives, the government of the day, whether Labor or Coalition, may modify the program or abolish it.⁸⁷

The results of the two year trial will permit those responsible for the implementation of public policy to determine whether drug courts are part of the answer to the problem, and whether additional drug courts should be set up.