

TASMANIA
LAW REFORM
INSTITUTE

**Responding to the Problem of Recidivist
Drink Drivers**

FINAL REPORT NO 24

APRIL 2018

Contents

| | |
|---|-----------|
| Information about the Tasmania Law Reform Institute | vi |
| Background to this Final Report | vi |
| List of Recommendations | viii |
| Executive summary | xii |
| Part 1: Introduction | 1 |
| 1.1 Background to this report | 1 |
| 1.2 Overview of the Final Report | 4 |
| Part 2: Why is a Specialist Response Necessary for Recidivist Drink Drivers? | 5 |
| 2.2 Community safety | 5 |
| The drink driving problem | 5 |
| Harm caused by drink driving | 8 |
| Repeat drink drivers | 11 |
| 2.3 Characteristics of recidivist drink driving offenders | 12 |
| Socio-demographic characteristics | 12 |
| Co-morbidity | 13 |
| Attitudinal factors | 15 |
| Criminal history | 16 |
| Repeat drink driving and unlicensed driving | 17 |
| 2.4 Inadequacy of current responses to repeat drink drivers | 18 |
| Current sentencing regime | 18 |
| Sentencing drink drivers | 22 |
| Programs available for drink drivers | 23 |
| Why doesn't the current sentencing approach work? | 25 |
| Part 3: Solution-Oriented Responses to Repeat Drink Driving | 36 |
| 3.1 Solution-oriented courts and therapeutic jurisprudence | 36 |
| 3.2 Driving while intoxicated courts/lists | 39 |
| Best practice for DWI Courts | 39 |
| Advantages and disadvantages of DWI courts | 41 |
| Effectiveness of DWI Courts | 41 |
| 3.3 'Swift, certain and fair' approaches to drink driving | 44 |
| HOPE project | 45 |
| South Dakota 24/7 program | 46 |
| The Northern Territory COMMIT Program | 47 |
| Effectiveness of SCF approaches | 47 |
| Other criticisms of SCF approaches | 48 |

| | | |
|-----|---|-----------|
| 3.4 | An alternative approach for Tasmania: A DWI list | 49 |
| | Consultations – views and issues..... | 49 |
| | Recommendations..... | 51 |
| | Part 4: A Preliminary Model for a DWI List in Tasmania | 53 |
| 4.1 | The target audience and eligibility criteria..... | 53 |
| | Position in other jurisdictions | 53 |
| | What does the evidence say? | 55 |
| | Consultations – views and issues..... | 57 |
| | Recommendations..... | 59 |
| 4.2 | Structure of the DWI list: Pre- or post-sentence model | 61 |
| | Position in other jurisdictions | 61 |
| | What does the evidence say? | 63 |
| | Consultations – views and issues..... | 69 |
| | Recommendations..... | 72 |
| 4.3 | The conditions of the order | 74 |
| | Position in other jurisdictions | 74 |
| | What does the evidence say? | 76 |
| | Consultations – views and issues..... | 77 |
| | Recommendations..... | 78 |
| 4.4 | The referral and assessment process | 79 |
| | Position in other jurisdictions | 79 |
| | What does the evidence say? | 81 |
| | Consultations – views and issues..... | 82 |
| | Recommendations..... | 82 |
| 4.5 | Services that need to be available as part of treatment and rehabilitation..... | 83 |
| | Position in other jurisdictions | 83 |
| | What does the evidence say? | 84 |
| | Consultations – views and issues..... | 85 |
| | Recommendations..... | 87 |
| 4.6 | Program phases | 88 |
| | Position in other jurisdictions | 88 |
| | What does the evidence say? | 90 |
| | Consultations – views and issues..... | 90 |
| | Recommendations..... | 91 |
| 4.7 | Supervision and judicial monitoring | 91 |
| | Position in other jurisdictions | 91 |
| | What does the evidence say? | 94 |

| | |
|---|-----|
| Consultations – views and issues..... | 96 |
| Recommendations..... | 97 |
| 4.8 Evaluation | 101 |
| Best practice | 101 |
| Position in other jurisdictions | 102 |
| Consultations – views and issues..... | 103 |
| Recommendations..... | 104 |
| 4.9 Sustainability, resources and funding..... | 104 |
| Position in other jurisdictions | 104 |
| What does the evidence say? | 106 |
| Consultations – views and issues..... | 106 |
| Recommendations..... | 107 |
| Appendix A: Survey of responses to drink driving..... | 108 |
| Appendix B: TLRI/TILES study | 113 |

Information about the Tasmania Law Reform Institute

The Tasmania Law Reform Institute was established on 23 July 2001 by agreement between the Government of the State of Tasmania, the University of Tasmania and the Law Society of Tasmania. The creation of the Institute was part of a Partnership Agreement between the University and the State Government signed in 2000. The Institute is based at the Sandy Bay campus of the University of Tasmania within the Faculty of Law. The Institute undertakes law reform work and research on topics proposed by the Government, the community, the University and the Institute itself. At the time that this report was concluded, the Institute's Director was Ms Terese Henning of the University of Tasmania. The members of the Board of the Institute were Ms Terese Henning (Chair), Professor Gino Dal Pont (Acting Dean of the Faculty of Law at the University of Tasmania), the Honourable Helen Wood (appointed by the Honourable Chief Justice of Tasmania), Dr Jeremy Prichard (appointed by the Council of the University), Ms Kristy Bourne (appointed by the Attorney General) Mr Craig Mackie (nominated by the Tasmanian Bar Association), Ms Ann Hughes (appointed at the invitation of the Institute Board as a community representative), Mr Rohan Foon (appointed by the Law Society of Tasmania) and Ms Kim Baumeler (appointed at the invitation of the Institute Board).

Background to this Final Report

In September 2013, the Tasmanian Institute of Law Enforcement Studies (TILES) and the University of Tasmania's Faculty of Law organised an international workshop intended to map pathways in addressing the issue of recidivist drink drivers. One of the main issues identified by key stakeholders was the poor fit of some criminal justice responses to instances of repeat drink driving. As a consequence of the issues arising from the workshop, the TLRI obtained funding from the Solicitor's Guarantee Fund to examine non-traditional responses to repeat drink driving. The TLRI and TILES also obtained a grant from the Motor Accident Insurance Board (MAIB) Injury Prevention and Management Foundation to construct a profile of recidivist drink driving offenders in Tasmania through an examination of records held by the Magistrates Court, Community Corrections and Tasmania Police.

The TLRI released an Issues Paper in May 2017, *Responding to the Problem of Recidivist Drink Drivers*, Issues Paper No 23, with a call for submissions by 17 August 2017. The Institute received 10 written responses to the Issues Paper:

- Damien Minehan, Georgina O'Donnell and Grant Blake, ForensicClinic Consulting Pty Ltd
- Benedict Bartl, Policy Officer, Community Legal Centres Tasmania (CLC Tas)
- Alcohol, Tobacco and other Drug Council Tasmania Inc (ATDC)
- Foundation for Alcohol Research and Education (FARE)
- Gerald Waters, Research Director, Researching Impaired Driving in New Zealand
- Vivian Hoy, community member
- Brian Hinson, community member
- James Crotty, Barrister and Solicitor
- Holyoake Tasmania Inc (Holyoake)
- Daryl Coates SC, Director of Public Prosecutions

The TLRI also conducted a series of consultations with key stakeholders from the justice and health sectors.

The TLRI thanks all those who responded or met with the TLRI. The TLRI also thanks Judge Tremewan from the Alcohol and Other Drug Treatment Court in New Zealand for her assistance and the information provided by the Ministry of Justice, New Zealand.

The Final Report is available at the Institute's website at <http://www.utas.edu.au/law-reform/> or can be sent to you by mail or email.

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List of Recommendations

Recommendations (p 52)

1. That a Drug Treatment (DWI) order be developed in Tasmania.
2. That a pilot Drug Treatment (DWI) order be established, supported by a Reference Group with representatives from the Magistrates Court, Police Prosecution Services, the Department of Health and Human Services, the Department of State Growth, Community Corrections, Legal Aid, service providers and the Law Society Criminal Law Committee.

Recommendations (p 61)

3. The eligibility criteria should specify that an offender is eligible to be allocated to the Drug Treatment (DWI) order if:
 - the court is satisfied on the balance of probabilities that the offender has an alcohol use disorder and the offender's underlying alcohol use contributed to the commission of the offence;
 - the offender is charged with a third or subsequent drink driving offence;
 - the court would have sentenced the offender to a term of imprisonment;
 - the court is satisfied in all the circumstances that it is appropriate to do so;
 - the court is satisfied that the facilities likely to be used for the assessment and treatment special conditions to be imposed are reasonably accessible to the offender;
 - the court has received and considered the Drug Treatment (DWI) order assessment report on the offender; and
 - the offender agrees in writing to the making of the order and to comply with the conditions of the order.
4. Offenders with any particular criminal history should not be excluded if they were otherwise eligible.
5. Other mental health conditions should be a factor taken into account in assessing suitability but this should not preclude participation in the Drug Treatment (DWI) order.

Recommendations (p 73)

6. The DWI model should be a post-sentence model using an amended drug treatment order as the sentencing order to underpin the Drug Treatment (DWI) order. Accordingly, the order should consist of a term of imprisonment which is not activated. This term would be the same length as if the court had not made the order. The order should also have a treatment and supervision component which operates for up to two years.
7. The provisions for a DTO in the *Sentencing Act 1997* (Tas) should be amended to accommodate DWI offenders and to enable the order to operate as a Drug Treatment (DWI) order within the current CMD list of the Magistrates Court.

Recommendations (p 79)

8. In structuring the order, the core condition and special conditions that are available under an amended DTO will allow the Drug Treatment (DWI) order to be tailored to meet offenders' rehabilitative needs.

9. The court should impose a condition that relates to driving, with it being made clear that there is a requirement that there be no driving in the absence of a legal driver's licence.
10. An alcohol ban should be mandatory, at least in phase one of the order. However, the transition from alcohol use to abstinence should be implemented under appropriate medical supervision, and include supervised detoxification programs. The court should have a discretion to allow an offender to resume the consumption of alcohol if this is considered appropriate by treatment providers.

Recommendations (p 83)

11. Referrals for the Drug Treatment (DWI) order should be able to be made by the prosecution, defence, Tasmania Police and magistrates.
12. A dual stage screening and assessment process should be adopted.
13. Screening should be undertaken using a screening assessment tool developed to inform the process to ensure consistency in decision-making between magistrates and to identify potentially eligible offenders based on a review of legal eligibility criteria, a preliminary assessment of dependency and a risk of reoffending assessment.
14. It is important that any offender who meets the screening eligibility criteria and wishes to participate in the DWI list program should be referred for a suitability assessment to determine his or her suitability for specific treatment types and levels of service intensity.
15. The requirements of a drug treatment assessment order contained in the *Sentencing Act 1997* (Tas) s 27D(2) should provide the basis for the suitability assessment for DWI offenders. However, feedback should be sought from suitable experts in relation to the appropriateness of the existing criteria to assess the eligibility of DWI offenders.
16. The assessment should be conducted by experienced and appropriately qualified health practitioners.

Recommendations (p 88)

17. Individual drug treatment plans should be developed by suitably qualified and trained personnel working within a specialist alcohol and other drug service.
18. Drug treatment location, length, setting and modality should be decided based on clinical indications and best-practice principles in the provision of alcohol treatment.
19. Treatment services should be provided predominantly from within a health framework and there should be scope for services to be provided by government and non-government service providers.
20. There should be a coordinated approach to the provision of treatment services through case management, as well as access (where appropriate) to evidence-based treatment programs that address all of an offender's criminogenic needs.
21. It is necessary to address the funding requirements created by any expansion in demand for community-based programs arising from a Drug Treatment (DWI) order addressing the issue of alcohol abuse and other treatment services.

Recommendations (p 91)

22. The Drug Treatment (DWI) order should adopt a three-phase approach (stabilisation, rehabilitation and reintegration) with each phase having clear objectives and expectations that need to be met in relation to behavioural change.
23. These criteria can be based on the criteria for the DTO and can be developed by the Reference Group in consultation with stakeholders in the development of the DWI pilot.

Recommendations (p 100)

24. The Drug Treatment (DWI) order pilot should be supported by a DWI team that comprises a multidisciplinary group of professionals with representatives from the court, community corrections, health, legal aid and the police.
25. Judicial officers will play a key role in the Drug Treatment (DWI) order participants' successful involvement in the programs. Specialist therapeutic magistrates who have a good understanding of addictions and a genuine interest in therapeutic jurisprudence should therefore be appointed. The TLRI recognises that there is already expertise of this kind among Tasmanian magistrates, and that the Drug Treatment (DWI) order could be accommodated within the existing therapeutic framework of the court.
26. Participants need to understand the consequences of non-compliance, and breaches need to be followed up promptly with sanctions swiftly imposed.
27. There needs to be consistency in the views expressed by the DWI team members about responses to non-compliance that reflect the policy and philosophy about the use of sanctions and rewards.
28. There should be a focus on rewards and acknowledgement of progress rather than an overly punitive approach focusing on punishment for non-compliance.
29. The schedule of sanctions and rewards can be based on the existing structure for the DTO order and should be settled by the Reference Group in the development of the Drug Treatment (DWI) order pilot.
30. Consideration should be given to a review of the penalty structure for drink driving offences, in particular access to restricted licences and better integration of the driver interlock scheme with the criminal justice response. This should be considered in consultation with key stakeholders, including Tasmania Police and the Department of State Growth.
31. The alcohol ban needs to be effectively monitored by frequent and random testing.

Recommendations (p 104)

32. The Drug Treatment (DWI) order pilot should be monitored, evaluated and be open to modification in response to the evaluative findings.
33. The legislative objectives of the Drug Treatment (DWI) order should include to:
 - facilitate the rehabilitation of offenders by providing a judicially-supervised, therapeutically-oriented, integrated alcohol treatment and supervision regime;
 - reduce the level of criminal activity associated with alcohol use disorder, in particular drink driving; and
 - reduce risks to offenders' health and well-being.

Recommendations (p 107)

34. The Drug Treatment (DWI) order should have a legislative basis.
35. Appropriate additional resources should be allocated to agencies that support the operation of the Drug Treatment (DWI) order.
36. A Steering Group, with representation from relevant key government agencies, should be established to provide strategic oversight of the Drug Treatment (DWI) order pilot and its implementation.
37. A Community Advisory Group representing a diverse range of relevant interests should be established to promote community engagement in, and to provide support for, the operation of the Drug Treatment (DWI) order.

Executive summary

This Final Report addresses the complex problem of recidivist drink driving in Tasmania and proposes an innovative solution through the establishment of a Drug Treatment (DWI) order. The report examines the deficiencies of the current criminal justice system approaches to repeat drink driving in Tasmania. It considers the application of non-traditional criminal justice responses to the problem of recidivist drink driving, and recommends a therapeutic jurisprudential approach as the best model for achieving behavioural and attitudinal change. The TLRI concludes that the current criminal justice system approach to repeat drink driving is inadequate and that a specialist response is necessary given the substantial risk posed to public safety by recidivist drink drivers and the enormous social and economic costs that arise from road trauma involving repeat drink driving.

The report makes 37 recommendations.

Its principal recommendation is that a Drug Treatment (DWI) order be created that would be situated within the drug treatment order that currently operates within the Magistrates Court.

Initially, the TLRI recommends the creation of a pilot under the guidance of a Steering Group consisting of representatives of all key government agencies. In addition, the Institute's view is that the Department of State Growth should be involved in the establishment of the pilot to allow for consistency between the criminal justice response to drink driving and the administrative licencing process, and a more effective rehabilitative focused and integrated approach. The legislative objectives of the Drug Treatment (DWI) order should include to:

- facilitate the rehabilitation of offenders by providing a judicially-supervised, therapeutically-oriented, integrated alcohol treatment and supervision regime;
- reduce the level of criminal activity associated with alcohol use disorder, in particular drink driving; and
- reduce risks to offenders' health and well-being.

This order will allow the court to adopt a solution-oriented approach according to the principles of therapeutic justice, as with the current drug treatment order. The TLRI's view is that a solution-oriented approach will reduce the likelihood of reoffending and so improve community safety by reducing the number of alcohol related casualties arising from motor vehicle crashes. Further, it will provide for financial savings by diverting these offenders from prison as well as reducing the economic and social costs incurred by the community arising from motor vehicle crashes.

Part 1 of this report details the background to the reference, its scope and the conduct of the reference including the establishment of an expert Advisory Group to guide the development of the Issues Paper and Final Report. The TLRI and TILES also applied for a grant from the Motor Accident Insurance Board Injury Prevention and Management Foundation to construct a profile of recidivist drink driving offenders in Tasmania through an examination of records held by the Magistrates Court, Community Corrections and Tasmania Police. A profile of recidivist drink drivers did not previously exist in Tasmania and the study aimed to describe the socio-demographic and criminal history characteristics of offenders who have been convicted in the Magistrates Court for multiple drink driving offences. This profile has been used to inform the recommendations in this report.

Part 2 of this report considers the need for a specialist response. It examines the risk to community safety posed by drink driving and repeat drink drivers in particular. It provides an overview of the characteristics of drink drivers. Finally, it considers the adequacy of the current response of the criminal justice system. The TLRI's conclusion is that research establishes that a specialist response is necessary given the substantial risk to posed to public safety by recidivist drink drivers and the enormous social and economic costs arising from road trauma involving repeat drink driving. Statistics show that drink driving is the leading factor in around 30% of fatal crashes in Australia. Furthermore, there is a clear relationship between blood alcohol concentration and crash risk. Whilst there has been a decrease over time in the number of crashes resulting in death or serious injury in Tasmania, the proportion of crashes where alcohol has been identified as a factor has remained consistent. Australian and overseas studies also show that recidivist drink drivers account for a disproportionate number of drink driving crashes.

Further, the TLRI concludes that the current criminal justice system approach to repeat drink driving is inadequate. While the current approach has seen the gradual introduction of more severe penalties in response to drink driving offences in an attempt to deter offenders, research generally shows that increasing the severity of traditional sentencing options has little or no impact on drink driving rates or recidivism rates for some drink drivers. This means that the criminal justice system becomes a 'revolving door' for these offenders with the offenders ultimately serving sentences of imprisonment, without the underlying causes of the drink driving behaviour being addressed. The TLRI/TILES study found that offenders in Tasmania commonly had a history of alcohol abuse, problematic drug use and/or mental health issues. This highlights that the offenders have complex needs with cross-sectional vulnerabilities that are unlikely to be resolved if the response is only directed at drink driving. Accordingly, while the TLRI recognises that there are existing powers under the *Sentencing Act 1997* (Tas) that would allow the court to impose treatment conditions on recidivist drink drivers, it is the TLRI's view that there is also a need for a more targeted and specialised response that incorporates rigorous assessment to identify the vulnerabilities of the individual offender, and targeted treatment and judicial monitoring delivered within a therapeutic framework. Similarly, it is the TLRI's view that there needs to be a more integrated response that is comprehensive and multifaceted and aligned with one of the key action areas within Tasmania's Key Strategy 3 of the *Alcohol Action Framework*.

Part 3 of this report examines the application of non-traditional criminal justice responses to the problem of recidivist drink drivers and provides an overview of national and international research literature on non-traditional approaches adopted in other jurisdictions. Problem-solving or solution-oriented courts have been developed over the past 30 years in response to a recognition that 'the adversarial nature of the traditional criminal justice model cannot effectively handle the complexity of certain human and social problems, where failing to deal with fundamental causes almost guarantees re-offending'.¹ In contrast to traditional courts, problem-oriented courts adopt a case-by-case approach to offending and seek to involve a range of partners (both government and non-government) in tackling the root causes of deviant behaviour and then addressing them holistically. Problem-oriented courts still seek to hold the offender accountable, but there is a view that the criminal justice system should do more than punish, it should also seek to prevent future harm.

¹ M Hill, 'Driving While Intoxicated (DWI) Courts: A Vital Part in the Battle to End Recidivist Drink Driving' (Paper presented at Alcohol, Tobacco and other Drugs Council of Tasmania (ATDC) Conference Vision and Values – Setting the Scene for the Future, Hobart, 7–8 May 2014).

Driving while intoxicated (DWI) courts/lists are an example of a problem-oriented court that have been developed internationally in response to the problem of recidivist drink drivers. The emphasis of the court is on accountability, and the aim is to facilitate rehabilitation by targeting the underlying causes of the behaviour and so protect the community by reducing the risk of reoffending. There are currently no specialist courts of this type in Australia, but in other jurisdictions DWI courts operate either as stand-alone courts or more commonly as a DWI/drug court hybrid. The recognised advantages of DWI courts are that they are forward-looking rather than backward-looking, allowing offenders to work towards a more positive future and re-engage with the community. There is evidence that DWI courts are effective in this regard and therefore meet their aim of facilitating rehabilitation and improving community safety. The cross-sectional nature of these courts challenges the 'framework of silos' and allows the problem of recidivist drink driving to be dealt with on multiple levels. Research on DWI courts overwhelmingly shows that where the courts are adequately funded and properly implemented they are effective in reducing recidivism. After reviewing the literature and approaches in other jurisdictions, the TLRI's assessment is that there is evidence to indicate that well designed DWI courts/lists provide a promising alternative to traditional sentencing approaches for repeat drink drivers. The literature (and experience elsewhere) is clear that a therapeutic approach that addresses the underlying causes of offending can be effective in reducing recidivism and improving community safety. However, more long-term evaluation is needed to fully understand what makes a DWI court successful.

Part 4 sets out the characteristics of a preliminary model for a Tasmanian Drug Treatment (DWI) order, including the target offending cohort and eligibility criteria. Although the TLRI accepts that all drink driving behaviour is a matter for concern and that rehabilitative approaches may be beneficial for a broad range of drink driving offenders, the TLRI's view is that the DWI list should target high-risk/high-needs drink drivers. Accordingly, the TLRI recommends that the eligibility criteria should specify that an offender is eligible for the Drug Treatment (DWI) order if the court is satisfied on the balance of probabilities that the offender has an alcohol use disorder; and the offender's underlying alcohol use contributed to the commission of the offence; the offender is charged with a third or subsequent drink driving offence; and the court would have sentenced the offender to a term of imprisonment. Further, offenders with any particular criminal history should not be excluded if they are otherwise eligible. Mental health should be a factor taken into account but should not preclude participation.

The model recommended by the TLRI is a post-sentence model using a drug treatment order, amended to accommodate the eligibility criteria for drink driving offences, as the sentencing order to underpin the DWI list. While this does not preclude magistrates from deferring sentence to allow drink drivers to access treatment/rehabilitation services prior to sentence, it is the TLRI's view that because of the onerous nature of the order, the high level of risks and needs of the offenders, the need to have a capacity to monitor and enforce the conditions of the order by an appropriate body and to direct the offender into treatment, it is more appropriate that the DWI operates as post-sentence option. The post-sentence model recommended by TLRI relies on an unactivated sentence of imprisonment (as is the current position with a DTO) rather than a non-custodial sentence. While feedback from stakeholders indicated that a model that depends on a determination that an unsuspended term of imprisonment is the only appropriate penalty (as required for a CMD order) may be unduly restrictive, the TLRI's view is that the DTO approach is the most appropriate model for the target cohort of the order (high-risk/high-needs repeat offenders for whom traditional criminal justice approaches have been ineffective). This DTO model provides a 'top' tier of intervention for these

offenders rather than immediately requiring the offenders to serve a short period of imprisonment, where they are unlikely to be able to access the necessary rehabilitative services and support required.

The TLRI also makes recommendations in relation to the conditions of the order to allow the court to tailor the order to meet the offender's rehabilitative needs. These should include a range of conditions depending on what is most suitable to address the criminogenic and other needs of the offender. While many of the proposed conditions are relatively uncontroversial, an issue exists in relation to the consumption of alcohol. In the Issues Paper, the TLRI sought feedback on whether a requirement for abstinence is appropriate, and whether it should be mandatory for a DWI list program. This is the approach in other DWI and drug courts (that included alcohol). However, there was very limited support for this position in any of the submissions received from both legal and treatment perspectives. Nevertheless, the TLRI's view is that an alcohol ban should be mandatory, at least at the initial stage of the order (phase one). The TLRI's view is that an alcohol ban has a punitive component as well as a therapeutic role and may address community concerns about recidivist drink drivers (who would otherwise have been sent to prison) undertaking their sentence in the community and being allowed to drink. Further, repeat offending demonstrates that the person has not been able to separate drinking from driving in the past and that a period of enforced abstinence may promote rehabilitation and ensure community protection. The TLRI acknowledges the concerns of treatment providers about the potential significant health risk to individuals from withdrawal from alcohol and therefore there should be scope within the order for the implementation of an alcohol ban to be managed under medical supervision and to include supervised detoxification programs.

The TLRI acknowledges an appropriate screening and assessment process is essential to the operation of the Drug Treatment (DWI) order. The TLRI's view is that, in the implementation of the pilot, feedback should be sought from suitable experts in relation to the appropriateness of the existing criteria available under the drug treatment order in the *Sentencing Act 1997* (Tas) to assess the eligibility of DWI offenders. Further, the TLRI stresses that the assessment should be conducted by experienced and appropriately qualified health practitioners.

In addition, the TLRI has identified the need for appropriate services to be available as part of treatment and rehabilitation. The precise treatment services to be offered will need to be determined as part of the implementation of the Drug Treatment (DWI) order pilot. However, the TLRI's view is that treatment services should be provided predominantly from within a health framework and that there is scope for services to be provided by government and non-government service providers. There is also scope for offenders to be directed to participate in the Sober Driver Program and EQUIPS (Addiction), where this is appropriate for the offender. Further, treatment must be evidence-based and effective for alcohol dependent individuals. There is also a need for a coordinated approach to the provision of treatment services through case management, as well as access (where appropriate) to evidence-based treatment programs that address all of an offender's criminogenic needs.

The TLRI stresses that the existence of community partnerships will be crucial for the success of the pilot to allow offenders to access the individualised treatment that is required. The TLRI also acknowledges that there is a need to address the funding requirements created by any expansion in demand for community-based programs addressing the issue of alcohol abuse.

A key feature of the Drug Treatment (DWI) order is judicial monitoring. Judicial officers play a key role in the DWI list participants' successful completion of DWI list programs. Specialist DWI list magistrates who are experienced in handling drink driving matters, have a good understanding of addictions and a genuine interest in therapeutic jurisprudence should therefore be appointed. The

TLRI recognises that there is already expertise of this kind among Tasmanian magistrates, and, as indicated, recommends that the Drug Treatment (DWI) order should be situated within the DTO list structure.

The use of rewards is another aspect of the Drug Treatment (DWI) order which is central to its solution-oriented focus. Research indicates that there are better outcomes for participants who are rewarded for their compliance and success in treatment.² The TRLI's view is that there should be a focus on rewards and acknowledgement of progress rather than an overly punitive approach focusing on punishment for non-compliance. However, sanctions for non-compliance are also a key feature of the Drug Treatment (DWI) order. Participants need to know the consequences of non-compliance, and breaches need to be followed up promptly with sanctions swiftly imposed. The TLRI's view is that a schedule of sanctions and rewards for the Drug Treatment (DWI) order can be based on the existing structure for the DTO order and should be settled in conjunction with the Steering Committee in the development of the pilot program.

A highly controversial issue raised in the Issues Paper was the use of driving privileges as a reward for compliance. Concerns were raised in the submissions received by the TLRI about the need for there to be consistency in approach with other drink driving offenders (who do not participate in the Drug Treatment (DWI) order or who are not able to afford an interlock, for example). However, the TLRI still considers that this is an issue that is worthy of further consideration, and that this option should be considered in consultation with key stakeholders such as Tasmania Police and the Department of State Growth.

Evaluation is a key feature of a successful DWI court. Accordingly, the TLRI recommends that the DWI list be monitored, evaluated and open to modification in response to the evaluation findings. It is the TLRI's view that it is important that comprehensive evaluation is built into any model adopted in Tasmania to determine: (1) which offenders achieved the best outcomes; (2) which interventions produced the best outcomes; and (3) which interventions worked for which categories of offender. It is necessary to evaluate short-term outcomes as well as longer-term outcomes. There should be a process and cost analysis evaluation conducted and it is also necessary to ensure that an appropriate management information system is in place to allow for necessary data to be captured to enable evaluation/monitoring to take place.

² A Freiberg et al, *Queensland Drug and Specialist Courts Review*, Final Report (2016) 254; J Long and C Sullivan, 'Learning More from Evaluation of Justice Interventions: Further Consideration of Theoretical Mechanisms in Juvenile Drug Courts (2017) 63 *Crime and Delinquency* 1091.

Part 1

Introduction

1.1 Background to this report

1.1.1 The first Tasmanian Road Safety Strategy was released in 2002 in the context of the alarming statistic that almost 5000 people were killed or seriously injured on Tasmanian roads between 1996 and 2006.³ While a shared responsibility approach to driver behaviour (with drivers, regulators, road designers and managers involved in safer transportation planning) has seen an improvement in road crash statistics on serious injuries and deaths, the issue of recidivist drink driving has become a focus of academic and policy interest. As recognised by Bartkowiak-Théron and Henning, the complex problem of recidivist drink driving is not new and ‘its persistence indicates ongoing failures in addressing a problem that has wide ranging social and economic consequences both at the individual and broader societal level in terms of well-being and safety’.⁴

1.1.2 Many legislative, education and law enforcement initiatives have been implemented in Tasmania to address the issue of drink driving. These have included the introduction of random breath testing and the lowering of the legal limit of permitted alcohol concentration in the blood.⁵ The detection of unlicensed drivers has been enhanced by the introduction of automatic number plate recognition technology, which allows police to identify vehicles where the driver is recorded as being disqualified from driving. Parliament has also sought to deter repeat offenders by the use of increased penalties for drink driving offences, the introduction of an education program (the Sober Driver program) and the use of alcohol ignition interlock devices. However, as Richardson notes, ‘[t]hese approaches alone, while necessary, do not appear to be effective for a group of core drink driving offenders who continue to reoffend’.⁶ This is illustrated by a case reported in *The Examiner*, where an offender was convicted of his fifth drink driving offence in five years and sentenced to a partly suspended sentence of four months imprisonment with two months suspended.⁷ While there is general community awareness of the unacceptability of drink driving and the risks it poses, for a cohort of offenders there appears to be a lack of awareness about the risk to public safety. Some offenders have expressed the view that drink driving is ‘just a traffic offence’.⁸ Concerns about the revolving door relating to repeat drink driving have been expressed by Tasmanian magistrates who have stressed that the escalation of penalties is ineffective as a response to these offenders and have highlighted the limitations of conventional court practices for these offenders.⁹

³ Department of Infrastructure, Energy and Resources, *Our Safety, Our Future: Tasmanian Road Safety Strategy 2007-16* (2006) 4.

⁴ I Bartkowiak-Théron and T Henning, ‘Therapeutic Justice and Recidivist Drink Drivers: Irreconcilable and Compatible Issues?’ *Tiles Briefing Papers*, Tasmania (2016) 1.

⁵ *Ibid* 2.

⁶ E Richardson, ‘A Driving While Intoxicated/Suspended Court List for Victoria’ (Australian Centre for Justice Innovation, Monash University, Background Paper, 2013) 3.

⁷ C Tang, ‘Five-Time Drink-Driver Jailed’, *The Examiner* (Launceston) 25 November 2015 <<http://www.examiner.com.au/story/3519146/five-time-drink-driver-jailed/>>.

⁸ See discussion at [2.3.10]–[2.3.12] in relation to drink driver attitudes.

⁹ Hill, above n 1. See also Bartkowiak-Théron and Henning, above n 4.

1.1.3 In light of these concerns, in September 2013, the Tasmanian Institute of Law Enforcement Studies (TILES) and the University of Tasmania's Faculty of Law organised an international workshop intended to map pathways in addressing the issue of recidivist drink drivers. One of the main issues identified by key stakeholders was the poor fit of some criminal justice responses to instances of repeat drink driving. Given that the circumstances of drink driving range from social drinking and ill-advised behaviour to the profound problem of alcohol addiction, stakeholders expressed the view that any solution to such a multifaceted problem needs to be sufficiently flexible to meet a wide spectrum of needs and circumstances. Stakeholders highlighted that the progressively harsher criminal justice response (such as increased penalties and mandatory penalties) does not appear to be effective for a cohort of recidivist drink drivers and expressed the view that these offenders should be considered as offenders with chronic health issues that require a more therapeutic response.¹⁰

1.1.4 As a consequence, the Tasmania Law Reform Institute (TLRI) obtained funding from the Solicitor's Guarantee Fund to examine:

- the adequacy of the current sentencing regime for drink driving offences;
- the application of non-traditional criminal justice responses to the problem of recidivist drink drivers;
- national and international research literature on non-traditional approaches adopted elsewhere;
- Whether a therapeutic jurisprudential approach might be appropriate in the context of recidivist drink driving; and
- Which approach offers the best model for achieving behavioural and attitudinal change in the recidivist drink driver.

The TLRI and TILES also applied for a grant from the Motor Accident Insurance Board (MAIB) Injury Prevention and Management Foundation to construct a profile of recidivist drink driving offenders in Tasmania through an examination of records held by the Magistrates Court, Community Corrections and Tasmania Police. A profile of recidivist drink drivers did not previously exist in Tasmania and the study aimed to describe the socio-demographic and criminal history characteristics of offenders who have been convicted in the Magistrates Court for multiple drink driving offences. This profile has been used to inform the recommendations in this report.

1.1.5 In May 2017, the Institute released an Issues Paper that considered options for reform that may improve the effectiveness of the criminal justice response to the problem of recidivist drink drivers. The Issues Paper explored sentencing options that are more likely to influence offenders' perceptions of the risks associated with their behaviour and bring about lasting attitudinal change. In accordance with the philosophy of therapeutic jurisprudence, some new initiatives have examined the creation of specialist problem-oriented courts for recidivist drink drivers. The Issues Paper sought feedback from local stakeholders and the community to determine how models from national and international jurisdictions that address the problem of recidivist drink drivers might be tailored to

¹⁰ J Costello, 'A Problem Oriented Court for Recidivist Drink Drivers – Providing a Foundation' (Paper presented at TILES Recidivist Drink Driving Workshop, Tasmania, September 2013); G Waters, 'One Size Does Not Fit All: Substance Impaired Driving Presentation' (Paper presented at TILES Recidivist Drink Driving Workshop, Tasmania, September 2013). See also Bartkowiak-Théron and Henning, above n 4.

local needs and limitations, including legislative and resource restrictions.¹¹ It also set out the findings of the TLRI/TILES study, described above, which constructed a profile of Tasmanian recidivist drink drivers. The Issues Paper set out 26 questions and the responses to the paper have informed the Institute's assessment of the appropriateness of a therapeutic/problem focused response to repeat drink driving (including the need for a drink driving list pilot) in Tasmania. The Institute also met with key stakeholders from fields including treatment providers, legal practitioners and community corrections.

1.1.6 In the development of the Issues Paper and this Final Report, the TLRI has been guided by the expertise of an Advisory Group which included Michael Hill (former Chief Magistrate), Dr Isabelle Bartkowiak-Theron (Tasmanian Institute of Law Enforcement Studies), Associate Professor Terese Henning (Director, TLRI) and Liz Moore (MA LLB).

1.1.7 In this report, the TLRI recommends the establishment of a Drug Treatment (Driving While Intoxicated (DWI)) order operating within the structure of the drug treatment order that currently exists within the Magistrates Court. Initially, the TLRI recommends the creation of a pilot under the guidance of a Steering Group consisting of representatives of all key government agencies. In addition, it is the view of the Institute that the Department of State Growth should be involved in the establishment of the pilot to allow for consistency between the criminal justice response to drink driving and the administrative licencing process, and a more effective rehabilitative focused and integrated approach. The legislative objectives of the Drug Treatment (DWI) order should include to:

- facilitate the rehabilitation of offenders by providing a judicially-supervised, therapeutically-oriented, integrated alcohol treatment and supervision regime;
- reduce the level of criminal activity associated with alcohol use disorder, in particular drink driving; and
- reduce risks to offenders' health and well-being.

1.1.8 This order will operate as a solution-oriented court according to the principles of therapeutic justice, as with the current drug treatment order. The Tasmanian Magistrates Court has shown commitment to therapeutic responses through the establishment on its own initiative of the Mental Health Diversion List (MHDL) as well as the implementation of the specialised response for drug affected offenders. This experience indicates the existing expertise in the court to implement effective therapeutic responses. That same expertise and commitment would necessarily underpin the success of the Drug Treatment (DWI) order.

1.1.9 The Drug Treatment (DWI) order must be supported by Tasmanian-oriented screening and assessment tools and allow for a coordinated and individualised response to the criminogenic needs of the offender that is evidence-based, best practice and appropriately funded. The legal mechanism for the treatment, supervision and monitoring of the offender will be an amended drug treatment order framework created under the *Sentencing Act 1997* (Tas). The target group of offenders are high-risk, high-needs drink drivers, evidenced by a diagnosis of an alcohol use disorder and repeat drink drive offending. The TLRI stresses the need for the order to be appropriately resourced. Ultimately, however, it is envisaged that there will be cost savings arising from the Drug Treatment (DWI) order in terms of reducing the likelihood of reoffending and diverting these offenders from prison.

¹¹ Inter-Agency Working Group on Drugs, Tasmanian Government, *Tasmanian Alcohol Action Framework 2010-2015* (2014) 38.

1.1.10 In preparing this Final Report, the TLRI's approach has been informed by the feedback received from stakeholders, its study into Tasmanian repeat drink drivers and research literature that indicates traditional criminal justice responses to drink driving have been largely ineffective for some repeat offenders, and that a solution-oriented response is a more promising alternative. The TLRI has also been guided by the views expressed by the Advisory Group. In preparing this report, the TLRI has drawn on the structure adopted in the *Queensland Drug and Specialist Court Review*.¹²

1.2 Overview of the Final Report

1.2.1 Part 2 of the report addresses the need for a specialist response to repeat drink drivers. It examines the risk to community safety posed by drink driving and repeat drink drivers in particular. It provides an overview of the characteristics of drink drivers. Finally, it considers the adequacy of the current response of the criminal justice system.

1.2.2 Part 3 examines the application of non-traditional criminal justice responses to the problem of recidivist drink drivers and provides an overview of national and international research literature on non-traditional approaches adopted in other jurisdictions.

1.2.3 Part 4 provides an overview of a structure for a model for a Driving While Intoxicated (DWI) court in Tasmania and addresses the issues that may arise in the implementation of the Drug Treatment (DWI) order.

1.2.4 In consultations with stakeholders, the relationship between alcohol and offending more generally was raised as an issue. The TLRI recognises the research that has demonstrated the strong association between substance use and crime,¹³ and acknowledges this is a significant issue. However, an examination of the response of the criminal justice system to offenders who are affected by alcohol beyond the context of drink driving is not within the scope of this review. The TLRI, however, considers that the development of a more effective response to recidivist drink drivers may have benefits in addressing the offenders' offending behaviour more generally. It will also potentially allow for improved health and overall quality of life for these offenders, as well as better outcomes for their families and the community.

¹² Freiberg et al, above n 2.

¹³ See Sentencing Advisory Council, Tasmania (TSAC), *Mandatory Treatment for Alcohol and Drug Affected Offenders*, Research Paper No 2 (2017) [2.2]–[2.3].

Part 2

Why is a Specialist Response Necessary for Recidivist Drink Drivers?

2.1.1 This Part provides evidence of the risk posed to the community by repeat drink drivers, the characteristics of repeat drink drivers and sets out the limitations of the current criminal justice response to these drivers. As discussed below, research confirms the enormity of the social and economic costs arising from road trauma involving repeat drink drivers. The role of alcohol as a major cause of health and social harms, including the involvement of alcohol in road traffic accidents, has been recognised in the national policy addressing alcohol, tobacco and other drugs and is clearly articulated in the National Drug Strategy 2011–2015.¹⁴ From a public health perspective, risky drinking behaviour was recognised as a challenge that still exists and was identified as a drug specific priority.¹⁵ Clearly, repeat drink driving is a crucial aspect of risky drinking behaviour; one that has a profound consequence for public safety and warrants considerable attention from a health and law enforcement perspective.

2.2 Community safety

The drink driving problem

2.2.1 Drink driving offences account for a considerable proportion of all finalised defendants in the Magistrates Court. In the period 2014–15 to 2016–17, there were 45 880 finalised defendants of whom 6176 were found guilty for the offences of driving under the influence of alcohol or other substances or exceeding the prescribed content of alcohol.¹⁶

2.2.2 Data provide an indication of the prevalence of drink driving in Tasmania. In 2015–16, Tasmania Police conducted a total of 469 610 random breath tests, with 2319 drivers found to be over the prescribed blood alcohol limit. This meant that of the drivers tested, 99.5% complied with the alcohol limit,¹⁷ which is consistent with previous years.¹⁸ However, these data are likely to be an underestimate of the extent of drink driving in the community as they do not include drivers who drink drive but are not detected by the police, and self-reports indicate that a greater proportion of drivers report driving while under the influence of alcohol. The National Drug Strategy Household Survey conducted in 2016 indicates that 9.9% of recent drinkers reported driving a vehicle while

¹⁴ Australian Government, *The National Drug Strategy 2010-2015*
<<http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/nds20102015~nds20102015-about>>.

¹⁵ Ibid.

¹⁶ Information provided by Betty Evans Email 3 October 2017.

¹⁷ Tasmania Police, *Annual Report 2015-16*, 28.

¹⁸ The percentages for previous years are: 99.5% in 2012–13, 99.4% in 2011–12 and 99.3% in 2010–11 (data from relevant annual reports). Data from earlier years are not comparable as a different reporting system was used, see Tasmania Police, *Annual Report 2010-11*, 32.

under the influence of alcohol in the previous 12 months.¹⁹ This was a reduction from 12.2% in the 2013 survey.²⁰ However, this research also found that ‘lifetime risky drinkers were 3.3 times as likely as low risk drinkers to drive a vehicle while under the influence of alcohol (21% compared with 6.65%).²¹

2.2.3 In the Tasmanian context, Matthews and Bruno report that 7% of drinkers self-reported driving under the influence in 2012.²² Queensland research examining self-reported drink driving found that 45.2% of respondents reported drink driving at least once in the six month period before the survey.²³ Other Australian research has found an even higher level of driving following the consumption of alcohol with a survey of drivers conducted by Owens and Boorman finding that 58% of participants reported driving when they believed that they may have been over the legal limit, with 64% of those respondents indicating that the most recent occasion occurred within the last 12 months.²⁴ In contrast, only 14% of participants indicated that they had ever been caught and penalised for drink driving.²⁵ Australian research published in 2017 stated that 21% of the sample reported drink driving at least once in the previous two years.²⁶

2.2.4 Research conducted elsewhere provides an insight into the extent of repeat drink and driving and suggests that a ‘small segment of the drinking and driving population ... drink heavily on a frequent or episodic basis and drive with very high BACs’.²⁷ In NSW, research conducted in 2009 found that 15.5% of drink drivers returned to court for another drink driving offence within five years.²⁸ Victorian data from 2009 show that overall, 28% of offenders convicted of drink driving were repeat offenders, with repeat offenders accounting for 39% of offenders convicted of driving with a high range blood alcohol level (.15 and over).²⁹ Other Victorian research indicates that between 1988 and 2000, the percentage of drink driver offenders that were repeat offenders ranged from 19.2% to 30.2%.³⁰ In a study conducted in Victoria in relation to drivers and riders convicted of a drink driving offences committed between 1996 and 2002, it was found that 15.6% were repeat offenders.³¹ In a 2014 examination of effective drink driving prevention and enforcement strategies, Terar and Brown

¹⁹ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016* (2017) 48.

²⁰ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2013* <<http://www.aihw.gov.au/alcohol-and-other-drugs/ndshs-2013/ch4/>>.

²¹ Australian Institute of Health and Welfare, above n 19, 47.

²² Cited in R Bruno and A Peacock, ‘Alcohol, the Brain and Drink-Driving: Behavioural and Psychological Perspectives’ 4 <http://www.utas.edu.au/__data/assets/pdf_file/0005/427775/R_Bruno_A_Peacock_alcohol_the_brain_drink_driving.pdf>.

²³ B Watson and J Freeman, ‘Perceptions and Experiences of Random Breath Testing in Queensland and the Self-Reported Deterrent Impact on Drunk Driving’ (2007) 8 *Traffic Injury Prevention* 11, 14.

²⁴ K Owens and M Boorman, ‘Evaluating the Deterrent Effect of Random Breath Testing (RBT) and Random Drug Testing (RDT): The Driver’s Perspective’ (Monograph Series No 41, National Drug Law Enforcement Research Fund, 2011) 34.

²⁵ *Ibid* 38.

²⁶ N Stephens et al, ‘Alcohol Consumption Patterns and Attitudes Towards Drink-drive Behaviour and Road Safety Enforcement Strategies’ (2017) 98 *Accident Analysis and Prevention* 241, 249.

²⁷ J Fell, ‘Update: Repeat DWI Offenders Involved in Fatal Crashes in 2010’ (2014) 15 *Traffic Injury Prevention* 431, 431.

²⁸ L Trimboli and N Smith, ‘Drink-driving and Recidivism in NSW’ (Crime and Justice Bulletin: Contemporary Issues in Crime and Justice No 135, NSW Bureau of Crime Statistics and Research, 2009).

²⁹ M Boorman, ‘The Drink and Drug Driving Enforcement Link to Public Health (1st International Conference on Law Enforcement and Public Health, Melbourne, 11–14 November 2012).

³⁰ Sentencing Advisory Council, Victoria (VSAC), *Maximum Penalty for Repeat Drink Driving*, Report, 2005, 12.

³¹ A Watson et al, ‘The Effects of Licence Disqualification on Drink-Drivers: Is it the Same for Everyone?’ (2017) 107 *Accident Analysis and Prevention* 40.

state that research ‘shows between 20 and 30 percent of drink drivers reoffend’.³² In the United States, ‘conviction rates suggest that approximately 30% of DWI offenders are recidivists’³³ and in New Zealand, data indicate that there was a reconviction rate of 36% over the period 1999 to 2008.³⁴ Self-report studies also highlight the extent of recidivism, with a Queensland study finding that around 80% of offenders who had been convicted for the first time of drink driving admitted to engaging in drink driving in the six months prior to the conviction³⁵ and 27% admitted to engaging in drink driving in the six months after the conviction.³⁶

2.2.5 In the context of this report, an important finding from research conducted in Victoria is that the highest rate of reoffending for drink drivers was pre-licence disqualification, that is after apprehension for the index offence but before receiving the corresponding sanction and the commencement of the licence disqualification period.³⁷ In addition, research has also found that the highest rate of drink driving crashes was during the period between being detected by police and the commencement of the licence ban.³⁸ This suggests that, for these offenders, even detection was not a deterrent and highlights the intractable nature of the problem for some drink drivers.

2.2.6 In Tasmania, available data does not allow a complete assessment of the number of drink drivers who have previously had a drink driving conviction. However, limited data available from the Magistrates Court makes it possible to examine the number of offenders who have further charges of the same type lodged against them within two years of their conviction. As shown in Table 2-1, preliminary results from the Magistrates Court database show that for offenders whose matter was finalised in 2011–12, 8% of those convicted of driving a motor vehicle while exceeding the prescribed alcohol limit had new similar proceedings lodged within two years, and 12% were convicted of driving without a licence with alcohol in their body. However, it is noted that this is unlikely to be a true representation of the extent of repeat offending given that it only identifies offenders who are charged within a two-year period. Further, the data only capture offenders charged with the ‘same’ type of offence, which means the same Australia and New Zealand Standard Offence Classification (ANZSOC) code. In ANZSOC, ss 6(1), 6(2) and 6A(1) of the *Road Safety (Alcohol and Drugs) Act 1970* (Tas) have the same code and ss 4, 4(a) and 4(b) have the same code. This means that the offences of drive while exceeding prescribed alcohol limit and drive while under the influence of alcohol/intoxicating liquor would not appear as a match.³⁹

³² K Terer and R Brown, ‘Effective Drink Driving Prevention and Enforcement Strategies: Approaches to Improving Practice’ (Trends and Issues in Crime and Criminal Justice No 472, Australian Institute of Criminology, 2014) 1.

³³ J Mullen et al, ‘Treatment Needs of Driving While Intoxicated Offenders: The Need for Multimodal Approach to Treatment’ (2015) 16 *Traffic Injury Prevention* 637, 637 citing NHTSA, *Traffic Safety Facts: DWI Recidivism in the United States: An Examination of State Level Driver Data and the Effect of Look-back Periods on Recidivism Prevalence* (2014).

³⁴ A Dawber and T Dawber, ‘The *One for the Road* Group Programme for Repeat Drink/Drugged Drivers’ (20th International Council on Alcohol, Drugs and Traffic Safety Conference, Brisbane, 2013) 2.

³⁵ H Wilson, *Reducing Recidivism by First Time Drink Drivers* (PhD Thesis, Queensland University of Technology, 2015) 186.

³⁶ H Wilson, M Sheehan and G Palk, ‘Who are the Real ‘First Offenders?’ (19th International Council on Alcohol, Drugs and Traffic Safety Conference, Oslo, 2010) 5.

³⁷ Watson et al, above n 31.

³⁸ Ibid. See also Filtness, et al, ‘Options for Rehabilitation in Interlock Programs’ (Austroads, 2015) cited in Watson et al, ‘The Impact of Safety Measures on the Re-offence and Crash Rates of Drink-driving Offenders in Victoria’ (2015 Australasian Road Safety Conference, Gold Coast, 14–16 October 2015).

³⁹ Note that: (1) this provides information about new charges lodged, not finalised; (2) the offender may not necessarily be found guilty of the new charges; (3) the ‘same type’ means the same Australia and New Zealand Standard Offence Classification (ANZSOC) code (in ANZSOC s 6(1), 6(2) and 6A(1) are all coded as 1431 and s 4, 4(a) and 4 (b) are 0411)). This means that the offences of drive while exceeding prescribed alcohol limit and drive while under the

Table 2-1: Drink driving offenders from 2011–12 who had further charges of the same type lodged within two years of conviction, Magistrates Court Tasmania

| Section of the of the <i>Road Safety (Alcohol and Drugs) Act 1970 (Tas)</i> | Yes | No | Total | % Yes |
|--|-----|------|-------|-------|
| Section 6(1) – Drive a motor vehicle while exceeding prescribed alcohol limit | 157 | 1901 | 2058 | 8% |
| Section 6(2) – Driver not holding Australian driver lic, foreign drive lic, international driver permit with alcohol in body | 71 | 597 | 668 | 12% |
| Section 4 – Drive whilst under the influence of alcohol or a drug | 0 | 91 | 91 | 0% |
| Section 4(a) – Drive a vehicle under the influence of intoxicating liquor | 0 | 49 | 49 | 0% |
| Total | 301 | 3046 | 3347 | 10% |

In addition, the research conducted by TLRI/TILES in creating a profile of repeat drink drivers allows an appreciation of the characteristics of these drivers in the Tasmanian context.⁴⁰

Harm caused by drink driving

2.2.7 The harm caused by drink driving has been long recognised in Australia and elsewhere as an ongoing and serious problem.⁴¹ It is a ‘serious global public health problem’ that ‘continues to be a major contributor to death and serious injuries internationally’.⁴² Drink driving has been identified as ‘the leading contributing factor in around 30% of fatal crashes in Australia’ with alcohol-related crashes being estimated to cost Australian society \$3.7 billion dollars in 2010.⁴³ In addition to the ‘devastating emotional and social costs to the road users involved in the crash’, Fitzharris and Stephens have estimated that each serious injury crash costs approximately \$804 618 and each fatal crash costs \$4.94 million.⁴⁴ In an analysis of risk factors for fatal crashes in rural Australia, Siskend et al observed that the literature showed that there is a ‘consistency of alcohol misuse as a major contributor to road crash fatalities in virtually all studies, regardless of variations in legal BAC levels and methods of enforcement’.⁴⁵ In their study, similarly, alcohol use was a strong risk factor for a fatal outcome.⁴⁶

2.2.8 In an analysis of coroners’ reports in South Australia for the period 2008 to 2010, Wundersitz and Raftery reported that ‘34% of drivers involved in a fatal crash recorded an illegal BAC, reinforcing the significance of alcohol impairment as a leading cause of fatal crashes for which interventions are required’.⁴⁷ Research examining casualty crashes on public roads in South Australia

influence of alcohol/intoxicating liquor would not appear as a match, Information provided by Betty Evans, email 2 February 2016.

⁴⁰ See [2.3].

⁴¹ J Ferris et al, ‘Random Breath testing in Queensland and Western Australia: Examination of How the Random Breath Testing Rate Influences Alcohol Related Traffic Crash Rates’ (2013) 60 *Accident Analysis and Prevention* 181.

⁴² L Wundersitz and S Raftery, ‘Understanding the Context of Alcohol Impaired Driving for Fatal Crash-involved Drivers: A Descriptive Case Analysis’ (2017) 18(8) *Traffic Injury Prevention* 781, 781.

⁴³ Ibid citing Manning et al 2013.

⁴⁴ A Stephens et al, above n 26, 241–242 citing M Fitzharris and K Stephan, *Assessment of the Need for, and the Likely Benefits of, Enhanced Side Impact Protection in the Form of a Pole Side Impact Global Technical Regulation* (Monash University Research Centre, 2013).

⁴⁵ V Siskend et al, ‘Risk Factors for Fatal Crashes in Rural Australia’ (2011) 43 *Accident Analysis and Prevention* 1082, 1087.

⁴⁶ Ibid.

⁴⁷ Wundersitz and Raftery, above n 42, 785.

who were admitted to the Royal Adelaide Hospital from 2008 to 2010 found that ‘alcohol intoxication was the leading contributing factor in the crashes investigated. More than 18 per cent of all active crash participants were identified as having a blood alcohol level or breath alcohol level about 0.05 at the time of their crash’.⁴⁸ Further, of the alcohol impaired drivers and motor cycle riders, more than 12% had been involved in at least one previous alcohol related crash.⁴⁹

2.2.9 Research demonstrates that there is a clear relationship between blood alcohol concentration and crash risk, ‘with a crash risk of a driver with a BAC of 0.10g/100ml being almost five times the risk of a driver with no alcohol in their system, and the crash risk of a driver with a BAC of 0.15g/100 ml being 22 times that of a driver with no alcohol at all in their system’.⁵⁰ In analysis and modelling of crashes in Tasmania, Mackenzie et al stated that ‘numerous studies have found that any reduction in the legal BAC limit is associated with significant reductions in fatal and serious crashes’.⁵¹ Research suggests that drink driving related crashes may be the result of the impairment in a driver’s level of skill or increased alcohol induced risk-taking or some combination of both.⁵² Driving performance is impaired by ‘increased reaction times, increased error rates, decreased car control, tunnel vision, slower visual information processing, increased ignorance of traffic rules and an inability to handle unexpected or emergency situations’.⁵³ Alcohol also affects a driver’s propensity to take risks, including increased impulsivity, sensation seeking and low risk perception’.⁵⁴

2.2.10 In Tasmania, as shown in Figure 2-1, there has been a reduction over time in the number of crashes resulting in death or serious injury.⁵⁵ This trend has been identified over several decades and has been attributed to ‘law enforcement measures such as random breath testing, lowering the legal limit of alcohol concentration in the blood, the compulsory wearing of seat belts, and the installation of speed cameras, as well as safer cars and better roads’.⁵⁶ There have also been changes to the licencing process, with more stringent requirements introduced for driving assessment tests. Other factors identified by the Department of State Growth as related to the reduction of the number of deaths or serious injuries on Tasmanian roads have been the introduction of 50 km per hour urban speed zones and the introduction of the Road Safety Strategy.

⁴⁸ V Lindsay, *Characteristics of Alcohol Impaired Road Users Involved in Casualty Crashes* (Centre for Automotive Safety Research CASR105, 2012) 1.

⁴⁹ Ibid 20.

⁵⁰ Wilson, above n 35, 11–12 citing Compton 2012.

⁵¹ J Mackenzie et al, *Analysis and Modelling of Crashing in Tasmania* (CASR Report Series 136, 2016) 12.

⁵² J Laude and M Fillmore, ‘Simulated Driving Performance Under Alcohol: Effects on Driver-risk Versus Driver-Skill’ (2015) 154 *Drug and Alcohol Dependence* 271, 275.

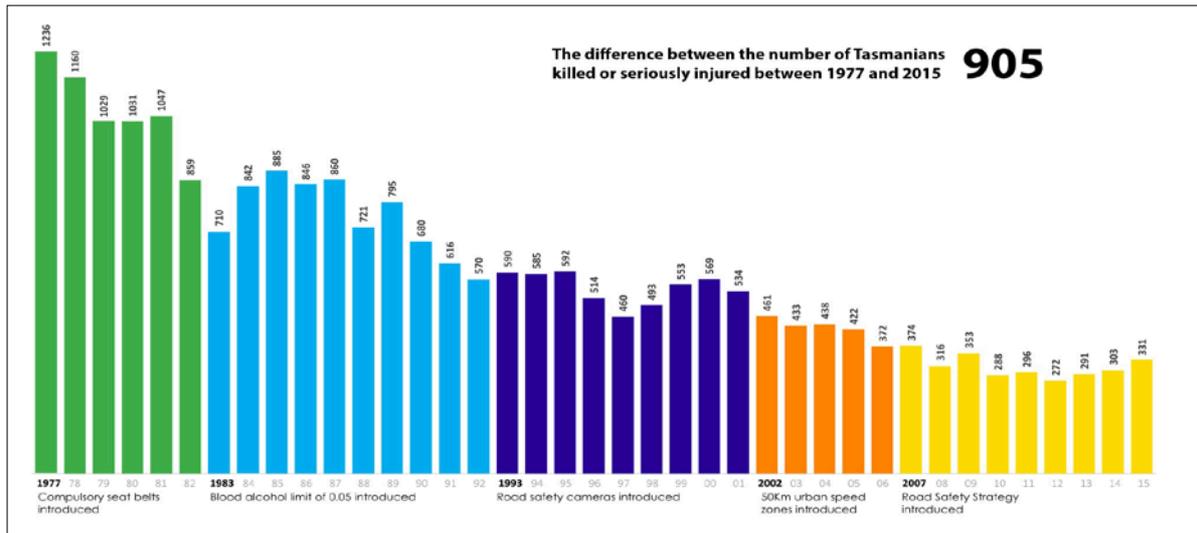
⁵³ M Møller, S Haustein and C Giacomo Prato, ‘Profiling Drunk Driving Recidivists in Denmark’ (2015) 83 *Accident Analysis and Prevention* 125, 125.

⁵⁴ Laude and Fillmore, above n 52, 272.

⁵⁵ This is consistent with Australian data that show a decrease in the number of deaths per 100 000 persons, as well as per 10 000 registered vehicles, see A McKenzie, *Drinking, Driving and Tragedy: An Options Paper for a New Approach to Drink Driving* (University of Tasmania with the Magistrates Court of Tasmania, 2013) 10–11.

⁵⁶ K Warner, ‘Sentencing Review 2012–2013’ (2013) 37 *Criminal Law Journal* 390, 397. See S Briscoe, ‘The Impact of Increased Drink-driving Penalties on Recidivism Rates in NSW’ (National Drug Research Institute, Alcohol Studies Bulletin No 5, 2004) 1.

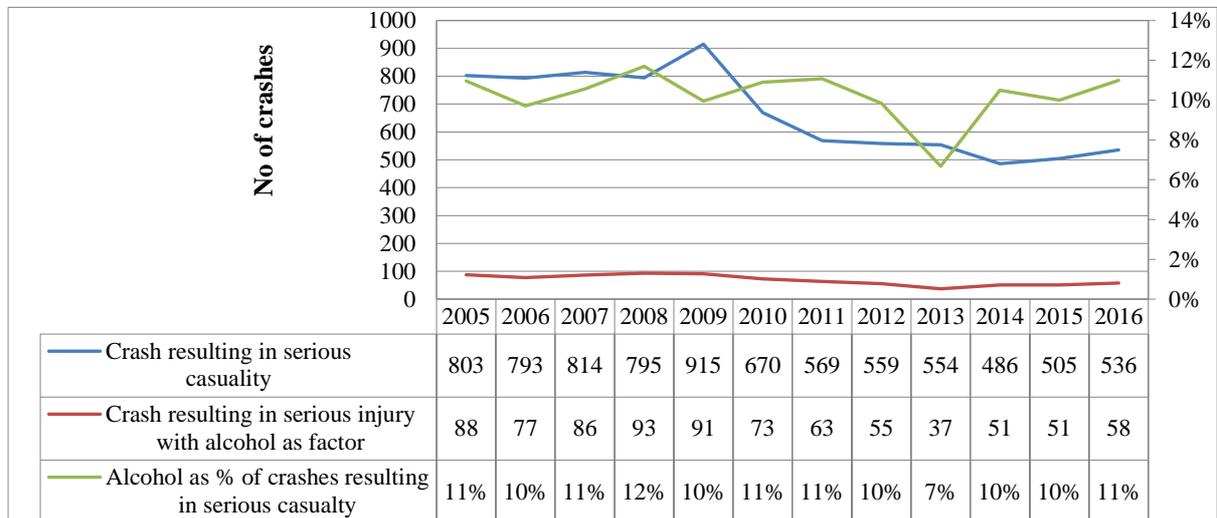
Figure 2-1: Number of Tasmanians killed or seriously injured between 1977 and 2015



Source: Road Safety Advisory Council <<http://www.rsac.tas.gov.au/>>

2.2.11 However, as shown in Figure 2-2, while the number of people killed or seriously injured between 2005–16 has decreased from 803 to 536, the proportion of crashes where alcohol has been identified as a factor has remained fairly constant.⁵⁷ This is consistent with the trends in other jurisdictions, where the percentage of fatally injured motorists with a blood alcohol concentration in excess of the legal limit has plateaued since the 1990s.⁵⁸ Accordingly, the challenge for society (and the legal system) is how to reduce further the proportion of crashes where alcohol consumption is a factor.

Figure 2-2: Crashes, Tasmania, 2005–16



Source: Department of State Growth, Crash Data Manager

⁵⁷ By way of background to the concept of crash factors, reporting police officers allocate one or more ‘crash factors’ to each crash. These are effectively a police officer’s best attempt (usually at the scene of the crash) to classify what factor or combination of factors has caused the crash. There are currently 24 defined crash factors of which alcohol is one. In addition, it should be noted that in the case of a multi-vehicle crash, the data are presented in terms of the crash as a whole and are not specific to each road-user, which means that in a crash resulting in serious causality, it is not possible to identify whether the driver under the effect of alcohol was seriously injured or killed some other person involved in the crash: Information provided by Simon Buddle, Crash Data Manager, Department of State Growth, email to Rebecca Bradfield, 14 September 2009.

⁵⁸ I Faulks, J Irwin and K Stewart, ‘Drink Driving and Australian Alcohol Policy Development in 2010’ (TRB Committee on Alcohol, Other Drugs, and Transportation, 2011) 7; Fell, above n 27, 431.

Repeat drink drivers

2.2.12 A number of Australian and overseas studies have indicated that a minority of recidivist drink drivers account for a significant proportion of drink driving crashes.⁵⁹ This research suggests that recidivist drink drivers are responsible for a disproportionate number of such crashes.⁶⁰ As such, repeat drink drivers have been identified as ‘a particularly high-risk group’ on the basis that they ‘are more likely than non-DWI drivers to involve themselves in fatal motor vehicle crashes or hit-and-run collisions with pedestrian fatalities, and to have high blood alcohol concentrations (0.15% and above) when driving.’⁶¹ Others have observed that repeat drink drivers, particularly at high blood alcohol concentrations, ‘are at extremely high risk of serious crash involvement’.⁶²

2.2.13 Wundersitz and Raftery’s study (see [2.2.8]) found that almost half (44%) of the drivers with an illegal BAC in a fatal crash recorded at least one previous traffic related alcohol offence, with the majority of offences ‘detected within 5 years before the fatal crash’.⁶³ The authors observed that this finding ‘of a high level of recidivism among crash-involved alcohol-impaired drivers replicate[d] previous research and appears to be a persistent problem’.⁶⁴ In relation to casualties, research examining crashes on public roads in South Australia where casualties were admitted to the Royal Adelaide Hospital from 2008 to 2010 found that 82 of the 203 alcohol impaired drivers and motorcycle riders (40.4%) had at least one previous infringement for an alcohol related driving offence.⁶⁵

2.2.14 There is no research conducted in the Tasmanian context that has specifically examined the contribution of repeat drink drivers to crashes that result in fatalities and serious injuries. Research conducted by the Tasmanian Sentencing Advisory Council examined sentences imposed for driving offences where death or injury was caused and noted that many offenders convicted of manslaughter arising out the use of a motor vehicle, dangerous driving causing death and dangerous driving causing grievous bodily harm had a pattern of risky driving including speeding, driving whilst disqualified,

⁵⁹ Richardson, above n 6, 5.

⁶⁰ Møller, Haustein and Prato, above n 53, 129; A Watson et al, above n 38; Terer and Brown, above n 32, 1 citing J Freeman and P Liossis, ‘Drink Driving Rehabilitation Programs and Alcohol Ignition Interlocks: Is There a Need for More Research?’ (2002) *Road and Transport* 4, 3; M Henderson, ‘Defining the Problem and Tasks of the Summit’, *Drink Driving Recidivism Summit* (Australian Advisory Committee on Road Trauma, 1996); M Longo, C Hunter and R Loan, ‘South Australian Drivers Involved in Non-fatal Crashes: How Many are Drink Driving Recidivists?’, *Drink Driving Recidivism Summit* (Australian Advisory Committee on Road Trauma, 1996); G Ryan et al, ‘Repeat Drink Driving Offenders in Western Australia, 1984-1994’, *Drink Driving Recidivism Summit* (Australian Advisory Committee on Road Trauma, 1996). See also M Sheehan et al, ‘Drink Driver Rehabilitation and Education in Victoria (RACV Research Report 05/01, 2005) 10; Dawber and Dawber, above n 34, 1; Ministry of Transport, New Zealand, *High-risk Drivers in Fatal and Serious Crashes*, (2012) 3, 12–14 <<http://www.transport.govt.nz/assets/Import/Documents/High-risk-drivers-in-fatal-and-serious-crashes-2006-2010.pdf>>; Office of Road Safety, Western Australia, *Drink Driving Fact Sheet* (2014) 1; R Elder et al, ‘Effectiveness of Ignition Interlocks for Preventing Alcohol-Impaired Driving and Alcohol-Related Crashes: A Community Guide Systematic Review’ (2011) 40 *American Journal of Preventative Medicine* 362, 362; Fell, above n 27; R Brewer et al, ‘The Risk of Dying in Alcohol-Related Automobile Crashes Among Habitual Drunk Drivers’ (1994) 331 *The New England Journal of Medicine* 513.

⁶¹ S Lapham and E England-Kennedy, ‘Convicted Driving-While-Impaired Offenders’ Views on Effectiveness of Sanctions and Treatment’ (2012) 22 *Qualitative Health Research* 17, 17. See also L Nadeau et al, ‘The Dilemma of Re-licensing DWI Offenders: The Offender’s Point of View’ (2016) 87 *Accident Analysis and Prevention* 43; Fell, above n 27.

⁶² Office of Alcohol, Drugs and Dependency Issues, Health Canada, *Highlights DWI Repeat Offenders: A Review and Synthesis of the Literature* (1997) 3.

⁶³ Wundersitz and Raftery, above n 42, 785.

⁶⁴ Ibid 786.

⁶⁵ V Lindsay, *Characteristics of Alcohol Impaired Road Users Involved in Casualty Crashes* (Centre for Automotive Safety Research CASR105, 2012) 21.

driving under the influence of drugs and/or exceeding the permitted blood alcohol concentration.⁶⁶ However, this research did not examine the contribution of repeat drink drivers to crashes more generally.

2.2.15 Research also suggests that a proportion of disqualified drivers continue to drink drive during periods of licence disqualification and that there is an over-representation of disqualified drivers in serious crashes.⁶⁷ The study conducted by the TLRI/TILES found that a large proportion of repeat drink drivers who were sentenced to a custodial sentence were driving while disqualified or unlicensed and also had prior convictions for driving while unlicensed/disqualified. This is discussed further at [2.3].

2.3 Characteristics of recidivist drink driving offenders

2.3.1 Assessing the adequacy of current criminal justice responses to repeat drink drivers and developing an appropriate and effective response to recidivist drink drivers requires an understanding of the characteristics of recidivist drink drivers. Accordingly, this section provides an overview of the literature that has outlined the characteristics of drink drivers and factors relevant to the risk of reoffending. A number of studies have examined the characteristics of drink driving offenders, including recidivist drink drivers. While there is ‘[n]o one factor [that] has been useful in explaining or predicting drink driving behaviour’, the ‘literature demonstrates [that] there are a number of characteristics that are more common in drink driving offender populations’.⁶⁸ Research has also found that there are differences in the characteristics of first-time and repeat offenders.⁶⁹ This section also provides a summary of the findings of the TLRI/TILES study that constructed a profile of recidivist drink driving offenders in Tasmania through an examination of records held by the Magistrates Court, Community Corrections and Tasmania Police to allow an assessment to be made of the applicability of research conducted elsewhere to the Tasmanian context.⁷⁰

Socio-demographic characteristics

Literature review

2.3.2 An analysis of current research conducted in Australia in 2015, found that, while most drink driving offenders are male, once women have been convicted of a drink driving offence, the risk of re-conviction is similar to that for men.⁷¹ The average age for first-time drink drivers is around 30 years old and recidivists tend to be older.⁷² First-time offenders tend to be better educated, more likely to be employed and have a higher household income than repeat offenders.⁷³ Drink drivers are more likely to be single.⁷⁴ However, research also shows that there is significant divergence in attributes for recidivist drink drivers. For example, a New South Wales study found that a majority of repeat drink

⁶⁶ TSAC, *Sentencing of Driving Offences that Result in Death or Injury*, Final Report 8 (2017).

⁶⁷ Richardson, above n 6, 6.

⁶⁸ Wilson, above n 35, 39.

⁶⁹ Watson et al, above n 38.

⁷⁰ Full details and results of this study are set out in the Issues Paper, see TRLI, *Responding to the Problem of Recidivist Drink Drivers*, Issues Paper 23, May 2017.

⁷¹ Wilson, above n 35, 32–33.

⁷² Ibid 33.

⁷³ Ibid 33. See Trimboli and Smith, above n 28.

⁷⁴ Wilson, above n 35, 33.

drivers were male, indigenous, below the age of 25 and lived in areas of high socio-economic disadvantage.⁷⁵ A Victorian study found that offenders who committed 10 or more offences were all male and ranged in age from 35–71.⁷⁶

TLRI/TILES study

2.3.3 The TLRI/TILES study found that:

- The majority of offenders were male (87.5%).
- Offenders were most commonly aged between 30 and 39 (30–34 (14%); 35–39 (13%)). However, there was no particular trend overall between younger and older recidivist drivers sentenced to imprisonment, with half of offenders aged under 35 (50%) and half aged 35 and over (50%).
- Limited information was available about the current employment status of the offenders at the time of the index offences but available information showed that there was no clear trend towards offenders being employed or unemployed.
- More offenders lived in postcodes within the highest two quartiles of socio-economic disadvantage (54.2%) than the lowest two quartiles of socio-economic disadvantage (45.8%) based on the Socio-economic Indexes for Areas (SEIFA) index. However, most offenders lived in postcodes within the second and third highest level of disadvantage (29.2% and 27.8% respectively).
- The marital status of 24 offenders was unknown but for those cases where it was known, the majority were married or in a de facto relationship (62.5%).

Co-morbidity

Literature review

2.3.4 Research has shown that there is also a strong link between risky alcohol use and drink driving and that a key factor associated with recidivism is the extent of a person's alcohol problem.⁷⁷ American research has found that there is a much higher rate of lifetime alcohol-use disorder in the drink driving population (85% female and 91% male) compared to a matched sample from the general population (22% and 44% respectively).⁷⁸ Recent research found that nearly all driving while intoxicated offenders in the sample studied met the criteria for lifetime alcohol use disorder (96.6%) and a majority met the criteria for alcohol dependence (70.6%).⁷⁹ Other research has examined explanations for heavy and binge drinking and driving under the influence. It found that use of illicit drugs, alcohol dependence, drinking before 3 pm and drinking more than once daily predicted heavy

⁷⁵ Richardson, above n 6, 5.

⁷⁶ Ibid.

⁷⁷ Ibid 7; Wilson, above n 35, 36.

⁷⁸ Lapham et al, 'Prevalence of Psychiatric Disorders Among Persons Convicted of Driving While Impaired' (2001) 58 *Archives of General Psychiatry* 943, 943.

⁷⁹ Mullen et al, above n 33, 640.

binge drinking and driving and the number of self-reported drinking and driving episodes in the past year.⁸⁰

2.3.5 Research conducted in Western Australia found that over half of recidivist drink drivers in the sample were alcohol dependent (55%) and most (90%) scored as having a defined alcohol-related disorder.⁸¹ It has been reported that ‘drink driving is around 8 – 20 times more likely among drivers that regularly engaged in heavy episodic drinking compared to those that did not’.⁸² Similarly, South Australian research that examined fatal crashes over a three year period found that ‘drivers involved in fatal crashes had a greater prevalence of alcohol dependency than the Australian national average and those that were identified as being alcohol dependent were likely to have a high BAC’.⁸³

2.3.6 In a 2017 Australian study examining drivers’ attitudes to drink driving and their alcohol consumption patterns, Stephens et al found that, ‘the frequency of drink driving increased in-line with risky alcohol consumption patterns’.⁸⁴ Their study found that ‘only 13% of those with low risk alcohol consumption patterns had driven when possibly over the legal BAC limit in the past two years’ in contrast to ‘more than 76% of those classified with the highest level of alcohol consumption’.⁸⁵ This finding was said to provide additional support for similar findings in earlier research ‘using a large sample of drivers, representative of the age and gender distribution across each Australian jurisdiction’⁸⁶ and to provide support for the need to consider the ‘broader alcohol consumption patterns of drink-drivers’.⁸⁷ The authors concluded that ‘the patterns of association that emerged suggest that drink-driving is the expression of a broader health issue for the most “at-risk” cohort of drinkers’.⁸⁸

2.3.7 Research has also highlighted the co-morbidity of alcohol problems with other substance abuse issues and psychiatric disorders. American research published in 2015 found that, consistent with previous research, drink driving offenders ‘represent[ed] a clinical population with high levels of unmet treatment needs beyond just their alcohol misuse’.⁸⁹ It found that a large proportion of offenders presented with ‘additional substance use disorders and psychiatric disorders’⁹⁰ with 50.4% having been diagnosed with a lifetime substance abuse disorder that included alcohol and other substance use disorders, and 26% having previously been diagnosed with a psychiatric disorder (not a substance use disorder).⁹¹ This is consistent with broader research that found that ‘for drink drive offenders with alcohol-use disorders, 50% of women and 33% of men had at least one additional

⁸⁰ F Sloan, L Eldred and D Davis, ‘Addiction, Drinking Behaviour and Driving Under the Influence’ (2014) 49 *Substance Use and Misuse* 661, 672.

⁸¹ S Lenton, J Fetherston and R Cercarelli, ‘Recidivist Drink Drivers’ Self-Reported Reasons for Driving Whilst Unlicensed – A Qualitative Analysis’ (2010) 42 *Accident Analysis and Prevention* 637, 639.

⁸² H Watling and K Armstrong, ‘Predicting Self-Reported Drink Driving Among Middle-aged Women’ (2017) 101 *Accident Analysis and Prevention* 154, 154–155. This research examined drink driving in middle-aged woman and found that ‘middle-aged women who engage in harmful alcohol consumption are more likely to drink drive; harmful alcohol use was associated with an 11% increase in the likelihood of self-reported drink driving per one unit increase’: at 158.

⁸³ Wundersitz and Raftery, above n 42, 786.

⁸⁴ N Stephens et al, above n 26, 249.

⁸⁵ Ibid.

⁸⁶ Ibid.

⁸⁷ Ibid 250.

⁸⁸ Ibid 241.

⁸⁹ Mullen et al, above n 33, 641.

⁹⁰ Ibid. See also, J Freeman, J Maxwell and J Davey, ‘Unraveling the Complexity of Driving While Intoxicated: A Study into the Prevalence of Psychiatric and Substance Abuse Comorbidity’ (2011) 43 *Accident Analysis and Prevention* 34.

⁹¹ Mullen et al, above n 33, 641.

psychiatric disorder other than drug abuse or dependence'.⁹² In addition, for drink driving offenders, 32% of females and 38% of male offenders had a drug use disorder compared to a matched sample from the general population (16% and 21% respectively).⁹³

TLRI/TILES study

2.3.8 The TLRI/TILES study indicated that:

- Of those 46 offenders (out of 72) where information about alcohol abuse was disclosed, 39 were identified for alcohol abuse (84.8%).⁹⁴
- Of those 43 offenders (out of 72) where information about substance abuse was disclosed, 32 were identified as using illicit substances and/or abuse of prescription medication (74.4%). The most commonly identified illicit substance was cannabis.
- Of those 44 offenders (out of 72) where such information was disclosed, 77.3% were identified as experiencing a mental illness, most commonly depression and anxiety. Other mental illnesses included Attention Deficit Disorder, Bipolar Disorder, Personality Disorder and Post-Traumatic Stress Disorder.⁹⁵

2.3.9 The majority of offenders had a blood alcohol reading for the index offence of 0.1 or greater and while most offenders were subject to a prior order or statutory requirement to have no alcohol in their bodies (94.4%), only five offenders (8.3%) had a blood alcohol reading under 0.05. This suggests that the index offence was not simply a matter of misjudgement. This is consistent with other research and with the observations of Richardson who noted that studies 'suggest that repeat drink drivers could appropriately be described as a clinical population rather than a non clinical population with long term problems requiring long term responses'.⁹⁶ This cohort of offenders had complex needs with cross-sectional vulnerabilities that were unlikely to be resolved without understanding those vulnerabilities and the use of targeted and individualised treatment.

Attitudinal factors

Literature review

2.3.10 Research shows that there is a strong link between attitudinal factors and drink driving. Attitudes relating to drink driving have been found to predict drink driving at a community level.⁹⁷ Research examining the attitudes of drink driving offender samples has found that offenders are 'more likely to think that the risks of drink driving [are] overrated and that everybody drinks once in a while'.⁹⁸ Other research has highlighted that despite the shift in community attitude towards drink driving, 'a significant number of individuals do not view drink-driving as a socially unacceptable or inappropriate behaviour' and that 'attitudes towards drink driving significantly relate to drink-driving

⁹² Lapham et al, above n 78, 943.

⁹³ Ibid.

⁹⁴ This information was obtained from pre-sentence reports (which were available for 50 offenders) and/or audio files of passing sentence.

⁹⁵ This information was obtained from pre-sentence reports (which were available for 50 offenders), audio files of passing sentence and/or from the cross-reference with the Magistrates Court Mental Health Diversion List.

⁹⁶ Richardson, above n 6, 7.

⁹⁷ Wilson, above n 35, 35, citing Mackenzie, Watling and Leal (2014) and Freeman and Watson (2009).

⁹⁸ Ibid 36. See M Ferguson et al, 'The Impact of the "Under the Limit" Drink Driving Rehabilitation Program on the Lifestyle and Behaviour of Offenders' (Road Safety Research Report CR 187, 2001) 24–25.

behaviour'.⁹⁹ Recent Australian research that reported on differences in attitudes to drink driving found '[d]rivers who reported drink-driving behaviour and had high-risk alcohol consumption patterns [were] less likely to agree that drink-driving leads to increased crash risk and more likely to agree they drink and drive when they believed they could get away with it'.¹⁰⁰ The authors indicated that the results suggested that 'drink-drivers may find this behaviour more socially acceptable'. It was reported that the results showed 'that attitudes to drink driving were remarkably worse for drink-drivers, but also further deteriorated as the level of drinking increased'.¹⁰¹ These attitudes have been anecdotally reported by Tasmanian magistrates, who have indicated that some repeat drink drivers demonstrate a 'too bad I got caught' attitude and that they 'do not necessarily think of the danger to themselves and others as a possible component of their behaviour'.¹⁰²

2.3.11 Other research has highlighted the factors underlying the decision to drink drive as a 'combination of their urge to drink, their lack of self-control, and their inability to foresee the consequences of their actions', which can be addressed (at least to some degree) by treatment.¹⁰³

2.3.12 Attitudinal factors may also lead an offender to continue to drive (and drink drive) during any disqualification period.¹⁰⁴ In addition, employment and social factors may motivate offenders to drive whilst disqualified.¹⁰⁵ Stephens et al's 2017 Australian study found that 'approximately half of hazardous (47%) and high-risk (57%) drinkers included in the study were employed full-time suggesting that driving is most likely a necessary activity in their daily lives'.¹⁰⁶

TLRI/TILES study

2.3.13 Attitudinal factors were not examined in the TLRI/TILES study, however, the association between repeat drink driving and unlicensed driving was identified.¹⁰⁷

Criminal history

Literature review

2.3.14 Previous studies have concluded that 'among at least a portion of DUI recidivists, drinking and driving might be best viewed *as just one manifestation of a host of deviant behaviours*'.¹⁰⁸ Repeat drink drivers have been found to have worse driving records and to be charged with more non-driving criminal offences than first-time offenders.¹⁰⁹ Repeat drink drivers have more extensive criminal

⁹⁹ Stephens et al, above n 26, 242 citing Davey et al, 'Drug and Drink Driving by University Students: An Exploration of Attitude' (2005) 6 *Traffic Injury Prevention* 44, and Freeman and Watson 'Drink Driving Deterrents and Self-reported Offending Behaviours Among a Sample of Queensland Motorists' (2009) 40 *Journal of Safety Research* 113.

¹⁰⁰ Ibid 241.

¹⁰¹ Ibid 250.

¹⁰² Bartkowiak-Théron and Henning, above n 4, 6.

¹⁰³ S Andersen, 'Drinking Alone? The Effect of an Alcohol Treatment Program on Relationship Stability for Convicted Drunk Drivers in Denmark' (2016) 665 *The Annals of the American Academy* 46, 50.

¹⁰⁴ Wilson, above n 35, 36.

¹⁰⁵ Lenton, Fetherston and Cercarelli, above n 81, 639.

¹⁰⁶ Stephens et al, above n 26, 249.

¹⁰⁷ See [2.3.18].

¹⁰⁸ M Hallstone, 'The Criminal History of Repeat DUI Offenders' (2013) 31 *Alcoholism Treatment Quarterly* 337, 344 (italics in original).

¹⁰⁹ N Bishop, 'Predicting Rapid DUI Recidivism Using the Driver Risk Inventory on a State-Wide Sample of Floridian DUI Offenders' (2011) 118 *Drug and Alcohol Dependence* 423, 423. See also Møller, Haustein and Prato, above n 53, 129-30.

histories (separate from drink driving and traffic offences) than other drink drivers.¹¹⁰ Research has found that DUI recidivists have ‘more extensive violent and property criminal histories than other drunk drivers’.¹¹¹ Accordingly, it has been suggested that reoffenders with a criminal history may need special attention in treatment programs as ‘they represent a more entrenched group (than offenders whose criminal history is limited to drink driving) who may be less responsive to traditional treatments’.¹¹²

TLRI/TILES study

2.3.15 Predictably, given that this cohort of offenders received a custodial sentence for the index offence, many of the offenders had several prior drink driving convictions. Nearly three-quarters of offenders had three or more convictions for drink driving (72.3%) and many offenders had previously received a custodial sentence for drink driving. Where the information was known (n = 62), 61.3% of offenders had previously received a fully suspended sentence for a drink driving offence, with approximately one in five previously having received a partly suspended sentence (21%) and/or a fixed term of imprisonment (16.2%). In total, 18 offenders had previously been imprisoned for a drink driving offence. Further, although not designed as a study to examine breaches of suspended sentences, the prior conviction information revealed that of the 41 offenders who had previously been sentenced to at least one suspended sentence for drink driving, 28 had breached the order (68.3%).¹¹³

2.3.16 The study also provides an insight into the wider offending history of repeat drink driving offenders. All of the offenders had had at least one prior conviction for an offence other than a drink driving offence in the past five years. For the 70 offenders whose lifetime history of offending was known, 80% had prior convictions for dishonesty and property offences, 55.7% had prior convictions for violent offending (excluding domestic violence), 34.3% had prior convictions for drug offences and 24.3% had prior convictions for domestic violence.

Repeat drink driving and unlicensed driving

2.3.17 Research has identified an association between drink driving and other illegal behaviour such as unlicensed driving or driving while suspended/disqualified.¹¹⁴ Previous research has also found that many disqualified drivers continue to drive while disqualified,¹¹⁵ and that some offenders continue to drive without a licence even after the period of disqualification as they do not reapply for a licence.¹¹⁶ Moreover, research has found that repeat drink drivers are also more unlikely to comply with court

¹¹⁰ Hallstone, above n 108, 342–343. This also reflects findings from research conducted in relation to high-range speeding offenders, where it was found that repeat high-range offenders are more likely to have committed a previous criminal offence compared to the other offenders or the once only low-range offenders. More than half of the repeat high-range speeding offenders had a criminal history (55.2%), compared to 21% of other offenders and 7% of once only low-range offenders: B Watson et al, ‘Profiling High-Range Speeding Offenders: Investigating Criminal History, Personal Characteristics, Traffic Offences, and Crash History’ (2015) 74 *Accident Analysis and Prevention* 87, 91.

¹¹¹ M Hallstone, ‘Types of Crimes Committed by Repeat DUI Offenders’ (2014) 27 *Criminal Justice Studies* 159, 166.

¹¹² Hallstone, above n 108, 344; T Nochajski et al, ‘The Effects of a Drinker-Driver Treatment Program: Does Criminal History Make a Difference?’ (1993) 20 *Criminal Justice and Behaviour* 174.

¹¹³ All breaches identified were actions for breach brought by prosecution noted on an offender’s criminal history except where no action was brought (but could have been brought) in one case.

¹¹⁴ B Watson, *The Psychosocial Characteristics and On-road Behaviour of Unlicensed Drivers* (PhD Thesis, Queensland University of Technology, 2004).

¹¹⁵ B Clark and I Bobevski, *Disqualified Drivers in Victoria: Literature Review and In-depth Focus Group Study* (Monash University Accident Research Centre, Report 272, 2008) x, xii; B Watson and A Nielson, *Submission to Travelsafe: Vehicle Impoundment for Drink Drivers* (Centre for Accident Research and Road Safety, 2006) 12.

¹¹⁶ VSAC, above n 30, 32.

sanctions.¹¹⁷ A recent Victorian study, published in 2017, examined the effects of licence disqualification on drink drivers convicted of drink driving between 1996 and 2002 (29 204 offenders) and found that 4% of the sample were detected drink driving while disqualified from driving.

TLRI/TILES study

2.3.18 Nearly 70% of the repeat drink drivers in this study were unlicensed or drove while suspended/disqualified at the time of the index offence. For the 72 offenders included in this study, most of the offenders sentenced to a custodial sentence were convicted of offences that related to breaches of no alcohol requirements (94.4%).¹¹⁸ This reflects their drink driving offending history — either their status as disqualified or unlicensed drivers or their number of prior convictions in a specified period. The majority of offenders were subject to a prior court order at the time of the index offence (62.5%) with the most common order being a licence disqualification or suspension. In addition, 87.1% of the offenders had a prior conviction for driving while disqualified/unlicensed driving.

2.4 Inadequacy of current responses to repeat drink drivers

2.4.1 The Issues Paper provided a detailed account of the current sentencing regime and practice in Tasmania in relation to drink driving. This Final Report provides an overview of the current sentencing regime and then focuses on the limits of the current criminal justice response to repeat drink drivers and the need for a different approach.

Current sentencing regime

2.4.2 The *Road Safety (Alcohol and Drugs) Act 1970* (Tas) s 6(1) creates an offence of driving with a concentration of alcohol in a person's breath or blood greater than a concentration of 0.05 of a gram of alcohol in 210 litres of breath or a concentration of 0.05 of a gram of alcohol in 100 millilitres of blood (known as exceed .05). It is an offence for certain drivers to drive with any alcohol present in their body — this includes people without a driver's licence, learner drivers, provisional drivers, drivers of prescribed vehicles (for example public passenger vehicles), people convicted of serious traffic offences who have also been convicted of driving under the influence and those people driving with a restricted driver's licence.¹¹⁹ In addition, certain repeat drink drivers must not drive with any alcohol in their body.¹²⁰ The *Road Safety (Alcohol and Drugs) Act 1970* (Tas) s 4 also creates a more

¹¹⁷ Lapham and England-Kennedy, above n 61, 17.

¹¹⁸ The offenders were either unlicensed, disqualified, suspended, previously convicted of three or more offences within any 10 year period arising from at least three separate incidents, or in breach of the conditions of their licence.

¹¹⁹ *Road Safety (Alcohol and Drugs) Act 1970* (Tas) ss 6(2)–(3).

¹²⁰ The *Road Safety (Alcohol and Drugs) Act 1970* (Tas) s 6(4) provides that the no alcohol rule applies if – (a) the person has been convicted within any 10 year period of 3 or more offences under this Act arising from at least 3 separate incidents; and (b) at least one of those offences was committed on or after 12 December 1991; and (c) either – (i) less than 10 years has passed since the last of those convictions was recorded; or (ii) 10 or more years have passed since the last of those convictions was recorded and the person has not provided to the Registrar of Motor Vehicles the certificate of a medical practitioner or a prescribed person certifying that the person is not alcohol-dependent.

serious offence of driving while under the influence of intoxicating liquor or a drug to the extent that he or she is incapable of having proper control of the vehicle.¹²¹

2.4.3 Sentencing for drink driving is governed by the *Road Safety (Alcohol and Drugs) Act 1970* (Tas), the *Sentencing Act 1997* (Tas) and the common law.

2.4.4 The *Road Safety (Alcohol and Drugs) Act 1970* (Tas) s 17 sets out specific penalties for drink driving offences, which include minimum and maximum fines, periods of disqualification and maximum terms of imprisonment (see tables 2–2 and 2–3). As a general rule, the court must impose:

- at least the minimum fine or a term of imprisonment; and
- must disqualify the person from driving for a period not less than the minimum period.¹²²

However, the court can impose a lesser fine or period of disqualification if there are special circumstances.¹²³ Nevertheless, the court must, in exercising this discretion, impose a fine of some amount (unless imprisonment is imposed) and a period of disqualification. In contrast, the court has a discretion as to whether to impose a term of imprisonment not exceeding the maximum term provided.

2.4.5 In addition, the *Road Safety (Alcohol and Drugs) Act 1970* (Tas) s 18B provides for immediate disqualification (from the time of the offence) in circumstances where a person is issued with an excessive drink driving notice. This notice can be issued to a person with a full licence whose blood or breath alcohol is 0.15 or more. It can also be issued to a person who does not hold a full licence or holds a foreign driver licence, a learner licence or provisional licence, and whose blood or breath alcohol reading is 0.07 or more. An excessive drink driving notice can also be served on a repeat drink drive offender.¹²⁴ If the offender is disqualified from driving, on the subsequent hearing of the charge the court must take into account, in fixing the period of disqualification, any disqualification served under an excessive drink drive notice.¹²⁵

2.4.6 The penalties imposed for drink driving aim to protect the public from the danger posed by addressing a number of sentencing aims — deterrence, rehabilitation, incapacitation and punishment. A fine is a punitive sanction aimed at deterring the public generally, as well as the individual offender, from drinking and driving.¹²⁶ Similarly, disqualification is viewed as a ‘major deterrent to the great majority of drivers’¹²⁷ and it also provides community protection by ‘keeping potentially dangerous drivers off the road’.¹²⁸ In this sense, it has an incapacitating effect (if the offender complies with the order). However, the period of disqualification imposed also should be of a length that is not ‘so great as to offer little or no hope’ in order to encourage the rehabilitation of the offender.¹²⁹ In relation to persistent offending, courts have stressed the need to give sufficient weight to the principle of deterrence and that the imposition of a term of imprisonment should not be

¹²¹ See Kate Warner, *Sentencing in Tasmania* (Federation Press, 2nd ed, 2002) [14.525].

¹²² *Road Safety (Alcohol and Drugs) Act 1970* (Tas) s 17(3).

¹²³ *Ibid* s 17(5). See *Harper v Cullen* (2002) 11 TAS R 211; *Bottomley v McDonald* (2002) TASSC 27 for a discussion of special circumstances. See also Warner, above n 121, [6.312].

¹²⁴ *Road Safety (Alcohol and Drugs) Act 1970* (Tas) s 18B(1)(b).

¹²⁵ *Ibid* s 18B(6).

¹²⁶ Warner, above n 121, [14.522].

¹²⁷ *Jarvis v Brown and McDonald* [1998] TASSC 120, 5 (Evans J).

¹²⁸ *Ibid*.

¹²⁹ *Ibid*.

reserved for extraordinary cases.¹³⁰ In addition, imprisonment is intended to encourage the rehabilitation of the offender by providing a ‘shock [that] may prompt him [or her] to revise his [or her] lifestyle and abstain from drink driving’.¹³¹

2.4.7 Under the *Road Safety (Alcohol and Drugs) Act 1970* (Tas), the courts have no discretion in regard to the imposition of fines and periods of disqualification and a constrained discretion as to the level of the fine and the length of disqualification. In addition, as shown in Table 3-1 and Table 3-2, a distinction is drawn between first and subsequent drink driving offences with more severe sanctions specified for repeat offences. The penalty for a repeat offender is double that for a first offender. A person is guilty of a subsequent offence if that person has previously been convicted of an offence contained in the Table in the *Road Safety (Alcohol and Drugs) Act 1970* (Tas) s 17.¹³²

Table 2-2: Penalties for first offence under the *Road Safety (Drug and Alcohol) Act 1970* (Tas), s 17

| Section of Act or offence | Concentration of alcohol in breath in grams per 210 litres of breath or in blood in grams per 100 millilitres of blood | Fine | Period of disqualification | Term of imprisonment |
|---------------------------|--|---|--------------------------------|----------------------|
| Section 6(2) | less than 0.05 | Min 2 penalty units Max 10 penalty units | Min 3 months Max 12 months | 3 months |
| Section 6(1) | 0.05 or more but less than 0.1 | Min 2 penalty units Max 10 penalty units | Min 3 months Max 12 months | 3 months |
| | 0.1 or more but less than 0.15 | Min 4 penalty units Max 20 penalty units | Min 6 months Max 18 months | 6 months |
| | 0.15 or more | Min 5 penalty units Max 30 penalty units | Min 12 months Max 36 months | 12 months |
| Section 4 | | Min 5 penalty units Max 30 penalty units | Min 12 months Max 36 months | 12 months |

Table 2-3: Penalties for subsequent offence under the *Road Safety (Drug and Alcohol) Act 1970* (Tas), s 17

| Section of Act or offence | Concentration of alcohol in breath in grams per 210 litres of breath or in blood in grams per 100 millilitres of blood | Fine | Period of disqualification | Term of imprisonment |
|---------------------------|--|--|--------------------------------|----------------------|
| Section 6(2) | less than 0.05 | Min 4 penalty units Max 20 penalty units | Min 6 months Max 24 months | 6 months |
| Section 6(1) | 0.05 or more but less than 0.1 | Min 4 penalty units Max 20 penalty units | Min 6 months Max 24 months | 6 months |
| | 0.1 or more but less than 0.15 | Min 8 penalty units Max 40 penalty units | Min 12 months Max 36 months | 12 months |
| | 0.15 or more | Min 10 penalty units Max 60 penalty units | Min 24 months Max 72 months | 24 months |
| Section 4 | | Min 10 penalty units Max 60 penalty units | Min 24 months Max 72 months | 24 months |

1 penalty unit is currently \$154.00¹³³

¹³⁰ *McDonald v Nilsson* [2009] TASSC 83, [14] (Crawford J).

¹³¹ *Jarvis v Brown and McDonald* [1998] TASSC 120, 5 (Evans J).

¹³² *Road Safety (Alcohol and Drugs) Act 1970* (Tas) s 17(1)(b). This includes driving under the influence, driving with excessive concentration of alcohol, driving with illicit drug present in blood, objecting to blood analysis and failure to comply with direction to have blood or breath test.

¹³³ See *Penalty Units and Other Penalties Act 1987* (Tas) s 4A(1).

2.4.8 In addition to the penalty provisions contained in the *Road Safety (Alcohol and Drugs) Act 1970* (Tas), the *Sentencing Act 1997* (Tas) s 7 sets out the range of sentencing options that are available to the courts in sentencing adult offenders (and young offenders sentenced as adults):

A court that finds a person guilty of an offence may, in accordance with this Act and subject to any enactment relating specifically to the offence —

- (a) record a conviction and order that the offender serve a term of imprisonment; or
- (ab) if the court is constituted by a magistrate, record a conviction and make a drug treatment order under Part 3A in respect of the offender; or
- (b) record a conviction and order that the offender serve a term of imprisonment that is wholly or partly suspended; or
- (c) record a conviction and, if the offender has attained the age of 18 years and the offence is punishable by imprisonment, make a community service order in respect of the offender; or
- (d) with or without recording a conviction, make a probation order in respect of the offender if the offender has attained the age of 18 years; or
- (e) record a conviction and order the offender to pay a fine; or
- (ea) in the case of a family violence offence, with or without recording a conviction, make a rehabilitation program order; or
- (f) with or without recording a conviction, adjourn the proceedings for a period not exceeding 60 months and, on the offender giving an undertaking with conditions attached, order the release of the offender; or
- (g) record a conviction and order the discharge of the offender; or
- (h) without recording a conviction, order the dismissal of the charge for the offence; or
- (i) impose any other sentence or make any order, or any combination of orders, that the court is authorised to impose or make by this Act or any other enactment.

2.4.9 In the context of drink driving, instead of imposing a term of immediate imprisonment to be fully served, the magistrate may impose a fully or partly suspended sentence of imprisonment.¹³⁴ A fully suspended sentence means that the whole sentence is not activated and the offender is immediately released into the community. A partly suspended sentence means that the offender spends a specified period of time in prison before being released into the community. Suspension is a means of achieving rehabilitative aims and the imposition of a sentence of imprisonment is said to have a symbolic effect of denouncing the crime, while its suspension acts as a specific deterrent for the offender, which is created by the threat of imprisonment (the ‘Sword of Damocles’ hanging over the offender’s head).¹³⁵ In its review of suspended sentences, TSAC found that exceeding the prescribed concentration of alcohol is one of the top ten offences dealt with in the Magistrates Court

¹³⁴ It is noted that the Tasmanian Government has indicated its intention to abolish suspended sentences and to replace them with ‘best practice sentencing options that provide an opportunity for rehabilitation and represent an appropriate response to the gravity of the crime committed’, Tasmanian Liberals, *Abolishing Suspended Sentences*, 2 <<https://www.tas.liberal.org.au/sites/default/files/policy/Abolishing%20suspended%20sentences.pdf>>.

TSAC has undertaken a reference that examines the phasing out of suspended sentences in Tasmania and the introduction of a new intermediate sentencing order(s): see, TSAC, *Phasing out of Suspended Sentences*, Consultation Paper (2015); TSAC, *Phasing out of Suspended Sentences*, Final Report No 6 (2016).

¹³⁵ See Lorana Bartels, *Sword or Feather? The Use and Utility of Suspended Sentences in Tasmania* (PhD thesis, University of Tasmania, 2008) [1.4.1]–[1.4.2].

for which fully suspended sentences (9.1% of all fully suspended sentences imposed) or partly suspended sentences are imposed (6.2% of all partly suspended sentences imposed).¹³⁶

2.4.10 The court also has the power to impose a community service order or a probation order. However, there is no power for the court to impose a community service order instead of imprisonment or a fine.¹³⁷

2.4.11 In addition, under s 8 of the *Sentencing Act 1997* (Tas), the court has the power to combine a number of sentencing orders, including a term of imprisonment, a community service order, a probation order (if a conviction is recorded) and a fine with a driving disqualification order.

Sentencing drink drivers

2.4.12 The majority of drivers sentenced for drink driving receive a fine and a period of licence disqualification. In the Issues Paper, the TLRI/TILES study found that in the period 2008–09 to 2013–14, only 730 custodial sentences were imposed (imprisonment or partially suspended sentence). In contrast, in this same period 21 222 offenders were sentenced in the Magistrates Court for drink driving offences.¹³⁸ This means that only a small proportion of offenders (3.4%) received a custodial sentence. The custodial sentences imposed (fixed imprisonment and partly suspended sentences) ranged from a sentence of less than three months to a sentence of between 18 months and less than 24 months. The most common sentence was a sentence of between three and less than six months (47.2%). Nearly all offenders were sentenced to a term of imprisonment of less than 12 months (93%).¹³⁹ It is not possible to isolate from the data the sentencing practice for repeat offenders (other than charges relating to the specific offence for repeat offenders convicted of three or more offences within any 10-year period, *Road Safety (Alcohol and Drugs) Act 1970* (Tas), s 6(4)), as the data do not distinguish between first and repeat offenders.

2.4.13 Magistrates Court data reported by then Chief Magistrate Hill show that 88.8% of drink drivers in prison had previously served a custodial sentence for a drink driving offence. Of offenders who received a custodial sentence between 2007–08 to 2012–13:

- 11.1% had previously received a fully suspended adult sentence;
- 44.4% had previously been sentenced to imprisonment with a partially suspended term;
- 44.4% had previously been sentenced to imprisonment for a determined term.¹⁴⁰

Chief Magistrate Hill concluded that ‘drink drivers in prison are principally recidivist, “hard core” offenders (with a BAC in excess of 0.15)’.¹⁴¹

2.4.14 In relation to repeat drink drivers sentenced to a custodial sentence, the TLRI study similarly found that, where prior sentence information was available (n = 62), many of the offenders had

¹³⁶ TSAC, Final Report, above n 134, 20. This related to all offences for which sentences were imposed in the Magistrates Court in 2011–14 (n = 114 195).

¹³⁷ *Wilkie v Taylor* [2015] TASFC 7 (Blow CJ, Pearce J, Estcourt J dissenting).

¹³⁸ Information provided by Victor Stojcevski, email 6 February 2017.

¹³⁹ See the TLRI/TILES study, TLRI, above n 70, [2.3].

¹⁴⁰ Hill, above n 1, 10.

¹⁴¹ *Ibid.*

previously received a fully suspended sentence for a drink driving offence (61.3%) with approximately one in five offenders previously having received a partly suspended sentence (21%) and/or a fixed term of imprisonment (16.2%). Eighteen offenders had previously been imprisoned for a drink driving offence and 27 offenders had previously been imprisoned for any previous offence.

Programs available for drink drivers

Sober driver program

2.4.15 In response to concerns about recidivist drink drivers, the ‘Sober Driver’ Program was instituted by Community Corrections in Tasmania in July 2008. This is a post-conviction education program, which magistrates may direct offenders to participate in as part of the sentences they impose. There is no explicit statutory basis for the sober driver program. Instead, the program can be imposed as a condition of a suspended sentence or as part of a probation order or a community service order.¹⁴² Based on the information provided in the Department of Justice Annual Report, it is an educational and skill based group program that targets adult offenders who are convicted of two or more drink driving offences within a five-year period.¹⁴³ The program was developed in NSW and is delivered over a nine-week period, consisting of one two-hour session per week. It is conducted by two trained facilitators and addresses issues associated with drink driving, including the consequences of drink driving, the effects of alcohol on driving, managing drinking situations, alternatives to drink driving and relapse prevention and stress management. A condensed version of the program has also been delivered.¹⁴⁴ The purpose of the program is to assist repeat offenders to separate drinking from driving.¹⁴⁵

2.4.16 Community Corrections receives a high number of offender referrals from the Magistrates Court, and there is a high demand for the Sober Driver Program. In 2014 and 2015, 1240 offenders were assessed as being eligible for the Sober Driver Program pre-sentence and 773 were found to be suitable for the program. This figure represents offenders who received a community-based order and were found suitable to participate in the Sober Driver Program post sentence. It does not indicate what proportion of these offenders commenced the program. They may have undertaken alternative interventions such as individual work with their supervising Probation Officer around decision making, alcohol use, and/or treatment for mental health issues.¹⁴⁶ From its inception in 2008 until 2014–15, 711 offenders had successfully completed the Sober Driver Program.¹⁴⁷

2.4.17 There has been no evaluation of the Tasmanian program that has identified recidivism rates for those who complete the program compared to those who were not referred to the program or those who were assessed as eligible and suitable but did not complete the program. However, the New South Wales Sober Driver Program (on which the Tasmanian program is based) has been evaluated. It

¹⁴² *Sentencing Act 1997* (Tas) ss 24(2), 28(g), 37(2)(a).

¹⁴³ Department of Justice, Tasmania, *Annual Report 2014–15*, 63–64.

¹⁴⁴ *Ibid* 64.

¹⁴⁵ E Mazurski, D Withaneachi and S Kelly, ‘The NSW Sober Driver Program: Recidivism Rates and Program Parameters’ (Paper presented at the Australasian Road Safety Research, Policing and Education Conference, Perth, Western Australia, 2011).

¹⁴⁶ Information provided by Michelle Lowe, email 20 March 2017.

¹⁴⁷ Information provided by Michelle Lowe, 4 March 2016.

was found that the program is ‘an effective intervention, demonstrating greater reductions in recidivism when compared with legal sanctions alone’.¹⁴⁸

Equips (Addiction)

2.4.18 Community Corrections delivers EQUIPS (Addiction) as a program to target offenders with high level addictive behaviours in relation to alcohol and other drugs and gambling. Eligibility for the program centres on the Alcohol Use Disorders Identification Test (AUDIT) with a score of 16 or above on the AUDIT making an offender eligible for the program. In addition, the use of alcohol needs to have some impact on their offending behaviour. Delivery of this program was introduced in 2017 to replace Getting SMART, which was not regularly delivered by Community Corrections due to resourcing issues.¹⁴⁹ Drink drivers are eligible for the program and Community Corrections have had a number of offenders complete the program as a result of their drink driving offences. Some have participated in both the Sober Driver Program and EQUIPS Addiction. As at November 2017, referral rates for drink drivers to the EQUIPS Addiction Program are as follows:

- North – five offenders referred and were waitlisted to commence in January 2018.
- North West – 12 offenders referred with three having completed the program and one person undertaking the program. There were eight offenders waitlisted to commence January/February 2018.
- South – six offenders referred with two people having completed the program and one person undertaking the program. There are three offenders who were waitlisted to commence January 2018.¹⁵⁰

Mandatory Alcohol Interlock Program

2.4.19 In recent years, a mandatory alcohol interlock program has been introduced in Tasmania ‘with the aim of reducing recidivism and promoting the rehabilitation of recidivist drink driving offenders’.¹⁵¹ It also serves as a means of incapacitation, because it prevents drivers from operating vehicles under the influence of alcohol.¹⁵² An alcohol ignition interlock is a ‘breath-testing device that is connected to a vehicle’s ignition and stops a driver starting a vehicle if they have been drinking alcohol’.¹⁵³ Unlike the approach in some other Australian jurisdictions,¹⁵⁴ the interlock program in Tasmania is not a sentencing option but is incorporated into the process of applying for a new licence

¹⁴⁸ K Mills et al, ‘An Outcome Evaluation of the New South Wales Sober Driver Programme: A Remedial Programme for Recidivist Drink Drivers’ (2008) 27 *Drug and Alcohol Review* 65, 65.

¹⁴⁹ TSAC, above n 66, 39.

¹⁵⁰ Information provided by Michelle Lowe, email 27 November 2017.

¹⁵¹ Bartkowiak-Théron and Henning, above n 4, 3.

¹⁵² Elder et al, above n 60, 372.

¹⁵³ Department of State Growth (Tasmania), Transport, *Tasmania’s Mandatory Alcohol Interlock Program Frequently Asked Questions* <<http://www.transport.tas.gov.au/licensing/offences/interlocks/faq>>.

¹⁵⁴ See for example, New South Wales, where the magistrate must impose an order (subject to limited exceptions) for drivers convicted of certain high range, repeat or other serious drink driving offences, *Road Transport Act 2013* (NSW) s 210. See also Roads and Marine, NSW, *Alcohol Interlock Program: Guide for Magistrates, Legal Practitioners and Police Prosecutors* (2015). In the Northern Territory, a court may impose an alcohol ignition lock program on certain repeat drink driver offenders to be served at the end of the period of disqualification. The person can apply to have an interlock installed or can service the alcohol ignition lock period as an additional period of disqualification, see Department of Transport, Northern Territory, *Alcohol Ignition Lock Program* <<http://www.transport.nt.gov.au/mvr/alcohol-ignition-locks>>.

after serving the period of court imposed disqualification.¹⁵⁵ The legislative framework is provided in the *Vehicle and Traffic (Driver Licensing and Vehicle Registration) Regulations 2010* (Tas), Part 2 Division 3A. The program is administered by the Department of State Growth and applies to repeat drink drivers (offenders convicted of two or more drink driving offences in a five-year period), high level drink drivers (with blood alcohol concentrations of 0.15 or more) and offenders convicted of driving under the influence of liquor or failing to provide a breath/blood specimen for analysis. At the end of the period of licence disqualification, a person's licence will be issued with an 'I Condition' for a minimum period of 15 months, which requires that the person have an interlock device installed in the vehicle that they drive. The program comprises two stages: (1) a 'learning period' of 270 days (nine months), followed by; (2) a 'demonstration period' of a minimum of 180 days (six months). In order to complete the program, a person must have zero lockouts (that is, be alcohol free when driving and not prevented from driving by the interlock device) in the last 180 days. An interlock costs between \$3000 to \$3500 (including installation, rental, servicing and removal costs) with holders of a Health Care Card being eligible for a discount of up to 35%.¹⁵⁶

2.4.20 From the introduction of Tasmania's mandatory alcohol interlock program to 6 April 2016, there were 1301 interlocks imposed and 522 people had completed the program. There were 633 interlocks imposed for high level drink driving, 536 for repeat drink driving, 92 for driving under the influence and 33 for failing to provide a breath/blood specimen for analysis. There were five people who had reoffended with a breathalyser offence after completing the program.¹⁵⁷ There is no publically available evaluation of the interlock program.

Why doesn't the current sentencing approach work?

Overview of the literature

2.4.21 Parliament has introduced progressively more severe penalties in response to drink driving offences, and courts have stressed that the penalties imposed need to be sufficient to deter the offender (specific deterrence) as well as to deter other people (general deterrence) from driving motor vehicles while affected by alcohol. Courts also stress the need to impose harsh sanctions on repeat offenders to condemn their behaviour and to deter others.¹⁵⁸ As Warner has stated, '[s]tatements of judicial policy abound asserting that drink driving is a grave social evil carrying a substantial risk of causing death and serious injury and that accordingly there is a need for penalties which will deter the

¹⁵⁵ In Victoria, re-licensing of repeat drink drivers and drivers with a blood alcohol concentration over 0.10 is managed by the Magistrates Court and the court must impose an interlock for repeat offenders. The court makes the order to remove the interlock, see Magistrates Court, Victoria, *Alcohol Interlocks FAQ* <<http://www.magistratescourt.vic.gov.au/howdoi/alcohol-interlocks-faq-0>>. In the ACT, a mandatory interlock is required if an offender is convicted of exceed 0.15 or has two or more drink driving offences in the past five years. The offender can apply to the Road Transport Authority after they have served at least half the period of disqualification. The offender also requires assessment from the Court Alcohol and Drug Assessment Services prior to sentencing, see Road Transport Authority, ACT, *ACT's Alcohol Ignition Interlock Program: Frequently Asked Questions* <http://www.rego.act.gov.au/__data/assets/pdf_file/0003/606972/Interlock-FAQs.pdf>. Mandatory alcohol interlocks are also required for re-licensing following the disqualification period for repeat drink drivers and drivers with a blood alcohol concentration at or over 0.15 in South Australia and Queensland. In these jurisdictions, the interlock scheme is managed by the Roads Department (or equivalent). In Western Australia, legislation has been passed that will create an alcohol interlock scheme that will apply to certain drink drivers including repeat drink drivers as part of the re-licensing process, see *Road Traffic Amendment (Alcohol Interlocks and Other Matters) Act 2015* (WA) (the relevant sections are yet to be proclaimed).

¹⁵⁶ Department of State Growth, above n 153.

¹⁵⁷ Information provided by Andrea Batchelor, Department of State Growth, email 26 October 2016.

¹⁵⁸ See *McDonald v Nilsson* [2009] TASSC 83, [14] (Crawford CJ); *Barrett v Pearce* A6/1986, 4 (Neasey J); *Lusted v Kenway* [2008] TASSC 47, [41]–[42] (Porter J).

public as well as the individual offender from drinking and driving'.¹⁵⁹ However, it appears that traditional criminal justice responses, such as fines, imprisonment and disqualification, are not effective to deter some offenders from repeat offending. Further, research has generally shown that increasing the severity of traditional sentencing options has little or no impact on drink driving rates or recidivism rates for drink driving.¹⁶⁰ This leads to the criminal justice system being a revolving door for these offenders.¹⁶¹

2.4.22 In relation to imprisonment, most studies show that this is an ineffective deterrent for repeat drink drivers.¹⁶² A report prepared for the Royal Automobile Club of Victoria identified the following limitations of imprisonment as a means of reducing offending for repeat offenders:

People in prison, who are often the most serious offenders, remain a group that are not specifically targeted by the current rehabilitation programs ... Prison programs for drink driving offenders are almost uniformly unsuccessful. This may in part reflect the fact that successful rehabilitation requires practice in life skills and lifestyle change and this is not available to a prison population. Hence, further research is required into the likely effectiveness of targeting serious drink driving offenders who are in prison, including the option of special post-release programs.¹⁶³

2.4.23 Another explanation is that prison sentences are likely to be ineffective in changing drink driving behaviour given that most offenders receive a short sentence. This means that the period of imprisonment provides insufficient opportunity for participation in a rehabilitation program either in prison (due to the length of the sentence) or following release (given that short short-term prisoners are released at the end of their prison term unconditionally).¹⁶⁴ In Tasmania, for the majority of drink drivers sentenced to imprisonment, the term is less than six months and very few offenders receive a sentence of imprisonment longer than 12 months.¹⁶⁵

2.4.24 There is also little support in the literature for fines as a means of reducing recidivism for drink drivers.¹⁶⁶ Research conducted by the New South Wales Bureau of Crime Statistics using a sample of more than 12 000 cases found that 'higher fines are not a specific deterrent to drink-driving'.¹⁶⁷

2.4.25 In respect of traditional penalties (fines, imprisonment and licence suspension), research suggests that licence suspension 'has provided the strongest and most consistent evidence of

¹⁵⁹ Warner, above n 121, [14.522].

¹⁶⁰ Mullen et al, above n 33, 637 citing Friedman et al (1995), Ross and Klette (1995); Terer and Brown, above n 32, 5; R Homel 'Penalties and the Drink-Driver: A Study of One Thousand Offenders' (1981) 14 *Australian and New Zealand Journal of Criminology* 225, 237. However, note S Briscoe, above n 56, who found 'some evidence of beneficial effect' after penalties in NSW were increased but only for offenders who lived outside of the Sydney metropolitan area. For non-Sydney locations, 'the overall effect of the increased penalties on recidivism rates was relatively small, with the probability of a drink-driver reoffending being reduced by just three percentage points': at 8.

¹⁶¹ Bartkowiak-Théron and Henning, above n 4, 2.

¹⁶² Terer and Brown, above n 32, 5.

¹⁶³ Royal Automobile Club of Victoria, *Drink Driver Rehabilitation and Education in Victoria* (Research Report, 2005) 20.

¹⁶⁴ Warner, above n 56, 397, 399.

¹⁶⁵ TLRI, above n 70, [3.3].

¹⁶⁶ E Palmer et al, 'The Effect on Reconviction of an Intervention for Drink-Driving Offenders in the Community' (2012) 56 *International Journal of Offender Therapy and Comparative Criminology* 525, 526.

¹⁶⁷ D Weatherburn and S Moffatt, 'The Specific Deterrent Effect of Higher Fines on Drink-Driving Offenders' (2011) 51 *British Journal of Criminology* 789, 799.

effectiveness in reducing recidivism'.¹⁶⁸ Watson et al have observed that 'a large body of research ... has generally demonstrated licence disqualification periods to be one of the most effective methods for reducing further drink-driving offences'.¹⁶⁹ However, there are some drivers who will continue to drink drive while disqualified from driving.¹⁷⁰ For these drivers, there are limitations in relying on disqualification periods for recidivist offenders because the 'effectiveness of disqualification is dependent on whether it actually prevents drink drivers from driving'. Evidence shows that many recidivist drink drivers continue to drive without a licence and that they often continue to do so after they are eligible to regain their licence.¹⁷¹ The TLRI/TILES study found that nearly 70% of repeat drink drivers were unlicensed or drove while suspended/disqualified at the time of the index offence.¹⁷²

2.4.26 Repeat offenders may be less likely to be deterred by disqualification given that their 'longer histories of punishment avoidance' support their view that it is unlikely that they will be detected if they continue to drive (and drink drive).¹⁷³ Perceptions of risk of detection for drink driving are also related to repeat offending and research shows that 'drivers will continue to engage in drink driving if they frequently avoid detection'.¹⁷⁴ In-depth interviews with offenders have found that 'once suspended from driving for long periods ... the low risk of apprehension for driving without a licence combined with family and employment demands, inconvenience, and the sense that they won't get their licence back in the foreseeable future, ... lead a significant number of suspended drivers to drive without a licence'.¹⁷⁵ Loss of licence can cause considerable financial difficulties for offenders and offenders may risk driving without a licence to avoid this problem. Employment and work related reasons have been found to be the most cited explanations why disqualified drivers continue to drive.¹⁷⁶ In addition, some offenders continue to drive without a licence even after the period of disqualification as they do not reapply for a licence.¹⁷⁷ For example, New Zealand research has found that '90% of those apprehended for driving whilst disqualified had their licence revoked as a result of driving under the influence'.¹⁷⁸

2.4.27 Recognition of the limitations of traditional sanctions for repeat offenders has led to the introduction of drink driving rehabilitation programs in many jurisdictions, including in Tasmania. These rehabilitation programs aim to separate drinking from driving for offenders, as well as

¹⁶⁸ Elder et al, above n 60, 362. See also S Moffat, 'Sentencing Drink-Drivers: The Use of Dismissals and Conditional Discharges' (2004) 81 *Crime and Justice Bulletin* 10, and Repeat Drink Driving Working Group (Western Australia, Report of the Western Australian Drink Driving Working Group (2003) 25 cited in VSAC, above n 30, 61; Trimboli and Smith, above n 28.

¹⁶⁹ A Watson et al, above n 31.

¹⁷⁰ Ibid.

¹⁷¹ Elder et al, above n 60, 362–363; T Brown et al, 'Brief Motivational Interviewing for DWI Recidivists Who Abuse Alcohol and Are Not Participating in DWI Intervention: A Randomized Controlled Trial' (2010) 34 *Alcoholism: Clinical and Experimental Research* 292; R Voas, A Tippetts and A McKnight, 'DUI Offenders Delay License Reinstatement: A Problem?' (2010) 34 *Alcoholism: Clinical and Experimental Research* 1282; Mullen et al, above n 33, 637.

¹⁷² TLRI, above n 70, [2.3.7].

¹⁷³ Lenton, Fetherston and Cercarelli, above n 81, 637.

¹⁷⁴ W Szogi et al, 'Does Getting Away with it Count? An Application of Stafford and Warr's Reconceptualised Model of Deterrence to Drink Driving' (2017) 108 *Accident Analysis and Prevention* 261, 265.

¹⁷⁵ Lenton, Fetherston and Cercarelli, above n 81, 642. See also, Sheehan et al, above n 60, 4.

¹⁷⁶ VSAC, above n 30, 33; Lenton, Fetherston and Cercarelli, above n 81, 638.

¹⁷⁷ VSAC, above n 30, 32.

¹⁷⁸ Lenton, Fetherston and Cercarelli, above n 81, 637; L Bakker, S Hudson and T Ward, 'Reducing Recidivism in Driving While Disqualified: A Treatment Evaluation' (2000) *Criminal Justice and Behavior* 531, 532.

potentially to reduce the level of drinking of participants, through education and/or treatment.¹⁷⁹ The use of such programs is generally supported by research that suggests that combining rehabilitation with licence disqualification ‘has additive benefits and provides potential for achieving better outcomes’ than legal sanctions alone.¹⁸⁰ Evaluative studies conducted in NSW of the Sober Driver Program (on which the Tasmanian Sober Driver Program is modelled) found that offenders who completed the program were over ‘40% less likely to re-offend in the 2 years following program completion, than offenders who received sanctions alone’.¹⁸¹ The review found that the recidivism rate for those who completed the Sober Driver Program (over a two-year follow up period) was 4.9% compared with 10.2% for the community control group who received legal sanctions only.¹⁸² Subsequent evaluation of the NSW program has confirmed that rehabilitation programs can reduce recidivism, with offenders who participated being 44% less likely to reoffend than the comparison group.¹⁸³ This evaluation examined recidivism over five and a half years and found that the program effect was maintained over this period, with recidivism rates of 15% for the Sober Driver Program participants and about 20% for the comparison groups.¹⁸⁴ The Centre for Accident Research and Road Safety (CARRS) evaluated the Queensland ‘Under the Limit Program’ and found that ‘when using subsequent reconviction rates as the outcome measures the most promising impact comes from combining alcohol treatment with either licence restrictions or licence suspension’.¹⁸⁵

2.4.28 In the Northern Territory, failure of imprisonment to provide an adequate response to the rehabilitation of drink drivers has been clearly recognised. In introducing changes to the *Sentencing Act* (NT) that would allow for drink drivers to participate in drink driver education courses, programs targeting road safety and alcohol rehabilitation as part of a community-based order or a community custody order, it was observed in the Second Reading Speech that:

approximately 25% of the prison population is made up of driving offenders who serve an average of 75 days. This provides limited opportunity to access treatment or training programs targeting alcohol misuse and bad driving behaviour. Driving offenders are almost always disqualified from obtaining a licence and, when released from prison, are placed at risk of quickly committing a further driving offence, particularly if they are placed in situations where there is no alternative for them but to drive while disqualified ... This further contributes to the revolving door of recidivism. What this cohort of offenders needs is intervention, supportive training, and rehabilitation targeting their offending behaviour such as treatment for alcohol misuse.¹⁸⁶

The aim is to divert this cohort from prison to appropriate residential treatment and training centres.¹⁸⁷

¹⁷⁹ Freeman and Liossis, above n 60, 4.

¹⁸⁰ G Palk, M Sheehan and C Schonfeld, ‘Review of the Under the Limit Drink Driving Rehabilitation Program (Centre for Accident Research and Road Safety, 2006) 15; Mills et al, above n 148, 65.

¹⁸¹ Ibid.

¹⁸² Ibid 72.

¹⁸³ Mazurski, Withaneachi and Kelly, above n 145, 8.

¹⁸⁴ Ibid 9.

¹⁸⁵ Palk, Sheehan and Schonfeld, above n 180, 27. See also Sheehan et al, *A Process and Outcome Evaluation of the Under the Limit (UTL) Therapeutic Drink Driving Program for Recidivist and High Range Offenders* (Centre for Accident Research and Road Safety, Queensland, 2012) 4.

¹⁸⁶ Justice (Corrections) and Other Legislation Amendment Bill 2011 (NT) 3
<http://www.austlii.edu.au/au/legis/nt/bill_srs/jaolab2011508/>.

¹⁸⁷ Ibid.

2.4.29 It is recognised that drink driving rehabilitation programs are more effective than other sanctions, particularly if they are multimodal in nature and target high-risk offenders who show a voluntary interest.¹⁸⁸ Multimodal programs ‘include a combination of psychotherapy/counselling, education and probation supervision [and] have proven to be a more effective strategy than programs with a single or two mode focus’.¹⁸⁹ In other words, programs that offer a range of interventions (such as counselling, education and supervision) that address individual needs and offer ‘wrap-around’ care are likely to be more successful in reducing drink driving. In particular, although it is difficult to disentangle the findings to determine which strategy is most effective, research suggests that ‘interventions that focus on treating their alcohol use and/or take a psychoeducational approach to reduce drink-driving have shown a greater level of success in reducing DUI’.¹⁹⁰ Canadian research ‘provides strong converging evidence that remedial alcohol education/treatment programs in combination with other sanctions [licence suspension] can provide substantial increases in road safety’.¹⁹¹

2.4.30 In addition, research demonstrates that rehabilitation programs need to be targeted to meet the needs of the particular offender. There has been criticism of rehabilitation programs on the basis that they treat offenders as a homogeneous group, whereas drink drivers ‘may engage in drink driving for a number of reasons including lack of education, lack of skills to separate drinking and driving, and due to the existence of alcohol-related disorders’.¹⁹² Consequently, it is argued that ‘the underlying causes of drink driving should be identified to inform the type of treatment that is more likely to be effective at addressing drink driving behaviour’.¹⁹³ It has also been argued that there is a failure to recognise that research findings about the characteristics of repeat drink drivers suggest that they ‘could appropriately be described as a clinical population rather than a non-clinical population with long term problems requiring long term responses’.¹⁹⁴

2.4.31 In terms of the cohort of offenders examined in the TLRI/TILES study, where the information was available, it disclosed that nearly 85% of offenders had a history of alcohol abuse, and nearly three quarters had a history of problematic drug use. Additionally, many offenders (over three-quarters) were identified as having mental health issues. This cohort of offenders has complex needs with cross-sectional vulnerabilities that are unlikely to be resolved without understanding how they influence offenders’ behaviour and in the absence of targeted and individualised treatment. The TLRI/TILES study also provides an insight into the failure of traditional criminal justice responses for these offenders. It shows that responses directed only at drink driving are not likely to be effective because they do not address comorbidity or co-existing vulnerabilities likely to undermine drink driving responses.¹⁹⁵ Research has highlighted the complexity of providing treatment that takes account of such problems as ‘severe alcohol problems (abuse and dependence) and high rates of comorbid psychiatric disorder; personality disorders and elevated hostility, aggression, and

¹⁸⁸ Palk, Sheehan and Schonfeld, above n 180, 16.

¹⁸⁹ Ibid 15.

¹⁹⁰ Palmer et al, above n 166, 526.

¹⁹¹ T Ma et al, ‘Working in Tandem: The Contribution of Remedial Programs and Roadside Licence Suspensions to Drinking and Driving Deterrence in Ontario’ (2015) 85 *Accident Analysis and Prevention* 248, 248.

¹⁹² Terer and Brown, above n 32, 5.

¹⁹³ Ibid.

¹⁹⁴ Richardson, above n 6, 7 referring to Lapham et al, above n 78.

¹⁹⁵ Lapham et al, above n 78, 947; S Lapham, B Skipper and M Russell, ‘Lifetime Drinking Course of Driving-While-Impaired Offenders’ (2012) 107 *Addiction* 1947, 1947.

impulsiveness; and extensive criminal histories'.¹⁹⁶ Such problems are not currently addressed in the Sober Driver Program, which is a generic education program. Further, offenders who suffer these problems may not be eligible for the Sober Driver Program.¹⁹⁷

2.4.32 The TLRI/TILES study also provides an insight into the wider offending history of repeat drink drive offenders. All of the offenders had at least one prior conviction for an offence other than a drink driving offence in the past five years. Lifetime offending histories of those for whom this information was available disclosed that 80% of offenders had prior convictions for dishonesty and property offences, 55.7% had prior convictions for violent offending (excluding domestic violence), 34.3% of offenders had a prior conviction for a drug offence and 24.3% of offenders had prior convictions for domestic violence. As noted earlier, this paints a picture of drink driving among 'a portion of DUI recidivists, ... *as just one manifestation of a host of deviant behaviours*'.¹⁹⁸ Research has also found that DUI recidivists had 'more extensive violent and property criminal histories than other drunk drivers'.¹⁹⁹ Accordingly, it has been suggested that reoffenders with a criminal history may need special attention in treatment programs as 'they represent a more entrenched group (than offenders whose criminal history is limited to drink driving) who may be less responsive to traditional treatments'.²⁰⁰

2.4.33 This aligns with recent research which has highlighted the need to address the public health problem arising from high levels of alcohol consumption and alcohol dependence by adopting a broader holistic approach.²⁰¹ Swedish research concluded that:

the personality, mental health and alcohol problems of both male and female severe DUI offenders are different from that of the general Swedish population, a fact that should have implications for the prevention, treatment and relapse of DUI offenders. Because drink driving is not only a symptom of alcohol problems, but also of other covarying psychosocial problems eg socioeconomic and mental health problems and criminality, rehabilitation programs ought to take into account the whole situation of the DUI offender.²⁰²

Similarly, in Denmark, it has been stated that:

In terms of prevention, the results of this study therefore imply that preventative measures aimed at drunk driving should not focus solely on punishment, but could also profitably address issues related to health, social marginalisation, and alcohol abuse contribution to drink driving and increasing the risk of drunk driving recidivism and accidents.²⁰³

2.4.34 In addition, research suggests that attention needs to be paid to those who withdraw from rehabilitation programs (non-completers). In a study of the Drink-Impaired Drivers (DID) program in the English and Welsh Probation Service, it was found that, at the one year follow up, there was a

¹⁹⁶ Lenton, Fetherston and Cercarelli, above n 81, 638 (references omitted).

¹⁹⁷ Reasons for exclusion from Sober Driver Program include mental health issues: Information provided by Michelle Lowe, email 4 March 2016. It is noted that offenders with mental health issues or significant, untreated alcohol or drug abuse issues that would prevent them from engaging in a group treatment program may be referred to individual treatment with an external service prior to engagement: Information provided by Michelle Lowe, email 20 March 2017.

¹⁹⁸ Hallstone, above n 108, 344 (italics in original).

¹⁹⁹ Hallstone, above n 111, 166.

²⁰⁰ Hallstone, above n 108, 344; Nochajski et al, above n 112.

²⁰¹ L Wundersitz and S Raftery, above n 42, 786.

²⁰² B Hubicka et al, 'Personality Traits and Mental Health of Severe Drunk Drivers in Sweden' (2010) 45 *Social Psychiatry Epidemiology* 723, 729.

²⁰³ Møller, Haustein and Prato, above n 53, 131.

zero reconviction rate for offenders who completed the DID program but that this was not significantly different to that of the comparison group (those who were not allocated to the DID program).²⁰⁴ However, it was found that only 51% of participants completed the program and that program non-completers had the highest level of drink-drive reconvictions and were significantly more likely to be reconvicted than the completers and comparison groups.²⁰⁵ This is consistent with research that evaluated the Queensland Under the Limit Program, which found that successful completers had an overall reduction of about 15% compared with controls, while unsuccessful completers had a re-offence rate that was estimated at 85% higher than controls.²⁰⁶ The study found that program completion had a significant effect on reoffending for offenders with a high BAC who had prior drink driving offences, achieving a 55% reduction in recidivism rates compared to controls, whereas first offenders with a BAC lower than 0.15/100 ml had much the same re-offence rates as similar controls.²⁰⁷

2.4.35 As detailed above, another recent response to recidivist drink drivers has been the introduction of alcohol interlock devices. There are different models for alcohol interlock regimes, including the requirement for mandatory interlock orders to be imposed at the sentencing stage,²⁰⁸ discretionary interlock orders imposed at the sentencing stage²⁰⁹ and mandatory interlock requirements for re-licensing administered either judicially²¹⁰ or administratively.²¹¹ International research has shown that interlock devices are effective in reducing recidivism when the interlock is installed,²¹² but there is limited evidence that the devices are effective in reducing recidivism once they are removed.²¹³ It has been argued that:

Unless interlocks are combined with interventions that address the underlying factors that contribute to recidivism — such as alcohol abuse and the lack of perceived alternatives to driving after drinking — it is likely that many users will continue to drive after drinking once the device is removed.²¹⁴

Canadian research has reported that ‘the literature is almost unanimous in showing that interlocks are effective at reducing drinking and driving while installed, but produces little long term change in drinking and driving behaviour after de-installation’.²¹⁵ Interlocks are a ‘physical barrier to drinking and driving, but do not “teach” the drinking driver to separate drinking from driving’.²¹⁶ This has been

²⁰⁴ Palmer et al, above n 166, 532.

²⁰⁵ Ibid 533.

²⁰⁶ Palk, Sheehan and Schonfeld, above n 180, 45.

²⁰⁷ Ibid.

²⁰⁸ This applies in New South Wales.

²⁰⁹ This applies in New Zealand.

²¹⁰ This applies in Victoria.

²¹¹ This applies in Tasmania, Queensland, South Australia, Australian Capital Territory and Western Australia.

²¹² Lenton, Fetherston and Cercarelli, above n 81, 638. See also P Miller et al, ‘Effectiveness of Interventions for Convicted DUI Offenders in Reducing Recidivism: A Systematic Review of the Peer-Reviewed Scientific Literature’ (2015) 41 *American Journal of Drug and Alcohol Abuse* 16, 18.

²¹³ Elder et al, above n 60, 367–368. See also Miller et al, above n 212, 18.

²¹⁴ Elder et al, above n 60, 370.

²¹⁵ T Ma et al, ‘Program Design for Incentivising Ignition Interlock Installation for Alcohol-Impaired Drivers: The Ontario Approach’ (2016) 95 *Accident Analysis and Prevention* 27, 31.

²¹⁶ Ibid.

said to highlight the ‘importance of combining ignition interlocks with interventions that are more likely to foster long-term behavioural change such as rehabilitation programs’.²¹⁷

2.4.36 Australian research, as with overseas research, has found that the driver interlock had a positive effect on drink driving offending for the interlock period.²¹⁸ However, (contrary to overseas research) this research also provided ‘some suggestion of long-term benefits of using interlocks with all repeat and first-time high range offenders’ beyond the interlock period.²¹⁹ This suggests that the driver alcohol interlock is ‘an effective safety intervention for reducing drink-driving rates for offenders’.²²⁰ However, this needs to be balanced with the concern that use of mandatory interlocks could act as a disincentive to re-licensing and may thereby increase the number of offenders who choose to drive without a licence, particularly in view of the financial burden of installing the interlock devices.²²¹ Bishop et al have written:

whilst interlocks have been shown to be an important component of treatment for individuals who repeatedly drink-drive, in and of themselves they do not address any underlying alcohol pathologies. Given that risky patterns of alcohol consumption are often precursors to drink-drive behaviour, there is a need to target the maladaptive alcohol consumption patterns. As such clinical interventions such as counselling and rehabilitation need to be considered as an integral part in helping to rehabilitate drink-drive offenders.²²²

This emphasises the need to ‘keep offenders *within the system* that consists of formal laws and informal social controls, rather than applying penalties in ways that undermine adherence to the law and reinforce unlicensed driving’.²²³

Submissions received

2.4.37 In the Issues Paper, the TLRI sought feedback in relation to limitations in the current response to the problem of repeat drink driving. Many of the submissions received identified issues with the current legal response and the programs available to address the rehabilitative requirements of repeat drink drivers. In its submission, Community Legal Centres Tasmania (CLC Tas) highlighted the limitations arising from short prison sentences, as offenders are not able to access rehabilitation programs. This concern was also raised in a consultation meeting with Chris Young (legal practitioner) and Anthony Mihal (legal practitioner). Similarly, concerns about the detrimental impact of short term prison sentences (loss of employment, housing and social connections) without addressing the underlying causes of offending were raised in a consultation meeting with Grant Herring and Don McCrae from the Salvation Army. The inability of prison to address the issues of alcohol abuse underpinning recidivist drink driving was also raised by Mark Doyle (legal practitioner), who highlighted the detrimental effect of prison. In relation to community-based sanctions, he considered that, while the Sober Driver Program was a positive initiative and helpful for some offenders, a probation order did not provide the appropriate structure to address the complex

²¹⁷ Terer and Brown, above n 32, 6.

²¹⁸ Watson et al, above n 38.

²¹⁹ Ibid. This also reflects research conducted in Nova Scotia which showed some reduction in recidivism post removal of the interlock, see W Vanlaar, M Hing and R Robertson, ‘An Evaluation of Nova Scotia’s Alcohol Ignition Interlock Program (2017) 100 *Accident Analysis and Prevention* 44.

²²⁰ Ibid.

²²¹ VSAC, above n 30, 34; Sheehan et al, above n 60, vi.

²²² C A Bishop et al, ‘Associations Between Alcohol Consumption Patterns and Attitudes Towards Alcohol Interlocks’ (2017) 108 *Accident Analysis and Prevention* 83.

²²³ Lenton, Fetherston and Cercarelli, above n 81, 643 (emphasis in original).

needs of vulnerable and disadvantaged people. Holyoake and Hannah Phillips (Tasmanian Aboriginal Community Legal Service (TACLS)) also highlighted the failure of the current system to address the underlying causes of offending, such as alcohol and or mental health issues.

2.4.38 Other stakeholders raised concerns about the limitations of the current programs that are available to address the underlying causes of offending and the lack of an appropriate supporting legal structure. In his submission, Gerald Waters (Research Director, Researching Impaired Driving in New Zealand) indicated that a DWI Court list would be capable of bringing together the current piecemeal attempts at reducing repeat drink driving in a collaborative and consistent manner. ForensiClinic stated that Tasmania lacks individualised risk reduction programs for repeat drink drivers, including standardised assessment of risk factors, the development and implementation of individualised risk reduction programs and the monitoring of effectiveness through longitudinal risk assessment. Nicolle Ait Khelifa (private practitioner, psychiatrist (addiction speciality)) noted that many people with a history of drink driving have an alcohol use disorder and go through the court process but do not go through the process of getting their licence back. She highlighted that for the repeat offender, there is a need to address a chronic relapsing condition.

2.4.39 Possible solutions that could be implemented outside of the criminal justice system were raised by Brian Hinson (community member) who suggested that the monitoring of individuals purchasing vehicles should be undertaken to ensure that unlicensed or disqualified drivers are prevented from purchasing petrol.

2.4.40 In contrast, the Director of Public Prosecutions noted that while there were limitations in the current responses, he did not consider that there was a need for changes to the legal structure. Instead, the DPP suggested that the current legal structure could be utilised in conjunction with the development of more appropriate programs. In his submission, the DPP observed that:

In general, the *Road Safety (Alcohol and Drugs) Act 1970* and the *Sentencing Act 1997* provide sufficient avenues to enable courts to impose sentences that achieve sentencing aims of denunciation, deterrence and rehabilitation. The main limitations in the current response to the problem of repeat drink driving are as a result of the limited availability of rehabilitation programs that operate under those Acts.

The DPP's view was that the penalties set out in the *Road Safety (Alcohol and Drugs) Act 1970* (Tas) met the sentencing aims of punishment and deterrence with rehabilitative aims being achieved by the imposition of orders that require participation in the sober driver program and probation orders which may include special conditions. In relation to the sober driver program, the DPP stated that:

the utility of the current Tasmanian Sober Driver Program is limited as it focuses on education in relation to the link between drinking and driving, and has significant barriers to entry. For instance, entry into the program is restricted to those offenders who have been convicted of two or more drink driving offences in the last five years. Research has shown that multifaceted rehabilitation programs, those that combine education, psychotherapy/counselling, probation and supervision, are the most effective at reducing recidivism rates for drink driving. The efficacy of the Sober Driver Program could be improved by modifying the length and content of the program and removing barriers to participation (including, but not limited to the eligibility requirement identified above), increasing the number of locations where the program is available and increasing the number of participants who can participate in each program.

These limitations can be overcome by imposition of community service and probation orders where they are made in such a way as to complement the Sober Driver Program. For example,

probation orders can include special conditions that an offender attend educational programs, undergo assessment for alcohol dependency, submit to medical, psychological or psychiatric assessment or treatment ... These orders could be utilised to ensure that recidivist drink driver orders, or offenders who require a greater level of intervention (which cannot practicably be achieved by the Sober Driver Program) are the subject of an order that ensures that they will obtain the level of assistance that is appropriate to their needs in order to identify and treat the underlying causes of the offending behaviour.

2.4.41 In addition, the DPP suggested that consideration be given to amending the penalty provisions in the *Road Safety (Alcohol and Drugs) Act 1970* (Tas) s 17 to allow the court to impose a community service order as an alternative to imposing a fine instead of implementing a DWI court or list. The DPP expressed the view that:

This, together with changes to the eligibility criteria for sober driver may result in a greater percentage of offenders receiving a rehabilitative sentence without reducing the personal or general deterrent elements of the sentence.

Further amendments requiring an offender to successfully complete a drink driver education course prior to being eligible to reapply for and obtain their licence following a period of disqualification and cancellation would also assist in this objective.

The Institute's view

2.4.42 While the TLRI acknowledges the need for a penalty structure that allows for the punitive and denunciatory aims of sentencing to be met for drink driving offenders and the positive effect on road safety arising from law enforcement measures directed to drink driving, existing research suggests that there are deficiencies in the traditional criminal justice system response. It appears that for some offenders escalating penalties have led to a 'revolving door', which does not allow the offender's underlying issues to be addressed. This finding is reflected in the Tasmanian context, given that a majority of offenders who received prison sentences for drink driving offences had previously received a custodial sentence and many had already spent time in prison for drink driving.²²⁴ For these offenders, traditional sentencing approaches have failed to rehabilitate or provide for community protection.

2.4.43 Research has highlighted the complexity of the vulnerability profiles and offender characteristics for repeat drink drivers and has found that many experience co-existing alcohol dependence and/or mental health issues. This complexity suggests that responses need to be 'tailored to the individual needs of each offender in terms of their offending behaviour, severity of alcohol abuse problems and psychiatric condition'.²²⁵ In the Tasmanian context, there is a deficiency in the criminal justice response to drink drivers in that the focus of the rehabilitation program offered to drink drivers is on education in relation to drinking and driving and does not address treatment for alcohol abuse/dependence. A further deficiency is that education programs occur in isolation from ongoing encouragement and supervision around alcohol use and driving. Accordingly, while accepting that education programs (such as the Sober Driver Program) are a component of the response to repeat drink driving and would be important as part of a suite of responses to repeat drink drivers, education programs alone are inadequate as there is a need for a more holistic and multi-faceted approach to repeat drink driving.

²²⁴ See [2.4.13].

²²⁵ Richardson, above n 6, 7.

2.4.44 The TLRI recognises that there are existing powers under the *Sentencing Act 1997* (Tas) that would allow the court to impose treatment conditions on recidivist drink drivers. Greater use of these powers combined with changes to the rehabilitation programs available would give courts greater flexibility in responding to drink drivers. However, it is the TLRI's view that there is also a need for a more targeted and specialised response that incorporates rigorous assessment to identify the vulnerabilities of the individual offender, targeted treatment and judicial monitoring delivered within a therapeutic framework. As Bartkowiak-Théron and Henning have argued, 'what is needed is a more interactive, actively interventionist approach, something that enables on-going assessment and supervised treatment of the offender as well as recognition of the specific criminogenic needs of individual offenders'.²²⁶ Similarly, it is the TLRI's view that there needs to be a more integrated response that is comprehensive and multifaceted and aligned with one of the key action areas within Tasmania's Key Strategy 3 of the *Alcohol Action Framework* to '[develop] an innovative problem-solving court and sentencing approaches to reduce the cycle of alcohol related offending behaviour and to address the challenges of repeat drink-driving offenders.'²²⁷

2.4.45 As discussed in detail in Part 3, the TLRI's view is that the creation of a solution-focused court offers a promising evidence-based approach that will enable resources necessary for the rehabilitation of the offender to be 'appropriately and effectively channel[ed]'.²²⁸ The alternative would appear to be continuation of revolving door recidivism resulting from the failure of traditional sentencing options to fulfil 'their rehabilitative, personal deterrence, and community protection goals in relation to these offenders'.²²⁹ The TLRI's view is that a solution-oriented approach will reduce the likelihood of reoffending and so improve community safety by reducing the number of alcohol related casualties arising from motor vehicle crashes. Further, it will provide for financial savings by diverting these offenders from prison as well as reducing the economic and social costs incurred by the community arising from motor vehicle crashes.

²²⁶ Bartkowiak-Théron and Henning, above n 4, 3.

²²⁷ Inter-Agency Working Group on Drugs, above n 11, 38.

²²⁸ M Edgely, 'Addressing the Solution-focused Sceptics: Moving Beyond Punitively in the Sentencing of Drug-Addicted and Mentally Impaired Offenders' (2016) 39 *University of New South Wales Law Journal* 206, 210.

²²⁹ *Ibid* 211.

Part 3

Solution-Oriented Responses to Repeat Drink Driving

This Part examines the application of non-traditional criminal justice responses to the problem of recidivist drink drivers and provides an overview of national and international research literature on non-traditional approaches adopted elsewhere.

3.1 Solution-oriented courts and therapeutic jurisprudence

3.1.1 Problem-solving or solution-oriented courts²³⁰ have been developed over the past 30 years in response to a recognition that ‘the adversarial nature of the traditional criminal justice model cannot effectively handle the complexity of certain human and social problems, where failing to deal with fundamental causes almost guarantees re-offending’.²³¹ Problem-oriented courts originally emerged in the United States with the creation of drug courts and have extended to different jurisdictions (driving while impaired courts, juvenile drug courts, mental health courts, family dependency treatment courts, domestic violence courts, community courts, veterans courts, unified family courts and tribal healing-to-wellness courts)²³² and to many countries (Australia, England, Canada, Scotland, Ireland, Wales, New Zealand, Brazil, Norway, Belgium, Guam, Mexico).²³³ In 2013, in the United States, it was estimated that there were 2800 drugs courts and 397 mental health courts.²³⁴ In Australia, there are several problem-oriented courts including drug courts, community courts, family violence courts, mental health courts, special circumstances lists, and family drug treatment courts.²³⁵ In South Australia, a Gambler’s Intervention Program pilot has been established in the Adelaide Magistrates Court.²³⁶ In Tasmania, there are three well-developed problem-oriented courts already in operation: the Youth Court,²³⁷ the Diversion List²³⁸ and the Court Mandated Drug Diversion program.²³⁹ In addition, there is a family violence list run by the Magistrates Court in each of its registries.²⁴⁰

²³⁰ See M King et al, *Non-Adversarial Justice* (Federation Press, 2nd ed, 2014) 155–156 for discussion of the nomenclature. There, it is observed that the ‘original terminology of “problem-solving” courts reflected the idea that the courts should change their focus from individuals and their criminal conduct to offenders’ problems and their solutions. ... In Australia, the term “problem-oriented” court came into use because it recognised that the complex and chronic problems that brought offenders before the courts were unlikely to be “solved” and that it was more realistic for the justice system to adopt an approach that signified the process rather than the hoped-for outcome. ... More recently, King has proposed the term “solution-focused” in preference to either “problem-solving” or “problem-oriented”, arguing that they did not sufficiently recognise the centrality of the offender’s role in bringing about change’.

²³¹ Hill, above n 1.

²³² King et al, above n 230, 155.

²³³ Hill, above n 1. This is not an exhaustive list.

²³⁴ Edgely, above n 228, 211.

²³⁵ King et al, above n 230.

²³⁶ Flinders University, ‘Gambling Program Reduces Prison Numbers’

<<http://news.flinders.edu.au/blog/2017/10/10/gambling-program-reduces-prison-numbers/>>.

²³⁷ For details, see V Stojcevski, *Hobart Specialised Youth Justice Court Pilot: Evaluation Report* (Magistrates Court of Tasmania, 2013).

3.1.2 In contrast to traditional courts, problem-oriented courts adopt a case-by-case approach to offending and seek to involve a range of partners (both government and non-government) in tackling the root causes of deviant behaviour and then addressing them holistically. It is widely accepted that the concept of therapeutic jurisprudence (although developing separately) provides the philosophical basis for problem-oriented courts.²⁴¹ The concept of therapeutic jurisprudence has been summarised by Freiberg as follows:

an approach to the study of the law as a therapeutic agent, focusing upon the impact of the law on the emotional life and psychological well-being of not only offenders but of all of the participants in a justice system: judicial officers, victims, offenders, plaintiffs, defendants and others.²⁴²

The focus of problem-oriented courts on addressing the issues that underpin an individual's offending and rehabilitation reflects this 'therapeutic approach'. This approach recognises the multi-dimensional nature of offending, for example, by accepting that substance abuse is not only a justice problem but also a health problem. Its focus is on identifying what works in reducing and eliminating offending behaviour while at the same time ensuring offenders take responsibility for their own behaviour. In doing so, it may focus on a multiplicity of issues including 'housing, education, employment, relationship, and personal effectiveness problems' so that rehabilitation might involve not only the 'promotion of law-abiding behaviour, but ... also ... the healing of mind, body, and relationships; the gaining of knowledge through education; and the development of vocational and other life skills'.²⁴³ While problem-oriented courts (as with traditional criminal justice responses) seek to hold an offender accountable, there is a view that the system should do more than punish and that the system should also seek to prevent future harm.²⁴⁴ This perspective recognises that for many recidivist offenders, punishment alone is not an effective preventative against future offending or harm to the community. It fails to equip these offenders with the necessary self-management skills either to take responsibility for their offending behaviour or depart from it. What is needed to protect the community is a model geared to identifying what does work in this regard and then the effective application of that knowledge.

3.1.3 In 1997, as part of the development of problem-oriented courts, ten key ingredients of a drug court were set out by the Drug Standards Committee of the United States National Association of Drug Court Professionals.²⁴⁵ These are 'internationally accepted as the hallmarks of drug courts'²⁴⁶

²³⁸ See Magistrates Court of Tasmania, *The Diversion List* <http://www.magistratescourt.tas.gov.au/about_us/criminal_division/diversion_list>.

²³⁹ See Magistrates Court of Tasmania, *Doing a Drug Treatment Order*, <http://www.magistratescourt.tas.gov.au/about_us/criminal_division/drug_treatment_orders>.

²⁴⁰ TSAC, *Sentencing of Adult Family Violence Offenders*, Final Report No 5 (2015) 49. The Council highlighted criticisms of the operation of the family violence list and made observations in relation to improving its operation: at 50–51.

²⁴¹ King et al, above n 230, 158; M King, *Solution-Focused Judging Bench Book* (Legal Services Board, 2009) 25; The Australasian Institute of Judicial Administration, *Problem-solving Courts* <<http://www.aija.org.au/index.php/research/australasian-therapeutic-jurisprudence-clearinghouse/problem-solving-courts?task=view&id=414>>; B Winick, 'Problem Solving Courts: Therapeutic Jurisprudence in Practice' in R Wiener and E Brank (eds), *Problem Solving Courts* (Springer, 2013) 220.

²⁴² A Freiberg, 'Psychiatry, Psychology and Non-adversarial Justice: From Integration to Transformation' (2011) 18 *Psychiatry, Psychology and Law* 297, 300.

²⁴³ M King, 'New Directions in the Courts' Response to Drug and Alcohol Related Legal Problems: Interdisciplinary Collaboration and Collaboration with Defendants' (2013) 6 *Phoenix Law Review* 917, 922–923.

²⁴⁴ H Blagg, *Problem Oriented Courts* (Research paper prepared for the Law Reform Commission of Western Australia, 2008), 6 citing J Butts, 'Introduction: Problem-Solving Courts' (2001) 23 *Law and Policy* 121.

²⁴⁵ Bureau of Justice Assistance, *Defining Drug Courts: The Key Components* (1997) <http://www.ndci.org/sites/default/files/nadcp/Key_Components.pdf>.

and have provided the framework for drug courts and also other problem-solving courts.²⁴⁷ These key components are as follows:

- Drug courts integrate alcohol and other drug treatment services with criminal justice system case processing.
- Using a non-adversarial approach, prosecution and defence counsel promote public safety while protecting participants' due process rights.
- Eligible participants are identified early and promptly placed in the drug court program.
- Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.
- Abstinence is promoted and monitored by frequent alcohol and other drug testing.
- A coordinated strategy governs drug court responses to participants' compliance.
- Ongoing judicial interaction with each drug court participant is essential.
- Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.
- Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.
- Forging partnerships among drug courts, public agencies, and community-based organisations generates local support and enhances drug court program effectiveness.

Subsequent research has demonstrated that the success of drug courts reflects the extent to which the court adheres to these principles, with courts that 'watered down or dropped core ingredients of the model [paying] dearly for their actions in terms of lower graduation rates, higher criminal recidivism, and lower cost savings'.²⁴⁸

3.1.4 Problem-oriented courts have different features and may operate on different models at different points in the justice process including at the pre-trial, pre-sentence or post-conviction sentencing stages. However, while the models differ between jurisdictions, King et al have identified seven common elements that are generally shared by problem-oriented courts:

- **case outcomes:** reduced recidivism and improved health outcomes for offenders;
- **system change:** changes in the way that government responds to social problems such as addiction and mental illness;
- **judicial monitoring:** active judicial involvement over time to address the chronic problems faced by the offender and to facilitate changes in behaviour;
- **collaboration:** collaboration between courts and service providers, between professionals in different disciplines, with the offender, between government and non-government health and welfare sectors, and between lawyers and behavioural scientists;

²⁴⁶ King et al, above n 230, 161.

²⁴⁷ National Association of Drug Court Professionals (NADCP), *Adult Drug Court Best Practice Standards: Volume I* (2013) 1.

²⁴⁸ Ibid.

- **interdisciplinary:** re-conceptualisation of the problem as extending beyond the law to behavioural sciences (cognitive psychology, psychiatry, clinical behavioural sciences, criminology, social work, nursing, neuropsychiatry);
- **non-traditional roles:** judges, defence and prosecution counsel adopt non-traditional roles with the process involving problem-solving dispute avoidance, therapeutic outcomes, collaborative process, people oriented, interest or needs based, emphasis on non-adjudication, judge as coach, forward looking, planning based, wide range of participants and stakeholders, interdependent, based on common sense, informal and effective;
- **service provision:** ‘comprehensive, multidisciplinary and integrated service programs’ to deal with the underlying problems that contribute to offending.²⁴⁹

3.2 Driving while intoxicated courts/lists

3.2.1 DWI courts/lists are an example of a problem-oriented court that has been developed in response to the problem of recidivist drink drivers. Typically, they incorporate the features of a problem-oriented court (as detailed at [3.1]). Existing DWI courts are based on the drug court model and involve treatment, supervision, testing for alcohol use, judicial monitoring and a system of incentives, threats and rewards.²⁵⁰ The emphasis of a DWI court is on the accountability of the offender,²⁵¹ with the offender having a primary role as an agent of change. The aim of a DWI court is to facilitate the rehabilitation of the repeat offender by targeting the underlying causes of the drink driving behaviour and so protect the community by reducing recidivism.²⁵²

3.2.2 The courts operate either as a stand-alone court or more commonly as a DWI/drug court hybrid.²⁵³ In the United States, as of 30 June 2014, there were 690 DWI courts (242 designated DWI courts and 448 hybrid DWI/drug courts).²⁵⁴ While a Drink Disqualified Driver list has been proposed in Victoria,²⁵⁵ there are currently no specialist courts in Australia dedicated to addressing the problem of repeat drink drivers. However, the Drug Court in Victoria has the jurisdiction to deal with driving offences. In New Zealand, an Alcohol and Other Drug Treatment (AODT) Court Pilot was established in 2010. Drink drivers are eligible if they are charged with a third or subsequent drink driving offence in an aggravated form, are assessed as alcohol or other drug dependent and have a high-risk of reoffending.²⁵⁶ An Alcohol and Drug Treatment Court is being developed (with the assistance of a New Zealand judge) in Samoa.²⁵⁷

Best practice for DWI Courts

²⁴⁹ King et al, above n 230, 158–160.

²⁵⁰ Richardson, above n 6, 13.

²⁵¹ D Wallace, ‘The Promise of DWI Court: What Does it Mean and Why Should Prosecutors Care?’ (2011) 2 *Chapman Journal of Criminal Justice* 101, 102.

²⁵² Richardson, above n 6, 14.

²⁵³ Ibid 13.

²⁵⁴ National Center for DWI Courts (NCDC), *The Bottom Line: Research Update on DWI Courts* (2015) 2.

²⁵⁵ See Richardson, above n 6. VSAC also recommended the introduction of a specialist list for driving offences, including driving while intoxicated, see VSAC, *Driving While Disqualified or Suspended*, Report (2009) ix.

²⁵⁶ See Appendix A.

²⁵⁷ *Alcohol and Other Drug Treatment Court marks two years of a new approach*, (21 November 2014) Auckland District Law Society <<http://www.adls.org.nz/for-the-profession/news-and-opinion/2014/11/21/alcohol-and-other-drug-treatment-court-marks-two-years-of-a-new-approach/>>.

3.2.3 In the United States, the National Centre for DWI Courts has developed ‘The Ten Guiding Principles of DWI Courts’, which indicate best practice. These are:

1. **Determining the population** — this is the process of ‘identifying a subset of the DWI population for inclusion in the DWI court program’.²⁵⁸ Elsewhere, this has included first-time offenders with high blood alcohol concentrations and/or repeat offenders with serious alcohol/drug dependences or addictions.
2. **Perform a clinical competent objective assessment** — this should address a number of biopsychosocial domains including alcohol use severity and drug involvement, the level of care needed, medical and mental health status, extent and stability of social support systems, and individual motivation to change.²⁵⁹
3. **Develop a treatment plan** — this must be individualised based on identified clinical needs that addresses an offender’s multiple problem areas/comorbidity with ‘treatment programs and systems, ... [being] constructed with a variety of approaches that have proven to be effective’.²⁶⁰ This plan needs to take account of an offender’s other drug dependency disorders and/or mental health issues.
4. **Supervise the offender** — to provide appropriate community protection, it is important for the offender to be monitored frequently by the court, community corrections and the treatment provider. This involves testing for drug and alcohol use but also close supervision by community corrections to develop knowledge about the life circumstances of the offender and to allow positive reinforcement and encouragement as well as surveillance.²⁶¹
5. **Forge agency, organisation and community partnerships** — ‘a broad-based, multi-agency, and grassroots partnership’ is important to enhance the credibility of the court, to bolster support and maximise the resources that are available.²⁶²
6. **Take a judicial leadership role** — the magistrate is vital to the success of the DWI court and must possess leadership skills and be able to motivate team members and communicate and elicit support from the community.²⁶³
7. **Develop case management strategies** — this allows for a ‘co-ordinated team strategy and seamless collaboration across the treatment and justice systems’.²⁶⁴ Case management involves: (1) assessment; (2) planning; (3) linking; (4) monitoring; and (5) advocacy.
8. **Address transportation issues** — by recognising that repeat drink drivers have previously lost their licence and many have solved their transportation problem by driving without a licence, a DWI court must assist an offender to develop other means to solve transportation issues.²⁶⁵
9. **Evaluate the program** — to document behavioural change and to map a program’s success or failure. This should aim to determine: (1) which types of clients have had the best outcomes; (2)

²⁵⁸ NCDC, *The Ten Guiding Principles of DWI Courts*, 3 <https://www.dwicourts.org/wp-content/uploads/Guiding_Principles_of_DWI_Court_0.pdf>.

²⁵⁹ Ibid 7.

²⁶⁰ Ibid 11.

²⁶¹ Ibid 16.

²⁶² Ibid 21.

²⁶³ Ibid 27.

²⁶⁴ Ibid 30.

²⁶⁵ Ibid 34.

which interventions produced the best outcomes; and (3) which interventions worked for which clients. It is necessary to evaluate short-term outcomes as well as longer-term outcomes.²⁶⁶

10. Ensure a sustainable program — this requires careful and strategic planning that considers structure and scale, organisation, participation and funding.²⁶⁷

Advantages and disadvantages of DWI courts

3.2.4 Advantages of DWI courts, as with problem-oriented courts generally, are that they are forward-looking rather than backward-looking, which means that the approach of the court is ‘geared towards encouraging positive future behaviour rather than simply punishing past actions’.²⁶⁸ There is evidence that DWI courts are effective in this regard and meet their aim of facilitating rehabilitation, thereby improving community safety.²⁶⁹ The courts are also said to have the ability to respond to complex social and legal problems by integrating responses to alcohol use, mental health and other issues that underpin offending behaviour.²⁷⁰ In this regard, the aim of the court is not to ‘resolve complex legal issues, but rather to bring the authority and machinery of the court to bear on a particular social problem or suite of problems’.²⁷¹ In this way, the court is able to operate as a ‘hub for intervention rather than a simple delegator of tasks’.²⁷² This approach challenges the ‘framework of silos [for example, that health deals with health, education deals with education, etc] that prevent a constructive alignment of resources and problem-solving processes across agencies and areas’.²⁷³

3.2.5 There are, however, concerns that can be raised about DWI courts. These include:

- net widening — the intensive and intrusive nature of DWI and drug courts means that concerns have been raised about using the court as a means of offering help to an offender when in reality it imposes an intensified and punitive order.²⁷⁴
- diminution of resources available for those who wish to seek treatment voluntarily.²⁷⁵

It can also be argued that therapeutic responses do not reflect community expectations about punishment as they can be perceived as being ‘soft on crime’.

Effectiveness of DWI Courts

3.2.6 Drug courts have been the subject of extensive research with meta-analysis indicating that drug courts are effective in reducing recidivism compared to offenders who are processed through the general criminal lists.²⁷⁶ These effects have been found in more recent studies involving longer

²⁶⁶ Ibid 37.

²⁶⁷ Ibid 42.

²⁶⁸ Blagg, above n 244, 2.

²⁶⁹ See [3.2.6]–[3.2.10] for discussion of effectiveness of DWI Courts.

²⁷⁰ Blagg, above n 244, 2.

²⁷¹ Ibid 3.

²⁷² Ibid 7.

²⁷³ Bartkowiak-Théron and Henning, above n 4, 8 citing I Bartkowiak-Théron and J Fleming, *Integration and Collaboration: Building Capacity and Engagement for the Provision of Criminal Justice Services to Tasmania’s Mentally Ill* (TILES, 2011).

²⁷⁴ See discussion in Blagg, above n 244, 21 in relation to drug courts generally. See also Freiberg et al, above n 2, 69–70.

²⁷⁵ King et al, above n 230, 168.

²⁷⁶ Edgely, above n 228, 214.

follow up studies, leading to the conclusion that ‘almost all experts now agree that the accumulated evidence is overwhelming — adequately funded and properly implemented drug courts’ and ‘[mental health courts] do indeed reduce recidivism’.²⁷⁷ However, there is greater complexity in attempting to isolate the factors that allow drug courts to produce better outcomes than alternative criminal justice responses. This requires a consideration of two questions: why do drug court graduates offend less often and how do drug courts create successful graduates?²⁷⁸ Possible reasons why drug court graduates commit fewer crimes include:²⁷⁹

- (1) drug courts address not only substance use but also offenders’ other criminogenic needs (housing, education/employment, family connections, physical and mental health, development of pro social life skills);
- (2) drug courts allow offenders to avoid the negative consequences of imprisonment;
- (3) the design and procedure of a drug court ‘foster[s] greater respect among participants for the authority of the police and judicial officers and a greater appreciation of the criminal justice system’s obligation to protect community safety’.²⁸⁰ This ‘enhances pro-social attachment to formal institutions and strengthens broader social bonds’;²⁸¹ and
- (4) graduation is a significant achievement that enhances self-worth and fosters a positive outlook.²⁸² In relation to producing successful graduates, it has been suggested that ‘the select and specialised nature of the drug court model maximises the likelihood that offenders receive drug use and criminal justice programs and treatments that are best practice’.²⁸³

In addition, the drug court model provides ‘leverage’ by affording successful clients a penalty reduction on graduation, and uses compliance monitoring mechanisms and court attendance to ‘send strong signals about the consequences of continued criminal or antisocial conduct’.²⁸⁴ Drug courts also ‘activate individual responsivity by challenging pre-existing perceptions of the criminal justice system, identifying personal motivators for change, and rewarding success and progress in treatment’.²⁸⁵

3.2.7 In New Zealand, an AODT Court pilot was established in 2012 with 30% of participants accepted into the court having drink driving offences only.²⁸⁶ An evaluation of the AODT Court reported that as at April 2016, of the 282 cases accepted, there were 79 offenders who had graduated from the AODT Court.²⁸⁷ At the same time, there were 108 offenders who had been exited from the court.²⁸⁸ An offender may be exited from the court by direction of the court (39%), a failure to appear

²⁷⁷ Ibid 216. For a summary of research see Freiberg et al, above n 2, 188–190.

²⁷⁸ Freiberg et al, above n 2, 192.

²⁷⁹ Ibid 192–193.

²⁸⁰ Ibid 192.

²⁸¹ Ibid.

²⁸² Ibid 193.

²⁸³ Ibid.

²⁸⁴ Ibid.

²⁸⁵ Ibid.

²⁸⁶ Litmus, *Final Process Evaluation for the Alcohol and Other Drug Treatment Court*, Final Evaluation (2016), 29.

²⁸⁷ Ibid 93.

²⁸⁸ Ibid.

(32%) or a voluntary exit (27%).²⁸⁹ In the final evaluation, it was reported that there had been 79 graduations from the AODT Court with 46% of the graduates being drink driving offenders,²⁹⁰ while these offenders accounted for 23% of the 108 offenders exited from the court.²⁹¹ Graduates ‘overall ... report[ed] the AODT Court [was] a successful and positive experience which has resulted in significant life changes’.²⁹² It was stated that ‘the consensus ... is that the AODT Court is resulting in transformational change for graduated participants and whānau’²⁹³ and that feedback demonstrated that the perceived outcomes achieved by graduates and current participants aligned with the intended outcomes, specifically perceptions of reduced reoffending, reduced AOD consumption and dependency, reduced use of imprisonment and a positive impact on health and wellbeing.²⁹⁴ As with Freiberg et al’s assessment of the protective features of participation in a drug court that contribute to its effect in reducing reoffending, it was also noted that there had been a significant change in the attitudes of graduated participants, including improved self-esteem and increased respect for the judicial system.²⁹⁵ In 2016, it was reported that 70 offenders had completed the program and none of these offenders had been returned to prison.²⁹⁶ It was also reported that the program to date had resulted in a saving of NZD\$5 500 000 in prison costs.²⁹⁷

3.2.8 Research that has examined reoffending rates for participants in the AODT Court indicates that preliminary data suggest:

in the short-term, data show that overall participants in the AODT Court were significantly less likely to reoffend, be re-imprisoned and reoffended less frequently. AODT Court participants were 54 per cent less likely to reoffend in 12 months and 58 per cent less likely to be re-imprisoned. When looking at graduates of the AODT Court alone, they had a 62 per cent lower rate of reoffending and 71 per cent lower rate of reimprisonment than the matched sample of offenders over a 12-month period.²⁹⁸

However, there is a need to evaluate the effectiveness of the AODT Court over the longer term.

3.2.9 There is evidence from the United States that DWI courts that comply with the Guiding Principles are effective in reducing recidivism. In a meta-analysis conducted in 2012, it was concluded that DWI courts ‘reduced both DWI recidivism and general criminal recidivism by an average of more than 12 percent. The best DWI courts reduced recidivism by as much as 50 to 60 percent as compared to other sentencing options’.²⁹⁹ Research shows that ‘higher service intensity [more services provided per participant per time period] was associated with better outcomes’³⁰⁰

²⁸⁹ Ibid.

²⁹⁰ Ibid 104.

²⁹¹ Ibid 95.

²⁹² Ibid 108.

²⁹³ This means ‘extended family, family group, a familiar term of address to a number of people. May also include friends who may not have any kinship ties to other members’: *ibid* 119.

²⁹⁴ Ibid 110.

²⁹⁵ Ibid 111.

²⁹⁶ Interview with Judge Lisa Tremewan, ‘The Alcohol and Drug Treatment Court in New Zealand’, *Radio New Zealand*, 29 January 2016. It was reported that an evaluation of the AODT Court is currently underway.

²⁹⁷ Ibid.

²⁹⁸ K Thom, ‘Exploring Te Whare Whakapiki Wairua/The Alcohol and Other Drug Treatment Court Pilot: Theory, Practice and Known Outcomes’ [2017] *New Zealand Criminal Law Review* 180, 190–191.

²⁹⁹ NCDC, above n 254, 2 citing Mitchell et al 2012. See also Miller et al, above n 212, 29.

³⁰⁰ F Sloan et al, ‘Effects of Admission and Treatment Strategies of DWI Courts on Offender Outcomes’ (2013) 53 *Accident Analysis and Prevention* 112, 112.

demonstrating that ‘creating a DWI court without thought as to the structure or design of the treatment aspect is not likely to be productive’.³⁰¹ Research examining offenders’ recidivism rates for at least four years after participation in the DWI program has shown that it has long-lasting effects.³⁰² Research also shows that there was a greater reduction in rearrests for DWI offenders who participated in a DWI court than for offenders who participated in a hybrid court.³⁰³ There is also evidence to suggest that participation in a DWI court program reduces the incidence of car crashes and fatalities and makes it more likely that offenders will comply with court orders, probation directives and Department of Motor Vehicle requirements and regain their licences.³⁰⁴ DWI courts are also considered to be a cost effective method of responding to drink driving³⁰⁵ and are said to ‘have saved local communities nearly \$1500 (US) per participant within two years and more than \$5000 (US) per graduate.’³⁰⁶

3.2.10 However, concerns have been expressed about the effectiveness of DWI courts in addressing drink driving — for example, Perry suggests that the effectiveness of DWI courts remains uncertain.³⁰⁷ Nevertheless, while there may be concerns that there are a lack of high quality evaluations of DWI interventions, analysis suggests that ‘multi-component programs are more effective than those which target only one aspect of the issue’.³⁰⁸ Other research has highlighted the need to evaluate DWI programs in a holistic manner and consider the benefits to offenders and the community that are gained through participation in the programs such as the transformative changes and the effect on diverse aspects of offenders’ lives.³⁰⁹ Such benefits, which extend beyond reduced recidivism and cost savings are ‘healthier families, better work productivity, fewer people on public assistance, [and] fewer medical costs’.³¹⁰ Accordingly, in 2013, the National Transportation Safety Board in the United States ‘endorsed DWI Courts as a proven strategy for rehabilitating repeat driving while [alcohol] impaired ... offenders’.³¹¹

3.3 ‘Swift, certain and fair’ approaches to drink driving

3.3.1 A criminal justice response developed in the United States that has been used in the context of drink driving has been the introduction of ‘swift, certain and fair’ (SCF) approaches to the management of offenders under sentence.³¹² The most prominent of these programs is Hawaii’s Opportunity Probation with Enforcement Program (HOPE).³¹³ HOPE is a ‘probation compliance

³⁰¹ Ibid 119.

³⁰² NCDC, above n 254, 3. F Sloan et al, ‘Does the Probability of DWI Arrest Fall Following Participating in DWI and Hybrid Drug Treatment Court Programs?’ (2016) 97 *Accident Analysis and Prevention* 197, 204.

³⁰³ F Sloan et al, above n 302, 197.

³⁰⁴ NCDC, above n 254, 4.

³⁰⁵ Ibid 5.

³⁰⁶ Ibid 6.

³⁰⁷ A Perry, ‘Sentencing and Deterrence’ in D Weisburd, D Farrington and C Gill (eds), ‘What Works in Crime and Prevention and Rehabilitation: Lessons from Systematic Reviews’ (Springer, 2016) 169, 189.

³⁰⁸ Miller et al, above n 212, 27.

³⁰⁹ B Liang, M Long and D Knottnerus, ‘What Do Clients Achieve in Drug/DUI Court? Examining Intended and Unintended Outcomes’ (2016) 37 *Justice System Journal* 272.

³¹⁰ Ibid.

³¹¹ NCDC, above n 254, 1, citing National Transport Safety Board, *Reaching Zero: Actions to Eliminate Alcohol-Impaired Driving* (2013).

³¹² VSAC, *Swift, Certain and Fair Approaches to Sentencing Family Violence Offenders*, Report (2017) x.

³¹³ VSAC, *Swift, Certain and Fair Approaches to Sentencing Family Violence Offenders*, Discussion Paper (2017) 13. It is noted that there are at least 18 states in the United States that have SCF programs operating: see discussion at 18–19.

regime that requires swift, certain and fair responses to *every* breach of a condition of probation³¹⁴ and primarily ‘targets drug offenders and others at high risk of recidivism’.³¹⁵ More recently, the Northern Territory has begun a pilot called the COMMIT program, which targets drug and alcohol offenders sentenced to a conditional suspended sentence.³¹⁶ Another program based on the SCF approach specifically targeting drink drivers is the South Dakota 24/7 program.

3.3.2 Six key elements of SCF approaches are defined in the international literature:

1. targeting offenders under sentence in the community who are subject to conditions;
2. identifying conditions that should receive non-discretionary (“zero-tolerance”) responses upon contravention;
3. establishing a behavioural contract with offenders so that they know what is expected of them and what the consequence of non-compliance with conditions will be (usually a fixed sanction);
4. utilising regular measures to detect condition contraventions on a regular basis (such as regular drug testing);
5. responding to condition contraventions quickly by holding a contravention hearing within 72 hours of a detected contravention; and
6. imposing fixed sanctions at a contravention hearing in accordance with the behavioural contract.³¹⁷

Another feature of SCF approaches is the use of short periods of custody (from a few hours to a month) as a fixed sanction.³¹⁸

3.3.3 The theoretical underpinnings of SCF approaches differ from the approach of problem-solving courts. SCF approaches are not generally considered to be informed by a therapeutic philosophy and a rehabilitative approach to the management of offenders. In contrast, problem-solving courts ‘aim to address the underlying issues that result in criminal behaviour’ with a specialised court model designed for a targeted group which uses ‘collaborative intervention and supervision, accountability through judicial monitoring, procedural fairness and a focus on outcomes’.³¹⁹ Instead, the basis for a SCF approach derives from the principle of deterrence based on the certainty and swiftness of punishment in response to offending.³²⁰

HOPE project

3.3.4 The HOPE project commenced in Hawaii in 2004 as a response to concerns about non-compliance with probation orders.³²¹ It forms part of a ‘continuum of supervision’ model for

³¹⁴ Ibid 13.

³¹⁵ L Bartels, ‘Swift and Certain Sanctions: Is it Time for Australia to Bring Some HOPE into the Criminal Justice System?’ (2015) 39 *Criminal Law Journal* 53, 53–54.

³¹⁶ VSAC, above n 312, 13.

³¹⁷ Ibid 16.

³¹⁸ Ibid.

³¹⁹ VSAC, above n 312, 17.

³²⁰ Warner, above n 56, 403; P Larkin, ‘Swift, Certain, and Fair Punishment 24/7 Sobriety and Hope: Creative Approaches to Alcohol-and Illicit Drug-Using Offenders’ (2015) 105 *The Journal of Criminal Law and Criminology* 101, 128–129.

³²¹ VSAC, above n 313, 13.

offenders on probation, with HOPE probation operating as the middle tier.³²² The first tier is for low risk offenders who are subject to routine probation (minimal supervision), HOPE probation is the middle tier for medium to high-risk offenders, and the third (and highest tier) is for higher risk offenders who are subject to Drug Court supervision (maximum supervision).³²³

3.3.5 The HOPE program uses swift and certain but moderate sanctions as a means of responding to alcohol and drug offenders. The HOPE program is underpinned by the idea that swift and certain punishment is a more effective deterrent than a potentially harsher penalty imposed at a future date.³²⁴ This program focuses on drug use and is not a drink driving specific program. The program operates as follows:

- offenders are given a warning hearing (in a group with other HOPE participants) and are then required to call a dedicated hotline daily to determine whether they are due for drug testing (offenders are given a colour code (eg red) and they call the hotline to determine if their colour has been selected for drug testing);
- offenders are initially tested at least weekly for drug use, moving to less frequent testing following compliance;
- offenders are swiftly arrested for failing to attend their probation appointment or drug test or returning a positive drug test and brought back before the court;
- *all* violations result in a short prison sentence, there being no discretion as to how probation or judicial officers may deal with violations; and
- drug treatment is reserved for offenders who request it or have multiple violations.³²⁵

HOPE is less resource intensive than a drug court as an offender only appears before a judge if they have breached their probation, rather than appearing before a judge on a regular basis.³²⁶ However, they can be resource intensive in the high level of administration, including frequent testing and monitoring and the need to resource immediate responses to breaches, including short prison sentences. There is also a capacity for treatment to be included if a probationer requests treatment referral or if an offender has multiple violations and is mandated to intensive substance abuse treatment services.³²⁷

South Dakota 24/7 program

3.3.6 The South Dakota 24/7 Sobriety Program, is an SCF program developed to target drink drivers, which allows the court to make participation in the 24/7 Sobriety program a condition of pre-trial release, a suspended sentence, probation or parole and requires that an offender remain alcohol free and submit to daily alcohol testing — either by twice daily breath testing or electronic testing devices.³²⁸ Failure of the test, or failure to attend a test, results in the imposition of a ‘swift and certain

³²² Ibid 14.

³²³ Ibid.

³²⁴ Larkin, above n 320.

³²⁵ Bartels, above n 315, 65.

³²⁶ A Hawken et al, *HOPE II: A Follow-up to Hawai'i's HOPE Evaluation* (US Department of Justice, 2016) 19.

³²⁷ Ibid 17.

³²⁸ Larkin, above n 320, 130–131.

but moderate sanction’³²⁹ known as ‘flash incarceration’ — usually 24 hours or 48 hours imprisonment for breach.³³⁰ Offenders who fail to take a test for the first time are immediately incarcerated for 24 hours and then taken to court the next day for the program conditions to be reimposed.³³¹ The program focuses on abstinence rather than specifically on an offender’s separation of alcohol use from driving. An additional aspect of the program is that it allows for testing for illicit drugs and ignition interlock devices to be used.³³² As with the HOPE program, this approach focuses on SCF responses to a breach of a condition of a community-based sentence. This program has been expanded to North Dakota, Alaska and other western states.³³³

The Northern Territory COMMIT Program

3.3.7 In 2016, the Northern Territory began a pilot program called Compliance Management or Incarceration in the Territory (COMMIT) program, based on the principles that underpin the HOPE model.³³⁴ Drug and alcohol offenders sentenced to a conditional suspended sentence are required to comply with drug and alcohol treatment and testing conditions and if an offender fails to comply, they are returned to court for a hearing and receive a short custodial sanction.³³⁵ VSAC reported that the ‘aim of COMMIT is to encourage behavioural change through short sanctions for breach, reduce the number of violations of suspended sentence conditions and, in turn, reduce the number of wholly reactivated sentences’.³³⁶ There is also a focus on rehabilitation as an initial period of residential rehabilitation treatment is standard for offenders in the COMMIT program.³³⁷

Effectiveness of SCF approaches

3.3.8 Original evaluations of the HOPE program in Hawaii suggest that during the period of monitoring, offenders have greater reductions in drug use and reoffending and fewer days in prison compared with control groups.³³⁸ However, an evaluation conducted in 2016 found that the differences in recidivism between HOPE and control subjects were primarily due to a reduction in the number of new drug charges (rather than property, violent or social disorder offending).³³⁹ Even the differences between HOPE subjects and the control group in relation to drug charges have been described ‘in perspective’ as showing that ‘[a]fter more than six years, the drug charges figure for the HOPE group was on average only a fraction of a single offence lower (0.15 of an offence difference)’.³⁴⁰ Positive findings reported in analyses of the 24/7 Sobriety program also show that the program has reduced recidivism for drink driving and domestic violence during the operation of the

³²⁹ Ibid 131.

³³⁰ Ibid.

³³¹ Warner, above n 56, 403.

³³² R Loudenberg et al, *South Dakota 24/7 Sobriety Program*, (Mountain Plains Evolution Supplemental Final Report, 2012) 5 <<http://apps.sd.gov/atg/dui247/247stats.htm>>.

³³³ Hawken et al, above n 326, 27.

³³⁴ VSAC, above n 312, 13.

³³⁵ Ibid.

³³⁶ VSAC, above n 313, citing Northern Territory Department of Correctional Services, *The HOPE Strategy and the COMMIT Program Manual* (2016) 4.

³³⁷ VSAC, above n 312, 14.

³³⁸ Bartels, above n 315, 53.

³³⁹ Hawken et al, above n 326, 13.

³⁴⁰ F Cullen, T Pratt and J Turanovic, ‘The Failure of Swift, Certain and Fair Supervision: Choosing a More Hopeful Future’ (2017) *Perspectives* 66, 70.

program and there is evidence suggesting that it may have reduced the number of traffic crashes by men aged between 18 to 40 years.³⁴¹

3.3.9 Concerns have been expressed about the long-term effectiveness of the use SCF, with the HOPE program being criticised on the basis that its effectiveness may be limited to the period during which the offender is monitored and that it may not lead to long term behavioural change.³⁴² Similarly, with the South Dakota 24/7 Sobriety program, the long-term effectiveness of the program as a deterrent after the monitoring period has finished is uncertain.³⁴³ In addition, despite some positive evaluations of SCF approaches, VSAC reports that ‘[t]here is now strong evidence that, compared with “probation as usual”, HOPE-like programs do not necessarily reduce recidivism, rearrest, probation revocations or time spent in jail’.³⁴⁴ This conclusion is based on evidence from the HOPE Demonstration Field Experiment, that sought to assess whether HOPE could be replicated in other jurisdictions in the United States.³⁴⁵ Following an analysis of evaluations of SCF approaches in the United States, Cullen et al have called for ‘[a]ny future use of the program ... to come with a warning label that HOPE can no longer be sold with the claim of being “evidence based”’.³⁴⁶ An evaluation of the 24/7 Sobriety Program in North Dakota found that the deterrent effect of the program was ‘not as strong for the most dangerous drivers — those likely to abuse alcohol and have issues with self-control’.³⁴⁷

Other criticisms of SCF approaches

3.3.10 As well as criticisms of the effectiveness of SCF approaches, there have been concerns raised about the punitive focus of the mandatory penalty for breach of probation requirements. While offenders have access to treatment under the HOPE model if requested, or if mandated after multiple violations, programs such as HOPE focus primarily on deterrence through mandatory, fixed penalties.³⁴⁸ SCF approaches remove discretion from corrections staff and judicial officers in responding to breaches and thus create ‘certainty’ as to the response. However, they have been criticised for relying on punishment as deterrence³⁴⁹ and ‘neglecting to address the underlying drivers of an offender’s behaviour’.³⁵⁰

3.3.11 Other concerns raised about SCF approaches relate to procedural fairness and human rights given that under the HOPE program, the offender is detained in jail before the court hearing with the effect that he or she has already served a period in custody before the matter is determined by the

³⁴¹ B Kilmer et al, ‘Efficacy of Frequent Monitoring with Swift, Certain, and Modest Sanctions for Violations: Insights From South Dakota’s 24/7 Sobriety Project’ (2013) 103 *American Journal of Public Health* e37, e41.

³⁴² Bartels, above n 315, 63.

³⁴³ Mountains Plains Evaluation, *Analysis of 24/7 Sobriety Program SCRAM Participant DUI Offence Recidivism* (2013) which found that once the Secure Continuous Remote Monitor (SCRAM) device was removed ‘behaviour change is not sustained, as over time recidivism rates begin to approach or exceed the recidivism rates of controls’: at 12. Similarly, in a review conducted in Montana, it was observed that a focus for future research will be the long-term effects of the 24/7 program: see G Midgette and B Kilmer, ‘The Effect of Montana’s 24/7 Sobriety Program on DUI Re-arrest: Insights from a Natural Experiment with Limited Administrative Data (RAND Justice, Infrastructure, and Environment, 2015) 23.

³⁴⁴ VSAC, above n 312, 20.

³⁴⁵ See VSAC, above n 313, 20, 22–24.

³⁴⁶ F Cullen, T Pratt and J Turanovic, ‘It’s Hopeless: Beyond Zero-Tolerance Supervision’ (2016) 15 *Criminology and Public Policy* 1215, 1222–1223.

³⁴⁷ A Kubas, P Kayabas and K Vachal, *Assessment of the 24/7 Sobriety Program in North Dakota* (2015) 34.

³⁴⁸ VSAC, above n 312, 17.

³⁴⁹ Cullen, Pratt and Turanovic, above n 346, 1216.

³⁵⁰ VSAC, above n 312, 32.

court.³⁵¹ In addition, it has been argued that fixed and mandatory penalties of short periods of custody for condition breaches are inconsistent with the principle of parsimony.³⁵² Short prison sentences have also been criticised due to the lack of opportunity they provide to engage meaningfully with offenders.³⁵³

3.4 An alternative approach for Tasmania: A DWI list

3.4.1 In the Issues Paper, the TLRI asked stakeholders whether a DWI court/list should be established in Tasmania, and, if so, whether a pilot program would be an appropriate approach to the establishment of the list. In addition, the Institute asked for feedback on whether there are aspects of the 24/7 Sobriety Program and HOPE program that could be incorporated into the court's approach.

Consultations – views and issues

3.4.2 In his submission, the DPP indicated that he did not support the establishment of a DWI court/list in Tasmania. The DPP wrote that:

Whilst there would likely be benefits to a DWI court/list, there are a number of resourcing implications in implementing such a list. The program would require clinicians, case workers, random testing, educational and medical facilities. Additionally, the court/list would preferably be run by a dedicated magistrate in each court district. Sentencing procedures would become more complicated and take considerably longer than at present, whereby judges would require reports and hear submissions on the various options that are available. It would create further pressure on judicial, prosecutorial and defence resources.

3.4.3 The DPP also questioned the appropriateness of the therapeutic model (as used in respect of illicit drugs in Tasmania) as a response to drink driving given the differences between the types of offenders and offences:

Repeat drink driving is often the result of attitudinal factors (eg a sense of entitlement to drive; an inability to see the danger and risks of drink driving to themselves or others; or a belief that they "will not get caught") rather than excessive alcohol use contributing to the offending (such as driving to obtain more alcohol to satisfy a craving). Indeed, there is no necessary link between drink driving convictions and alcohol dependency.

This may be contrasted with offenders sentenced to a drug treatment order (DTO). Offences that may result in an offender being made subject to a DTO are generally motivated by illicit drug use, such as committing dishonesty offences to sustain a habit. To be eligible for a DTO, there must be a link between the drug use and the commission of the relevant offence. The court can only make a DTO if satisfied on the balance of probabilities that the illicit drug use contributed to the commission of the offence or offences for which the offender is to be sentenced.

The DPP's view was that it is more practical that any additional resources should be used to improve the existing Sober Driver Program (removing barriers to entry and increasing the educative

³⁵¹ Ibid 26.

³⁵² Ibid 28.

³⁵³ Ibid 29.

component covered within the course) and to improve other related services that may be utilised by the imposition of CSOs or probation orders.

3.4.4 In contrast, other submissions (from both legal and treatment perspectives) supported the introduction of a DWI court/list in Tasmania. CLC Tas indicated that it strongly supported such an approach to drink driving on the basis that a more targeted program is needed to respond to the high incidence of recidivism, alcohol and other drug abuse and mental illness. For repeat drink drive offenders, for whom the criminal justice system is a ‘revolving door’ ultimately leading to a prison sentence, CLC Tas highlighted the limitations of short prison sentences in addressing the rehabilitative needs of offenders. Gerald Waters also supported the introduction of a Tasmanian recidivist drink driving list as a means ‘to bring together the current piecemeal attempts at reducing repeat drink driving in a collaborative and consistent manner’. In consultation meetings with CLC Tas, support was also expressed for a DWI list.³⁵⁴ It was noted that if a DWI list is effective it will improve community safety and also save money spent on the prison system. Other participants in stakeholder meetings were supportive of the idea of a DWI list.³⁵⁵ Hannah Phillips, from TACLS indicated that such a list would assist her clients. Mark Doyle (legal practitioner) indicated that he was supportive of a DWI list in Tasmania. In his view, it will be critical that the list have access to appropriate expertise to address the needs of the offenders, that it provide for a timely response in allowing an offender to access help and that it is supported by immediate and proportionate consequences for non-compliance with the conditions of any order. He also remarked that it will need to operate in a therapeutic rather than a punitive framework.

3.4.5 Stakeholders involved in treatment and mental health also considered that the creation of a DWI court or list would be beneficial. ForensiClinic’s view was that a DWI list would ‘provide a framework for recidivist drink drivers to be directed into individual risk reduction programs, with risk assessment and management communicated to the court by qualified professionals’. Its view was that a DWI list would provide for a better interface between the health and justice sectors. Similarly, Holyoake’s view was that a DWI court would offer offenders a blend of justice and treatment by providing them with ‘the opportunity to access meaningful support to change their behaviour in order not to reoffend’. In meetings with stakeholders, Marita O’Connell (Tasmanian Health Service) considered a DWI court to be a good idea.

3.4.6 FARE also considered that there are a sufficient number of cases for a DWI court or list to be established in Tasmania. FARE’s approach to the DWI list was to develop a model based on the SCF approaches (HOPE and 24/7 Sobriety as discussed above).

3.4.7 However, some reservations were expressed in stakeholder meetings. The Law Society (James Crotty and Phillip Zeeman) considered that a DWI court is a good idea but thought that there may be questions about whether the public is ready for it given the current focus on punishment. In a meeting with Fran McCracken (legal practitioner), she indicated that, in her view, a DWI list is not the highest resource priority in Northern Tasmania and that additional resources should be used to expand the CMD program dealing with illicit drugs.

3.4.8 In respect of the development of a pilot DWI court/list as an appropriate approach to the establishment of the court/list, stakeholders were supportive of this idea. FARE’s view was that a preliminary pilot of two years would appear to be an effective approach in establishing a DWI

³⁵⁴ Consultation meeting with Jess Downie, CLC (Hobart) and Chris Young.

³⁵⁵ Consultation meeting with Anthony Mihal.

court/list. It indicated that the pilot should be evaluated to determine its effectiveness as well as any impact on rates of imprisonment, results of drug and alcohol testing including numbers failed, numbers of breaches, information on further offences and other crimes such as property damage and family violence. ForensiClinic and Holyoake also supported a pilot.³⁵⁶ ForensiClinic considered that a pilot would enable various stakeholders to establish and review processes and procedures and review data to inform long-term efficiencies. Gerald Waters also supported conducting a pilot.

3.4.9 The DPP, who did not support the introduction of a DWI list, indicated that if such a list is established, a pilot would be appropriate. He also stated that if one is established, he would welcome the opportunity to provide further comments on the scope and operation of any such program and proposed legislative amendments.

Recommendations

3.4.10 After reviewing the literature and approaches in other jurisdictions, the TLRI's assessment is that there is evidence to indicate that well designed DWI courts/lists provide a promising alternative to traditional sentencing approaches for repeat drink drivers. The literature (and experience elsewhere) is clear that a therapeutic approach that addresses the underlying causes of offending can be effective in reducing recidivism and improving community safety. Unlike traditional sentencing approaches, key aspects of the therapeutic model are assessment and an individualised response, supervision and judicial monitoring. These are discussed further in Part 4.

3.4.11 The TLRI has also taken into account the models based on SCF approaches and the support for these models expressed in the submission of FARE. While the TLRI recognises the importance of timely interventions and clear expectations and consequences (which are components of SCF approaches), it does not support a model based on these approaches. As indicated at [3.3], SCF approaches are underpinned by a punitive, zero tolerance supervision approach, whereas research suggests that lasting change is better achieved using a therapeutic response. In addition, there are significant differences between the Australian and United States legal systems (such as the focus on judicial discretion and individualised justice in Australia) that raise real questions about adopting the US model.³⁵⁷ In Tasmania, concerns also exist about the availability of custodial places for 'flash incarceration'. Moreover, in the Tasmanian context, it is not clear that imprisonment is a 'fair' response to any breach of a condition of a sentence. It may infringe Australia's human rights obligations in relation to the right to liberty,³⁵⁸ by breaching Art 9 of the *International Covenant on Civil and Political Rights* ('ICCPR').³⁵⁹ Article 9 of the *ICCPR* provides that everyone has the right to liberty; that no-one shall be subjected to arbitrary arrest or detention; and that no-one shall be deprived of his or her liberty except on such grounds and in accordance with such procedures as are established by law. This requirement has been interpreted to mean that detention must be proportionate and not automatic.³⁶⁰ Additionally, the automatic incarceration component of the 24/7 Sobriety program/HOPE project conflicts with the Australian common law principle that detention in the criminal justice arena can only be imposed by a court.³⁶¹

³⁵⁶ Holyoake indicated that it would be willing to take part in any pilot.

³⁵⁷ Bartels, above n 315.

³⁵⁸ Ibid.

³⁵⁹ Warner, above n 56, 403–404.

³⁶⁰ See J Gans et al, *Criminal Process and Human Rights* (Federation Press, 2011) 132–134.

³⁶¹ Warner, above n 56, 403.

3.4.12 In order to determine the viability of a specialised approach to repeat drink drivers in Tasmania, it is the Institute's recommendation that a repeat drink driver pilot be established using the framework of the Drug Treatment Order (DTO). It is proposed that the provisions for a DTO in the *Sentencing Act 1997* (Tas) be amended to accommodate DWI offenders and that the order operate as a Drug Treatment (DWI) order situated within the current CMD list of the Magistrates Court.³⁶² There was support for the pilot in the submissions received. Further, the New Zealand experience in developing an AODT Court has highlighted the benefit of having a pilot court established as a means to monitor and evaluate the operation of the AODT Court and to allow for flexibility in its operation while the roles and processes of the court evolve.³⁶³ The pilot approach in New Zealand has also allowed for community feedback to be taken into account in the development of the court through the use of an advisory group. This enables community confidence in the effectiveness of the court to grow. The use of a pilot scheme has also been effective in the establishment of a MHDL in the Magistrates Court in Tasmania.³⁶⁴ In addition, it is the TRLI's view that a project team should be established to resolve practical issues around the procedures and operation of the list and the provision of services for the list. This team should comprise representatives from the Magistrates Court, Police Prosecution Services, the Department of Health and Human Services, the Department of State Growth, Community Corrections, Legal Aid, service providers and the Law Society Criminal Law Committee.

Recommendations

1. That a Drug Treatment (DWI) order be developed in Tasmania.
2. That a pilot Drug Treatment (DWI) order be established, supported by a Reference Group with representatives from the Magistrates Court, Police Prosecution Services, the Department of Health and Human Services, the Department of State Growth, Community Corrections, Legal Aid, service providers and the Law Society Criminal Law Committee.

³⁶² This is discussed further in Part 4.

³⁶³ L Gregg and A Chetwin, *Formative Evaluation for the Alcohol and other Drug Treatment Court Pilot* (Litmus, 2014).

³⁶⁴ M Hill, 'Developing Therapeutic Judging – The Tasmanian Experience' (Paper presented at Non-Adversarial Justice: Implications for the Legal System and Society Conference, Melbourne, 4–7 May 2010).

Part 4

A Preliminary Model for a DWI List in Tasmania

As indicated, the TLRI's view is that it is desirable to establish a Drug Treatment (DWI) order in Tasmania. This Part considers the characteristics of a preliminary model for a Tasmanian Drug Treatment (DWI) order, including:

- (1) the structure of the order;
- (2) the target offending cohort and eligibility criteria;
- (3) the conditions of DWI court orders;
- (4) the referral and assessment process;
- (5) the services that need to be available as part of treatment and rehabilitation;
- (6) program phases;
- (7) supervision and judicial monitoring;
- (8) evaluation;
- (9) resources and funding.

4.1 The target audience and eligibility criteria

Position in other jurisdictions

4.1.1 In other jurisdictions, the target cohort for a DWI List has included first-time offenders with high blood alcohol concentrations (BAC over .15) and/or repeat offenders.³⁶⁵

4.1.2 In Victoria, the proposal for a Drink Disqualified Driver List recommends that orders endure for no more than two years. It was proposed that eligibility be restricted to 'hardcore' drink driving offenders, including repeat offenders or first-time offenders with high or extreme BAC levels. The List would also deal with offenders convicted of driving whilst disqualified or suspended.³⁶⁶ These offenders were selected on the basis that their conduct was likely to have the most negative impact on

³⁶⁵ Richardson, above n 6, 18.

³⁶⁶ Ibid.

the community,³⁶⁷ and, in the case of repeat offenders, typically their offending behaviour is not addressed adequately by traditional criminal justice responses.

4.1.3 In New Zealand, the AODT Court is directed at serious repeat drink drive offenders. As indicated in Table 4-1, in terms of total driving under the influence offences only a small proportion of offenders participate in the AODT Court.³⁶⁸

Table 4-1: Number of people charged with driving under the influence offences nationally in New Zealand, by AODT Court participants

| Participants in AODTC | 2012 | 2013 | 2014 | 2015 | 2016 |
|-----------------------|--------|--------|--------|--------|--------|
| No | 25 719 | 23 724 | 19 871 | 16 919 | 16 587 |
| Yes | 4 | 34 | 22 | 24 | 21 |
| Total | 25 723 | 23 758 | 19 893 | 16 943 | 16 608 |

4.1.4 In New Zealand, the AODT Court eligibility criteria include the following:

- aged 17 years or older; and
- have been charged with offending and that offending is being driven by AOD dependency, including recidivist drink-drivers; and
- are at high-risk in terms of reoffending and risk to themselves, their families and the community; and
- have a moderate-severe substance-related dependency (as per DSM IV or DSM V); and
- are facing charges, which on a guilty plea, could result in a sentence of imprisonment (for a period of up to three years) but the completion of the AODT Court program will mean that a non-custodial sentence can properly be imposed on a principled sentencing basis; or
- are charged with their third or subsequent drink driving offence in the aggravated form and/or have a medium/high RoC*RoI score.³⁶⁹

In summary, in New Zealand, drink driving offenders are eligible if they are charged with offending that is being driven by AOD dependency, have a moderate-severe substance related dependency and are charged with their third or subsequent drink driving offence.³⁷⁰ While it is not necessary that drink drivers fall within the RoC range, during the pilot stage of the program, it was reported that only 15% of drink drive participants were not in that range.³⁷¹ There are some restrictions on eligibility with offenders not being eligible if they are facing charges of serious violence, sexual offending or arson, or if they have a serious mental health condition (other than the AOD addition/dependency) that would prevent participation in the court.³⁷² In addition, participants must live Auckland or Waitakere

³⁶⁷ NCDC, above n 258, Guiding Principle 1.

³⁶⁸ Driving under the influence offences include driving under the influence of alcohol or other substance, exceed the prescribed content of alcohol or other substance limit or driving causing death where the driver was under the influence of alcohol or other substances, Ministry of Justice, email 15 September 2017.

³⁶⁹ Ministry of Justice, New Zealand, *Alcohol and Other Drug Treatment Court Handbook* (2014) Appendices AODT Court Eligibility Criteria. RoC*RoI measures risk of reconviction multiplied by risk of imprisonment.

³⁷⁰ *Ibid* 27.

³⁷¹ Litmus, above n 286, 29.

³⁷² Ministry of Justice, New Zealand, above n 369, 5.

District Court catchment areas. While the focus is intended to be on high-risk offenders, in the final evaluation of the pilot program, ‘feedback from stakeholders was mixed on whether all participants with EBA [Exceed Blood Alcohol] offences met the high-risk, high-need eligibility criteria’.³⁷³

4.1.5 In New South Wales, the Sober Driver Program is available for the following categories of offenders:

- category 1 – offenders convicted of two or more drink driving offences within five years; or
- category 2 – offenders convicted of a single serious drink driving offence with no prior convictions and offenders who have been convicted of a repeat drink driving offence after more than five years and less than ten years from their initial offence. In addition, category 2 offenders must meet at least one of the following criteria: the offender admits or suggests that they regularly drink and drive without being detected by police; the offender’s pattern of alcohol consumption continues to place them at risk and/or the offender’s Level of Service Inventory – Revised (LSIR) is *24 or greater.³⁷⁴

4.1.6 The current criteria in Tasmania for the Sober Driver Program include a requirement that the offender has two or more drink driving offences in the last five years.³⁷⁵

What does the evidence say?

4.1.7 As discussed at [3.2], the First Guiding Principle for DWI courts is to identify their target offending cohort. Accordingly, clear, written eligibility criteria for access to DWI court programs would need to be developed in Tasmania to ensure consistency in their application and also to reduce the risk of net widening.³⁷⁶ In addition, the First Guiding Principle for DWI Courts suggests that the court focus ‘on those offenders who are assessed by a substance abuse professional as being in significant need of treatment’.³⁷⁷ As recognised in relation to drug courts, eligibility criteria should be reflect ‘empirical evidence indicating the types of offenders that can be treated safely and effectively in drug courts’.³⁷⁸ In addition, Freiberg et al have observed that a key feature of successful court-based intervention includes ‘clear and broad eligibility criteria that allow streaming of people based on their assessed risk, needs and responsivity’.³⁷⁹

4.1.8 Considerable research has examined effective treatment for drug and alcohol users in the criminal justice system and a key principle that has been accepted as best practice in reducing reoffending is to match offenders to appropriate service levels and intervention types based on prognostic risk and criminogenic needs.³⁸⁰ Research makes it clear that ‘the intensity of drug

³⁷³ Litmus, above n 286, 28.

³⁷⁴ Department of Justice, NSW, *Compendium of Offender Behaviour Change Programs in New South Wales* (2016) 35. LSIR stands for Level of Service Inventory – Revised and is an assessment tool used to identify an offender’s needs and risks in terms of recidivism, see <<http://www.mhs.com/product.aspx?gr=saf&id=overview&prod=lsi-r>>.

³⁷⁵ See [2.4.12].

³⁷⁶ Maryland Drug Courts, *Maryland’s Guidelines for Planning and Implementing Adult DUI/DWI Treatment Court Programs* 9 <<http://cdm16064.contentdm.oclc.org/cdm/ref/collection/p266901coll7/id/916/>>.

³⁷⁷ NCDC, ‘DWI Court Model Compliance Checklist’, Guiding Principle # 1 <https://www.dwicourts.org/wp-content/uploads/2011%20NCDC%20Checklist%20Final-Form_0.pdf>.

³⁷⁸ Freiberg et al, above n 2, 207.

³⁷⁹ Ibid 172.

³⁸⁰ Jason Payne and Anthony Morgan, *Drug and Specialist Courts Review Appendix E: Building Effective Interventions for Drug Users in the Criminal Justice System* (2016) 4; D Wilson, ‘Correctional Programs’ in D Weisburd, D Farrington

treatment, the provision of allied treatment and the intensity of supervision by the criminal justice system should be guided by the principles of risk, needs and responsivity' (RNR).³⁸¹ RNR has three key principles:

- The risk principle – that the level of program intensity be matched to offender risk level (defined as the risk of reoffending, absent intervention or treatment), and that intensive levels of intervention and treatment be reserved for offenders with the highest level for risk;
- The need principle – that criminogenic needs (ie those functionally related to persistence in offending) require commensurate and concurrent redress; and
- The responsivity principle – that the types and modes of intervention be matched or tailored to each individual offender's learning style and abilities and be responsive to individual strengths and level of motivation.³⁸²

A crucial feature of the RNR principles is that 'low-risk offenders should not be over-treated or over-supervised. Not only is it potentially unethical and net-widening, but the over-treating of offenders who are low-risk and low-need has the potential to exacerbate drug use and worsen criminal justice outcomes'.³⁸³ In relation to the triaging of risk and need, Marlowe presented a model that sets out a framework for 'alternative tracks within an adult drug court' (as shown in Table 4.2).³⁸⁴ Acknowledging that this framework may be challenging to apply in practice, it has been said to be 'useful for understanding how a continuum of criminal justice services could be designed'.³⁸⁵ It shows how the offenders prognostic risk of reoffending and criminogenic need 'inform different intensity of supervision and treatment'.³⁸⁶

Table 4-2: Alternative tracks within an adult drug court

| | | Prognostic risk | |
|-------------------|--|--|--|
| | | High | Low |
| Criminogenic need | High (substance dependence) ³⁸⁷ | Offenders require all the services typically provided under a drug court program. | Offenders require drug treatment and cognitive behavioural interventions, but need only be required to appear before the court for matters of non-compliance (treatment emphasis). |
| | Low (substance abuse) | Offenders require the same level of supervision and compliance monitoring as would be provided under a drug court; however, drug treatment should be replaced with behavioural interventions that target other criminogenic needs and criminal thinking (accountability emphasis). | Offenders do not require drug treatment or cognitive behavioural interventions, and should only appear before the court for matters of non-compliance (diversion emphasis). |

Source: Freiberg et al 134 adapted from Marlowe 2012

and C Gill (eds), *What Works in Crime Prevention and Rehabilitation: Lessons from Systematic Reviews* (Springer, 2016) 193.

³⁸¹ Freiberg et al, above n 2, 35.

³⁸² Ibid 133.

³⁸³ Ibid.

³⁸⁴ D Marlowe, 'Alternative Tracks in Adult Drug Courts: Matching Your Program to the Needs of Your Clients' (2012) 7(2) *National Drug Court Institute* 1, 3.

³⁸⁵ Freiberg et al, above n 2, 134.

³⁸⁶ Ibid.

³⁸⁷ It is noted that DSM 5 has replaced the categories of alcohol abuse and alcohol dependence (as appeared in DSM-IV) with a single disorder (alcohol use disorder) with subcategories of mild, moderate and severe.

4.1.9 In the Ten Guiding Principles, it is suggested that DWI Courts should primarily target repeat offenders with serious alcohol/drug dependences or addictions on the basis that addressing the underlying causes of a repeat offender's behaviour will have the greatest community impact in terms of road safety and savings to the criminal justice system.³⁸⁸ This reflects research that highlights the disproportionate number of DWI fatalities and crashes caused by repeat offenders.³⁸⁹

4.1.10 In determining eligibility, it is necessary to consider whether offenders should be excluded from participation if they are suffering from a mental health disorder. Evidence suggests that there is a 'high incidence of comorbidity' of substance use and other mental health related issues in criminal justice populations.³⁹⁰ This was reflected in the offender profile constructed by the TLRI/TILES study, which provided information about the socio-demographic and criminal history characteristics of repeat drink drivers in Tasmania. As discussed, this study found that many offenders had a history of alcohol abuse and problematic drug use and co-existing mental health issues. It also found the majority of repeat offenders recorded a blood alcohol concentration of 0.1 or greater. In addition, the study showed the association between drink driving and other illegal driving behaviour such as unlicensed driving or driving while suspended/disqualified. Over an offender's lifetime, the study also found that over half of the research cohort had prior convictions for violent offending (excluding domestic violence) and nearly a quarter had a prior conviction for domestic violence.

Consultations – views and issues

4.1.11 In the Issues Paper, the TLRI asked a number of questions in relation to the eligibility criteria and offence qualifiers and disqualifiers. Generally, most stakeholders supported a flexible approach to eligibility, but there were divergent views on this issue.

4.1.12 In relation to the type and level of recidivism and whether first-time offenders should potentially be included in a DWI list, CLC Tas' view was that there should be no restrictions if people want to access treatment. The DPP's view was that first-time offenders should not be excluded and neither should there be a minimum or maximum limit for the number of drink driving offences committed. His view was that 'where the primary sentencing aim is to reduce recidivism, there is no reason why a particular level of recidivism should be required for participation'. The DPP's view was that there should be a set of guidelines that can be discretionarily applied by the sentencing magistrate. In other consultations with stakeholders, it was indicated that legal eligibility criteria should allow for broad judicial discretion to facilitate participation where appropriate rather than defining eligibility in terms of a particular blood alcohol level or a specified number of prior convictions. There was also support expressed for the DWI list to include drug drivers.³⁹¹ In addition, the view was expressed that the requirement of the CMD model that imprisonment be the only suitable penalty was too restrictive in the context of drink driving, and so eligibility should not be dependent on a sentence of imprisonment. However, the Law Society in consultation expressed the view that if the DWI list was modelled on the CMD approach, then the order should be tied to imprisonment. Gerald Waters considered that high level first offenders should be eligible and there should be no requirement for a particular number of offences.

³⁸⁸ NCDC, above n 258, Guiding Principle 1.

³⁸⁹ See [2.2].

³⁹⁰ Freiberg et al, above n 2, 211.

³⁹¹ This was the view of Holyoake (written submission) and raised in the consultation with Anthony Mihal and Chris Young.

4.1.13 Holyoake observed that the focus of the paper was on recidivist drink drivers, who are more likely to have an alcohol dependence of some degree. However, it considered that if first-time offenders have an excessive BAC or display other factors of recklessness creating risk to others as part of their DWI offence, then perhaps they should be included. It also considered that first-time offenders who were assessed as having an alcohol/drug dependence should be included. In contrast, the consultation with Forensic Mental Health Liaison indicated that it should apply for repeat drink drivers.

4.1.14 In the consultation with Community Corrections the view was expressed that there needs to be a cap to match the funding available, otherwise the services that can be provided are likely to be diluted.

4.1.15 As indicated, James Crotty, who chairs the Criminal Law Committee of the Law Society, considered that the CMD program in the *Sentencing Act 1997* (Tas) should be expanded to include alcohol, thereby allowing it to accommodate drink driving offences. He was also of the view that the program should be amended to remove the criteria that the offending would otherwise result in imprisonment. An offender would be eligible if alcohol use had contributed to the commission of the offence. This would not be limited to drink driving offences.

4.1.16 ForensiClinic's submission stated that 'recidivism implies longitudinal risk factors that result in the continuation of a behaviour that places self and others at risk, as opposed to an isolated event which may be situational in nature. Each case should be judged on its merits.' ForensiClinic suggested that the DWI list and associated risk reduction interventions be based on a RNR model, in which 'those at highest risk with the highest needs are targeted for intervention, and responsivity measured over time'. Risk would be assessed by using two risk assessment tools — the first, a screening tool for justice or health workers to assess the risk posed by a drink driving offender, and the second, a more comprehensive tool administered by mental health professionals to assess the more detailed aspects of the offender's psychological and risk profile.

4.1.17 Holyoake also stressed that in relation to repeat drink drivers, while there is a need for more therapeutic support, it is also important to provide a message to the wider community that this behaviour endangers the lives of others and will not be tolerated. Holyoake cautioned against including in the DWI court's jurisdiction, DWI-related death or serious personal injury cases. This was also the view of Gerald Waters. The DPP suggested that in these types of cases, a DWI list order should not be the sole sentencing outcome. Fran McKracken (legal practitioner), indicated that a DWI list order should not be available if the offence had an identifiable victim who had suffered actual bodily harm or if significant property damage had resulted because there should be a focus on punishment in such cases. In contrast, ForensiClinic considered that these offences should be included within the jurisdiction of the DWI list given that all recidivist drink driving behaviour is directly associated with risk to self and others, and hence serious injury or fatalities are inevitably associated with this behaviour.

4.1.18 In terms of the severity of alcohol abuse that should be stipulated by the eligibility criteria, the DPP did not believe that particular level of severity should be a determinative factor but rather should be one factor in determining whether an offender is suitable for participation. ForensiClinic believed that it should be 0.5 blood alcohol reading but that if there were resourcing issues for screening due to a high volume of drink driving offences, then an arbitrary higher reading (eg 1.0) could be applied to warrant the risk assessment screening process and possible referral for individual intervention. Holyoake considered that the eligibility criteria used in NSW for the sober driver

program was a good option. As stated at [4.1.5], this provides for two categories: (1) offenders convicted or two or more drink driving offences within five years (this is the same as Tasmania's sober driver program); and (2) offenders with no prior drink driving convictions or with a repeat conviction more than five years and less than 10 years from their initial offence. In addition, the offender must admit or suggest that they regularly drink drive or the offender's pattern of alcohol consumption continues to place them at risk and/or the offenders' needs and risks in terms of recidivism (measured using the LSIR) are above a particular level. In FARE's submission, reference was made to 'alcohol use disorder' (AUD) contained in DMS-5 with the presence of at least two symptoms being an indication of an AUD. It was suggested that the classification of an AUD could be used as part of the eligibility criteria as it encompasses individuals with mild, moderate and severe AUDs.

4.1.19 There was general agreement that drink drive offenders with co-morbidity issues should be eligible to participate in DWI court programs. As highlighted in the submission of ForensiClinic, currently what is lacking is an individualised risk reduction program that can 'fill the gaps' of the existing group programs provided by Community Corrections. ForensiClinic indicated that probation and parole officers who run the group programs have identified individual issues that prevent offenders from participating effectively, or being included at all in the group program. These issues included intellectual disability or acquired brain injury, major mental illness, personality disorder or co-morbid illicit drug use problems. Holyoake also stressed that the DWI treatment programs must be tailored to the individual needs of each offender and must address the multiple factors that contribute to their offending, including alcohol/drug dependence and other comorbidities such as mental health issues or disabilities. Holyoake observed that 80% of its clients seeking help for their alcohol or other drug use also have a mental health comorbidity, so it would be impossible to exclude this category of clients from a DWI Court. FARE also agreed that offenders with comorbid issues should not be excluded.

4.1.20 Stakeholders also generally supported the position that offenders with any particular criminal history should not be excluded, if they were otherwise eligible.³⁹²

Recommendations

4.1.21 Although there was stakeholder support for a broad-based DWI list, there was also support for an approach that targeted high-risk offenders. Although the TLRI accepts that all drink driving behaviour is a matter for concern and that rehabilitative approaches may be beneficial for a broad range of drink driving offenders, the TLRI's view is that the DWI list should target high-risk/high-needs drink drivers. This is on the basis of the following:

- These drivers have demonstrated that their drink driving behaviour is not amenable to traditional criminal justice responses such as fines and licence disqualifications. In contrast, there are a large number of drink drivers sentenced in the Magistrates Court each year for whom the traditional responses (fine and disqualification) are adequate for rehabilitation, deterrence and community protection.
- RNR principles indicate that more intensive (and costlier) criminal justice system interventions should be reserved for high-needs, high-risk offenders, while briefer (and

³⁹² Gerald Waters was opposed to this and considered that the DWI list should not be available for sexual or violent offenders. James Crotty considered that the expanded CMD order should not be available where alcohol was related to the commission of sexual offences.

cheaper) interventions should be provided to low-risk or first-time offenders. Low-risk offenders should not be over treated or over supervised.³⁹³

- The treatment interventions need to be of an adequate period to allow for effective intervention and to impose an order of this length on a first-time offender may result in a disproportionate sentence. Interventions or sanctions should not be longer or more onerous because of the desire to treat, rehabilitate or assist a person than if that were not a major purpose (proportionality).³⁹⁴ In addition, when using the authority of the state to encourage engagement with treatment services, where possible, the least restrictive alternative should be used to ensure the intervention is not more severe than that which is necessary to achieve its purpose (principle of parsimony).³⁹⁵
- Research suggests that intensive drug court/DWI interventions should be focused on a smaller cohort of offenders so as not to dilute impact. This takes account of the availability of community resources (treatment availability and supervision and alcohol testing capacity).³⁹⁶

4.1.22 Accordingly, the TRLI's view is that the eligibility criteria should specify that an offender is eligible for the Drug Treatment (DWI) order if:

- the court is satisfied on the balance of probabilities that the offender has an alcohol use disorder and the offender's underlying alcohol use contributed to the commission of the offence;
- the offender is charged with a third or subsequent drink driving offence;³⁹⁷
- the court would have sentenced the offender to a term of imprisonment;
- the court is satisfied in all the circumstances that it is appropriate to do so;
- the court is satisfied that the facilities likely to be used for the assessment and treatment special conditions to be imposed are reasonably accessible to the offender;
- the court has received and considered a Drug Treatment (DWI) order assessment report on the offender; and
- the offender agrees in writing to the making of the order and to comply with the conditions of the order.

These criteria are based on the eligibility criteria for the DTO. Further, offenders with any particular criminal history should not be excluded if they are otherwise eligible. Mental health should be a factor taken into account but should not preclude participation.³⁹⁸

4.1.23 The offender's suitability for the Drug Treatment (DWI) order should be evaluated using a rigorous assessment tool and this is discussed further at [4.4].

³⁹³ Freiberg et al, above n 2, 35.

³⁹⁴ Ibid 34.

³⁹⁵ Ibid.

³⁹⁶ Maryland Drug Courts, above n 376, 8.

³⁹⁷ This reflects the likely judicial approach that would contemplate the imposition of a sentence of imprisonment for a third offence. It also reflects the approach adopted in New Zealand to the inclusion of drink driving offences within the AODC.

³⁹⁸ Freiberg et al, above n 2, 212.

4.1.24 Based on the number of offenders sentenced to a term of imprisonment (including partially suspended sentences), in the period 2014–15 to 2016–17, there were 99 offenders imprisoned with a fixed term. This equates to approximately 33 offenders per year. It is noted that not all these offenders would necessarily meet the other eligibility and suitability criteria for the DWI list Drug Treatment (DWI) order.

Recommendations

3. The eligibility criteria should specify that an offender is eligible to be allocated to the Drug Treatment (DWI) order if:
 - the court is satisfied on the balance of probabilities that the offender has an alcohol use disorder and the offender’s underlying alcohol use contributed to the commission of the offence;
 - the offender is charged with a third or subsequent drink driving offence;
 - the court would have sentenced the offender to a term of imprisonment;
 - the court is satisfied in all the circumstances that it is appropriate to do so;
 - the court is satisfied that the facilities likely to be used for the assessment and treatment special conditions to be imposed are reasonably accessible to the offender;
 - the court has received and considered the Drug Treatment (DWI) order assessment report on the offender; and
 - the offender agrees in writing to the making of the order and to comply with the conditions of the order.
4. Offenders with any particular criminal history should not be excluded if they were otherwise eligible.
5. Other mental health conditions should be a factor taken into account in assessing suitability but this should not preclude participation in the Drug Treatment (DWI) order.

4.2 Structure of the DWI list: Pre- or post-sentence model

Position in other jurisdictions

4.2.1 Based on experience in other jurisdictions, there are two models that could be adopted in incorporating a DWI court within the current criminal justice framework in Tasmania: (1) a pre-sentence program by way of adjournment and deferral of sentencing (as in New Zealand); or (2) a post-sentence program (as is generally the case in the United States, with the Victorian Drug Court and as proposed for the Victorian Drink Disqualified Driver List).³⁹⁹ In Tasmania, the current problem-oriented courts rely on both a pre-sentence model for the Mental Health and Cognitive Disability Diversion List and the post-sentence model for the DTO.

(1) Post-plea, pre-sentence (New Zealand model)

³⁹⁹ See Appendix A.

4.2.2 One model for a DWI court is a court that operates after the offender has entered a plea of guilty but before sentence is imposed. The proceedings are adjourned and sentencing is deferred while the offender participates in the drug court program. This is the model adopted in New Zealand for the AODT Court Pilot which is based on the model recommended by the Law Commission of New Zealand.⁴⁰⁰ The AODT Court Pilot was established in 2011 and sits in the Waitakere and Auckland District Courts. It caters for around 100 participants per year. In the period 2012 to 2016, 105 of the 332 AODT Court participants had a charge of driving under the influence (31.6%).⁴⁰¹ Overall, 30% of all participants had only drink driving offences.⁴⁰² General legislation using bail and judicial discretion provide the legal foundation for the Court's operation.⁴⁰³ The deferred sentencing model is the model adopted by several Australian drug courts⁴⁰⁴ and in Canada.⁴⁰⁵ The deferred sentencing model differs from the model that was established in Tasmania for the Mental Health and Cognitive Disability Diversion list, as the latter does not have an explicit legislative basis, but rather was instituted by the Magistrates Court to meet an identified need. In the Diversion List there is no requirement for the offender to have entered a plea of guilty (although the objective facts cannot be contested).⁴⁰⁶ However, there are similarities between the deferred sentencing model and the diversion model that operates in Tasmania given that both models are multi-disciplinary, informed by principles of therapeutic jurisprudence and utilise bail provisions as the mechanism to monitor an offender's compliance with the treatment program.⁴⁰⁷ In both cases, the offender's progress while on the list, and compliance with bail order conditions are relevant to the sentence that is finally imposed.⁴⁰⁸

4.2.3 This approach would create a pre-sentence diversionary option utilising either the provisions of the *Bail Act 1994* (Tas) to impose treatment conditions and to provide the framework for regular judicial monitoring, and s 7(eb) and Division 1 of Part 8 of the *Sentencing Act 1997* (Tas) to allow the court to defer sentence.⁴⁰⁹ After the court determined the period of deferral, magistrates could then take into account the offender's progress in imposing a final sentence. In New Zealand, a common sentence for graduates of the AODT Court is a sentence of 12 months intensive supervision with judicial monitoring as a condition of sentence.⁴¹⁰

⁴⁰⁰ Law Commission New Zealand, *Controlling and Regulating Drugs – A Review of the Misuse of Drugs Act*, Final Report (2011) 341.

⁴⁰¹ Participants may also have had other charges.

⁴⁰² Litmus, above n 286, 28.

⁴⁰³ Gregg and Chetwin, above n 363, 1.

⁴⁰⁴ This is the position in NSW, South Australia and Western Australia, see King et al, above n 230, 162–166.

⁴⁰⁵ See K Hannah-Moffat and P Maurutto, 'Shifting and Targeted Forms of Penal Governance: Bail, Punishment and Specialised Courts' (2012) 16 *Theoretical Criminology* 206.

⁴⁰⁶ Magistrates Court of Tasmania, above n 238. A pre-plea program for offenders with alcohol addiction issues is the Magistrates Early Referral into treatment (Alcohol) (MERIT) that operates in New South Wales.

⁴⁰⁷ See E Newitt and V Stojcevski, *Mental Health Diversion List: Evaluation Report* (Magistrates Court of Tasmania, 2009) for a discussion of the operation of the mental health list.

⁴⁰⁸ Ibid 13.

⁴⁰⁹ These provisions were introduced by the *Sentencing Amendment Act 2016* (Tas). They allow a court to defer sentence (postpone sentencing) for a period of time so that an offender's capacity and prospects for rehabilitation can be assessed, so that the offender can demonstrate rehabilitation, or so that an offender can participate in a pre-sentence program: *Sentencing Act 1997* (Tas) ss 7(eb), 57A(2).

⁴¹⁰ Litmus, above n 286, 101.

(2) Post-conviction, sentencing option

4.2.4 In the United States, DWI courts generally operate post-conviction, as a sentencing option.⁴¹¹ This was also the model proposed for the Victorian Drink Disqualified Driver List and is the model used in the Victorian Drug Court, which also deals with offenders whose offending relates to alcohol dependency.⁴¹² It is also the model adopted for the drug courts that operate in New South Wales and Tasmania and the former drug court in Queensland.⁴¹³ In addition, it is the model proposed for the new drug court in Queensland.⁴¹⁴

4.2.5 Some drug or DWI courts based on this model require the court to impose a sentence of imprisonment, that is then not activated. Recently, a post-sentence model has been recommended for a drug court in Queensland on the basis that it will create greater certainty and transparency and to ensure proportionality between the overall length of the program and treatment conditions and the offence. It was considered that the likely duration and intensity of the program are too onerous for a pre-sentence model.⁴¹⁵ This is also the approach of the Victorian Drug Court and the Court Mandated Drug Diversion (CMD) program in Tasmania.⁴¹⁶ According to this model, imprisonment is the ultimate sanction for non-compliance with the requirements of the program or for reoffending so that the threat of activation of the sentence operates as a ‘stick’ to motivate the offender. Other models, such as that proposed for the Drink Disqualified Driver List in Victoria, operate as post-sentence programs based on community-based sanctions. In Victoria, the community correction order provisions of the *Sentencing Act 1991* (Vic) Part 3A are intended to provide the legislative basis for the program. As stipulated in Appendix A, such orders may include conditions like unpaid community work, supervision, non-association, residence restrictions, place or area exclusions, curfews, alcohol exclusions, treatment and rehabilitation and judicial monitoring.

What does the evidence say?

4.2.6 In their evaluation of the appropriate model for a drug court in Queensland, Freiberg et al noted that the ‘international literature [is] largely silent on the question of whether drug courts perform more or less favourably as post-sentence or pre-sentence’ regimes.⁴¹⁷ This is not a matter that is addressed in the literature considering the operation of DWI courts. Instead, as Freiberg et al have observed, ‘a core consideration in the design of criminal justice-based drug treatment interventions is, therefore, the extent to which the legal framework can leverage offenders into longer and more active treatment such that there is sufficient time for best-practice interventions to have their greatest effect’.⁴¹⁸ Accordingly, the structure of the DWI list will be dependent on the target population with high-risk offenders requiring ‘greater leverage in order to initiate and maintain ongoing contact with treatment services’.⁴¹⁹ In the context of drug courts, for these high-risk offenders, it has been argued that bail-based programs are not appropriate given their high likelihood of reoffending and the

⁴¹¹ Richardson, above n 6, 18.

⁴¹² See Appendix A.

⁴¹³ See King et al, above n 230, 162–167.

⁴¹⁴ Freiberg et al, above n 2, 203.

⁴¹⁵ Ibid.

⁴¹⁶ See *ibid.*

⁴¹⁷ *Ibid* 200.

⁴¹⁸ *Ibid.*

⁴¹⁹ *Ibid* 201.

likelihood of incarceration as the ultimate sentence.⁴²⁰ Bail-based programs must also be restricted in time.

4.2.7 The following advantages have been identified in relation to pre-sentence models:

4.2.8 **Early opportunity for intervention/treatment** — Research suggests that the time of initial contact with the criminal justice system constitutes a ‘crisis point’ and presents an important opportunity for intervention as it can trigger an offender’s motivation to change.⁴²¹ However, given that the program must be tailored to meet the needs of the individual offender, there must be sufficient time for assessments to be undertaken and reports to be provided, and so this largely eliminates this advantage. In any event, this advantage can also apply to some extent where there is an early plea of guilty and a sentence imposed.

4.2.9 **Deferral of sentencing is aligned with therapeutic approaches** — Deferral of sentencing for drink driving offenders allows the courts to adopt a problem-solving approach that addresses the underlying causes of the behaviour. In this regard, it would align with the approach adopted in the Mental Health and Cognitive Disability Diversion List, which is intended ‘to deliver a more therapeutic response to the offending behaviour of defendants with mental health or cognitive disability issues’.⁴²²

4.2.10 **Greater incentive for compliance** — A pre-sentence approach has been argued to provide a more powerful incentive for offenders to complete the program.⁴²³ The prospect of avoiding a custodial sentence is said to operate as a ‘carrot’ and is likely to allow an offender to have a greater sense of autonomy and develop more positive relationships with the court team.⁴²⁴ Evaluations of drug court programs have found reasonably high dropout rates from the programs⁴²⁵ and adopting a pre-sentence approach may improve retention rates. This concern influenced the decision to adopt a pre-sentence model for the New Zealand Alcohol and Other Drug Treatment Court Pilot.⁴²⁶ Nevertheless, in an evaluation of the pilot scheme, it was observed that it was ‘too early in the pilot to make a judgement on the termination rate’ with early indications suggesting that a termination rate of 26% looked acceptable compared with international figures.⁴²⁷ Subsequent evaluation found a termination rate of 58%, which was also said to be acceptable based on international comparison.⁴²⁸

4.2.11 **Greater flexibility in dealing with breaches** — A pre-sentence model has been considered to provide greater flexibility in dealing with breaches than a formal sentencing order given that if the conditions were part of a sentencing order ‘there would be much greater pressure upon both probation officers and judges to respond to breaches of those conditions with formal sanctions’.⁴²⁹ This is a

⁴²⁰ Ibid.

⁴²¹ Ministry of Justice, New Zealand, above n 369, 5.

⁴²² Magistrates Court of Tasmania, above n 238.

⁴²³ Law Reform Commission of Western Australia (WALRC), *Court Intervention Programs*, Final Report, Project No 96 (2009) 27.

⁴²⁴ Law Commission New Zealand, above n 400, 340.

⁴²⁵ See WALRC, *Court Intervention Programs*, Consultation Paper, Project No 96 (2008); Gregg and Chetwin, above n 363, 96.

⁴²⁶ Law Commission New Zealand, above n 400.

⁴²⁷ Gregg and Chetwin, above n 363, 101.

⁴²⁸ Litmus, above n 286, 93.

⁴²⁹ Law Commission New Zealand, above n 400, 340.

significant consideration in a context of addiction where relapse has a level of inevitability.⁴³⁰ It recognises that addiction is a chronic condition that usually responds to treatment only over time. However, bail does not necessarily permit the necessary time for treatment.

4.2.12 Addresses concerns about undue leniency — A pre-sentence model may more easily accommodate victim and community concerns about undue leniency, given that the offender has not yet been sentenced and it may be that victims and general members of the community would be more likely to accept a sentence imposed after the successful treatment of the offender rather than if a treatment program was imposed originally as part of the sentence, without proof of the offender's compliance.⁴³¹

4.2.13 No need for legislative reform — A pre-sentence model can utilise the recently introduced provisions in the *Sentencing Act 1997* (Tas) regarding deferred sentences. The deferred sentence provisions allow the court to adjourn proceedings, grant bail under the *Bail Act 1994* (Tas) and defer sentencing.⁴³² A court may postpone the sentencing of an offender formally for one or more of the following purposes:

- to allow for the assessment of the offender's capacity, and prospects, for rehabilitation;
- to allow for the offender to demonstrate that the offender is being, or has been rehabilitated;
- to allow the offender to participate in a pre-sentence program.⁴³³

4.2.14 A pre-sentence program is defined as a program aimed at addressing the underlying causes of offending.⁴³⁴ The court may defer sentences for a period of two years and may extend this period to up 30 months if that allows an offender to complete a program or if there are special circumstances.⁴³⁵

4.2.15 If the court adjourns proceedings, grants bail and defers the sentence pursuant to the *Sentencing Act 1997* (Tas) s 7(eb), the court may include any bail conditions that it considers appropriate for these purposes. These include conditions that:

- allow for judicial monitoring by requiring that offender appear back before the court prior to the date of sentence to check the offender's compliance with bail conditions; and
- allow for conditions relevant to an offender's rehabilitation.⁴³⁶

4.2.16 Further, under the *Bail Act 1994* (Tas), bail can include any conditions that the judicial officer thinks are desirable (s 7(4)) including a condition that the person be assessed for suitability for an intervention program (s 7(5)(c)) and that a person undertake an intervention program (s 7(5)(d)). Intervention programs include supervised treatment, supervised rehabilitation, supervised behaviour management and/or supervised access to support services that are designed to address behaviour problems including alcohol abuse.⁴³⁷

⁴³⁰ Ibid 320.

⁴³¹ Law Commission New Zealand, above n 400, 340.

⁴³² *Sentencing Act 1997* (Tas) s 7(eb).

⁴³³ Ibid s 57A.

⁴³⁴ Ibid s 4 (definition 'pre-sentence program').

⁴³⁵ Ibid ss 7A, 57C(3).

⁴³⁶ Ibid s 57B(2).

⁴³⁷ *Bail Act 1994* (Tas) s 3.

4.2.17 The ability to use deferred sentencing and bail to impose treatment conditions may be advantageous as it is immediately available without legislative reform and avoids any community backlash that may be associated with the view that a problem-solving approach to drink driving is ‘soft on crime’.⁴³⁸ It also allows for the court to assess the extent of an offender’s rehabilitation before sentence.

4.2.18 Concerns about the use of a pre-sentence program for drink drivers relate to:

4.2.19 **Harsher sentencing** — There is a risk that offenders who do not complete the program may receive a harsher sentence than they might otherwise have received because they have failed to comply with program directives. Further, as noted above, failure to comply with conditions of court orders (either bail or sentence conditions) is also an offence, subjecting the person to a risk of additional punishment for that offence. This creates a risk of over-punishment and net widening as an offender is required to comply with the conditions imposed and then because of their failure to complete the program they would receive a sentence similar to what they would otherwise have received.⁴³⁹

4.2.20 **Inappropriate use of bail/criticisms of deferred sentencing** — In New Zealand, it has been reported that the offenders who participate in the AODT Court undertake an intensive and onerous program that includes the requirement to undertake treatment (including residential treatment), courses and programs (such as parenting, anger management, literacy, driver safety, and/or moral reconnection therapy), voluntary community work and vocational training, attend recovery support such as Alcoholics Anonymous or Narcotics Anonymous, appear regularly in court and submit to regular and random drug and alcohol testing.⁴⁴⁰ The innovative use of deferred sentencing and bail to impose onerous requirements (such as these) on the offender can be criticised on the basis that such conditions are more appropriately attached to a formal sentence of the court. This has been said to lengthen, intensify and layer punishment ‘in a manner that obscures penal and administrative boundaries’.⁴⁴¹ The imposition of onerous conditions as part of a deferral of sentence has been criticised on the basis that, in principle, such conditions should only ‘be part of a formal sentence’ of the court and not as a condition of a deferral of sentence, otherwise deferral becomes a ‘conditional non-sentence’.⁴⁴² This is said to blur the appropriate boundaries between guilt, conviction and sentence as such an order has ‘all the hallmarks of a sentence’.⁴⁴³ Accordingly, the use of deferred sentence and bail provisions in this way runs counter to fundamental principles, which stand in opposition to the use of bail conditions for sentencing purposes. It was for this reason that TSAC expressed the view that ‘if a court considers it necessary to impose conditions (other than bail conditions), then the court should proceed to impose sentence and not defer the sentence’.⁴⁴⁴ However, these concerns can be mitigated to some extent by a requirement that the offender enter a plea of guilty.

⁴³⁸ Bartkowiak-Théron and Henning, above n 4, 7.

⁴³⁹ Law Commission New Zealand, above n 400, 340.

⁴⁴⁰ Interview with Judge Lisa Tremewan, ‘The Alcohol and Drug Treatment Court in New Zealand’, *Radio New Zealand*, 29 January 2016.

⁴⁴¹ Hannah-Moffat and Maurutto, above n 405.

⁴⁴² A Freiberg and N Morgan, ‘Between Bail and Sentence: The Conflation of Dispositional Options’ (2004) 15 *Current Issues in Criminal Justice* 220, 230.

⁴⁴³ *Ibid.*

⁴⁴⁴ TSAC, Final Report, above n 134, 115.

4.2.21 Inability to impose short periods of imprisonment as a sanction under the bail/deferred sentence model — An issue with using deferred sentencing and bail as the framework for a DWI list/court is that short periods of imprisonment are not able to be used as a sanction if an offender does not comply with the conditions of the order. Under the CMD model currently operating in Tasmania, there is provision for the offender to be required to serve a short period in prison (not less than one day and not more than seven days) if the offender has failed to comply with a condition of a drug treatment order, other than by committing an offence punishable by a term of imprisonment exceeding 12 months.⁴⁴⁵ This is only available for offenders sentenced to a drug treatment order who are in breach of that order and does not operate for an offender with treatment conditions imposed as part of his or her bail conditions. Under the *Bail Act 1994* (Tas), it is an offence to contravene the conditions of bail and the offender may be sentenced to a fine and/or a term of imprisonment not exceeding 12 months.⁴⁴⁶ Further, if an offender is in breach of bail conditions, then bail may be revoked and the offender may be required to remain in custody.⁴⁴⁷ However, this does not readily permit a court to impose a short period of imprisonment as a sanction and then allow the offender to be released from custody and resume participation in treatment. The offender has to be charged separately with, and prosecuted for, this offence. This process is obviated where orders can be structured to allow for imprisonment upon failure to comply with the order as under the CMD model.

4.2.22 Less transparency and certainty — It can be argued that a pre-sentence model that uses deferred sentencing and bail has less transparency than a post-sentence model that would arguably be more transparent and subject to accepted sentencing principles (such as proportionality).⁴⁴⁸ This lack of transparency could be overcome by the use of formal deferral of sentencing provisions. In addition, transparency is increased in New Zealand by judges indicating the sentence that the offender would have otherwise received without graduation from the AODT Court.⁴⁴⁹ This is also the approach in Western Australia, where offenders accepted into the Drug Court Regime are provided with an Indicated Sentence, which is the sentence that would have been imposed if the matter was dealt with immediately by the magistrate. The offender has the choice to cease participation in the program and serve this sentence.⁴⁵⁰

4.2.23 The following advantages have been identified in relation to post-conviction problem-solving regimes:

4.2.24 Provides greater leverage for high-risk offenders — As indicated, it has been argued that a post-sentence model is more appropriate to obtain compliance with the program requirements because the sentence is known to the offender at the beginning of their participation in the program, and so the consequences of failure are certain.⁴⁵¹

4.2.25 Appropriately reflects coercive nature of order — Unlike the use of pre-sentence conditions to impose onerous conditions on an offender, the imposition of treatment and monitoring requirements as part of the final sentence reflects the traditional boundaries of guilt, conviction and sentence.

⁴⁴⁵ *Sentencing Act 1997* (Tas) s 27M. See [4.7.4].

⁴⁴⁶ *Bail Act 1994* (Tas) s 9.

⁴⁴⁷ *Ibid* s 25.

⁴⁴⁸ Law Commission New Zealand, above n 400, 340.

⁴⁴⁹ Interview with Judge Lisa Tremewan, 'The Alcohol and Drug Treatment Court in New Zealand', *Radio New Zealand*, 29 January 2016.

⁴⁵⁰ Legal Aid Western Australia, *Drug Court Information for Accused*, 2

⁴⁵¹ Freiberg et al, above n 2, 200.

4.2.26 **Transparency** — There is greater transparency when the order operates as part of the final sentence imposed by the court and its use is also constrained by the principles of proportionality. Unlike the pre-sentence model, which may mean that the sentence finally imposed does not reflect the extent of the obligations actually imposed on an offender by the court, using a post-sentence model the recorded sentence will accurately reflect the offender’s obligations matched to his or her offence.

4.2.27 The following issues have been raised in relation to post-conviction problem-solving regimes:

4.2.28 **Lack of legislative framework** — in Tasmania, concerns have been expressed about the current lack of a legislative framework for a DWI court. The current CMD legislation only applies to illicit drugs and, therefore, not to alcohol.⁴⁵² There are limits on the ability to apply a solution-focused response to drink driving through the use of suspended sentences given that there is no capacity for judicial monitoring. There are also limitations on using the current community-based orders such as probation or community service orders as a vehicle to achieve a therapeutic approach because neither of these orders allows for judicial monitoring. This is a critical component of successful problem-solving approaches to sentencing.⁴⁵³ However, it is noted that the government has introduced a Bill to Parliament that will create the legislative framework for a community-based sentencing order. It will also be necessary to make amendments to the *Sentencing Act 1997* (Tas) to allow the DTO framework to apply to drink drivers.

4.2.29 It may also be necessary to revisit the relationship between the mandatory sentence requirements contained in the *Road Safety (Alcohol and Drugs) Act 1970* (Tas) s 17(3) and the use of community-based sentencing options. As noted, it was stated in *Wilkie v Taylor*⁴⁵⁴ that the court (subject to special circumstances) must impose the minimum fine or a period of imprisonment and must also impose the minimum period of disqualification. The court cannot impose a community service order or a probation order instead of a fine or a period of imprisonment (although it is open to the court to impose a combination sentence). No issues arise in the case of CMD orders because the court imposes a sentence of imprisonment that is not activated. However, in the case of a community-based order, it will be necessary to amend the *Road Safety (Alcohol and Drugs) Act 1970* (Tas) to allow the court to impose the order as an alternative to a fine and/or imprisonment.

4.2.30 **The use of a ‘suspended’ sentence** — If a term of imprisonment is imposed and then suspended or held in abeyance so that an offender can take part in the program, it is in essence a suspended sentence. The Law Commission of New Zealand considered that because suspended sentences had been abolished in that jurisdiction, there were unacceptable risks that the limited reintroduction of suspended sentences would create problems of net-widening, particularly given the number of participants who drop out and fail to complete the drug court program.⁴⁵⁵

4.2.31 Similarly, in Tasmania, the government has indicated its commitment to abolish suspended sentences and TSAC has previously prepared a report that has outlined options to replace suspended sentences.⁴⁵⁶ However, in Tasmania, the approach of the drug court is different to that in New

⁴⁵² *Sentencing Act 1997* (Tas) s 27B(1)(b)(i).

⁴⁵³ Bartkowiak-Théron and Henning, above n 4, 7. See also [3.1], [3.2] for discussion of the importance of judicial monitoring.

⁴⁵⁴ [2015] TASFC 7.

⁴⁵⁵ Law Commission New Zealand, above n 400, 337.

⁴⁵⁶ TSAC, Final Report, above n 134. See also *Sentencing Amendment (Phasing Out of Suspended Sentences) Act 2017* (Tas).

Zealand, given that the CMD order is already a sentencing option that is distinct from a suspended sentence.

4.2.32 Relationship with support team and offender motivation — It has been suggested that a pre-sentence model is preferable because it is more likely to encourage an offender to comply with the order as well as to develop positive relationships with the drug court team. The Law Commission of New Zealand expressed the view that if treatment conditions are imposed pre-sentence, offenders have greater incentive to comply as they are likely to feel that they have more influence over the eventual sentence and that this will help build the relationship with the drug court team.⁴⁵⁷ The Commission considered that the prospect of a more lenient sentence would be viewed by an offender as a ‘carrot’ and as a reward. In contrast, concern was expressed in relation to post-sentence requirements that offenders may view the threat of cancellation of the drug treatment order and the imposition of a substituted sentence as a ‘stick’ and that this may have a negative impact on motivation and may also make it less likely that an offender will develop positive relationships with the court team.⁴⁵⁸

4.2.33 Less flexibility — It has been argued that there is less flexibility for judges in dealing with breaches of post-conviction sentences given their formal nature as sanctions.⁴⁵⁹

Consultations – views and issues

4.2.34 Stakeholders expressed differing views in relation to the most appropriate structure for a DWI list with no clear preference emerging for a pre- or post-sentence approach. In addition, some stakeholders considered that there were benefits from having both a pre- and post-sentence model to allow the DWI list to respond appropriately to different categories of offenders. For example, CLC Tas considered that a hybrid model was desirable to provide the court with flexibility to respond to different types of offenders. Its suggestion was that deferred sentences may be appropriate for offenders who required attitudinal change, and these offenders could be directed to take part in the Sober Driver Program. For offenders who abused alcohol or had a recognised alcohol addiction, a post-sentence response was more appropriate to allow judicial supervision conditions to be imposed. However, CLC Tas stated that if there was to be only one model it should be post-sentence. FARE also considered that, overall, the post-sentence model appeared to be the strongest to pursue if the court imposes a sentence of imprisonment which is not activated. Other stakeholders expressed the view that a post sentence approach in Tasmania is appropriate but that it needs to draw on the current approach of the MHDL rather than the CMD model because the MHDL approach is more health focussed and supported by very experienced clinical health service providers that are embedded in the health system.

4.2.35 In the consultation with Community Corrections support was also expressed for a model like the CMD that involves intensive case management. The view was expressed that it should not be part of the probation order as this is a very different way of managing offenders than under a therapeutic model. Community Corrections also considered that the order may be structured as a combined imprisonment/CMD order, with the offender spending a period of time in prison addressing any comorbid factors and then participating in a specialised response to drink driving on release. This was on the basis that this would more closely align to the time at which the offender was eligible to

⁴⁵⁷ Law Commission New Zealand, above n 400, 339–340.

⁴⁵⁸ Ibid 340.

⁴⁵⁹ Ibid.

receive their licence back and allow treatment to address the problem behaviour (drinking plus driving).

4.2.36 In its submission, ForensiClinic considered that the model could be either pre- or post-sentence but believed that mandated interventions would be necessary to maximise the success of risk reduction interventions. Holyoake was also concerned with the provision of appropriate therapeutic support to explore and address the reasons behind problematic drinking. Holyoake considered that both pre-sentence and post-sentence approaches have advantages and disadvantages. They have worked with clients who have been directed into treatment pre-sentence as well as offenders on CMD. Holyoake's view was the post-conviction option seems to be fair and less open to punitive measures being implemented should offenders fail in their treatment, which for many is inevitable.

4.2.37 In contrast, the DPP considered that a pre-sentence model should be preferred because it would utilise the existing sentencing framework. Vivian Hoy also suggested that a pre-sentence model should be available to allow a repeat drink driver to voluntarily request diversion treatment early to treat any underlying issues which need to be addressed. Her view was that the option to allow a voluntary request for diversion would overcome any abuse of process and human rights concerns. Gerald Waters also preferred a pre-sentence model. Forensic Mental Health Court Liaison indicated during consultations that the pre-sentence approach works as an incentive to participation in programs.

4.2.38 In relation to the post-sentence model, the TLRI sought feedback in relation to whether the DWI list should rely on an unactivated sentence of imprisonment (as with CMD) or should the problem-solving approach operate by using conditions that can be attached to a community-based order (as with the proposed Victorian model) or whether both options should be available. There was strong support in the submissions for making both options available. There were, however, divergent views in relation to whether CMD should be expanded to include drink drivers or whether a separate stand-alone order should be developed. The DPP, ForensiClinic, and Community Corrections considered that there should be a stand-alone DWI list separate from CMD. Community Corrections' view was that it could sit within the CMD regime but operate as a separate stand-alone unit with its own order. This would need to be funded appropriately and not instituted within existing resources.

4.2.39 Concerns were also raised in consultation meetings about the onerous nature of the CMD process and the compatibility of this model for drink drivers who are currently employed. In the experience of stakeholders, there are, broadly speaking, two categories of repeat drink drivers: (1) the functional alcoholic (who does not acknowledge his or her condition) who is able to maintain employment, family and social connections, and is able to access services; (2) the chronic alcoholic who is unemployed, tends to have fewer social and family connections, and whose lifestyle is more dysfunctional. This person may not have the personal resources to attend appointments and maintain contact with case workers. It was suggested that the requirements of a CMD order made it suitable only for a person who was unemployed. Its time demands would be unsuited to a person who is currently employed. Clearly an offender will not be able to work while in prison but it was highlighted in consultations that an employer may find it easier to accommodate the absence of an employee for a short sentence of imprisonment than for the lengthier disruption to employment arising from the requirements of a CMD order. CMD was also said to place too much focus on the 'stick' (supervision and compliance) and too little focus on the 'carrot' and that there should be more focus on the therapeutic aspect of the order.

4.2.40 Other stakeholders expressed the view that CMD should be expanded to include alcohol generally and should have application beyond drink driving offenders.

4.2.41 In Tasmania, a legislative framework would need to be created for the DWI list to allow for appropriate orders to be made. Under s 7(ab) and Part 3A of the *Sentencing Act 1997* (Tas), a drug treatment order is the only sentencing order that allows for judicial monitoring and this only applies to illicit drugs. There is provision for judicial monitoring over the period of the order and the court may vary the order based on the offender's progress, including adding or removing program conditions, varying conditions to adjust the frequency of treatment, the degree of supervision and the type or frequency of vocational, educational, employment or other programs that the offender must attend.⁴⁶⁰ The DTO has two components: (1) a custodial part; and (2) a treatment and supervision part. The court imposes on the offender the sentence of imprisonment it would have imposed were it not making the order, but the offender is not required to serve the custodial component of the order unless it is activated by contravention of the order. The treatment and supervision component is subject to a two-year review, if the order has not been cancelled within the two-year period.⁴⁶¹ Previously, TSAC has recommended that CMDs be expanded to include alcohol related offending. Such an amendment would allow a CMD order to be made (in limited circumstances) in respect of drink drivers.⁴⁶² Currently, a CMD order can only be made where the offender has a demonstrated history of drug use, the drug use has contributed to the commission of the offence and the offender receives a sentence of actual imprisonment.⁴⁶³ TSAC has recommended that CMD should be available where the court considers that a suspended sentence of imprisonment (as well as an actual sentence of imprisonment) is the appropriate sentence.⁴⁶⁴

4.2.42 Another option to allow the court to impose an unactivated sentence of imprisonment on a repeat drink driver would be to use the provisions in the *Sentencing Act 1997* (Tas) to allow the court to impose a conditional suspended sentence or to combine a suspended sentence with a probation order to require the offender to take part in appropriate rehabilitation programs. However, there is no power to impose a judicial monitoring condition under these orders. This difficulty also exists in relation to community-based sentencing orders, where although treatment conditions can attach to a probation order, there is no provision under the *Sentencing Act 1997* (Tas) for probation orders to contain a requirement for ongoing judicial monitoring. Previously, TSAC has recommended that a community correction order be introduced in Tasmania as a replacement for suspended sentences, probation and community service orders.⁴⁶⁵ The order would sit below imprisonment and a CMD order and above a fine. The order would contain core conditions in relation to reporting to community corrections and not reoffending and also allow the court to impose special conditions, including options in relation to assessment and treatment for alcohol dependency.⁴⁶⁶ The court would also be able to impose judicial monitoring and alcohol exclusion conditions. Using these conditions, the community corrections order could provide the legislative framework for a DWI list to allow a problem-oriented response to repeat drink drivers. In this regard, it is noted that the order proposed by the TSAC is similar to the community correction order that operates in Victoria and that the

⁴⁶⁰ See *Sentencing Act 1997* (Tas) s 27J.

⁴⁶¹ *Sentencing Act 1997* (Tas) s 27R(2).

⁴⁶² TSAC, Final Report, above n 134, Recommendation 6.

⁴⁶³ *Sentencing Act 1997* (Tas) s 27B.

⁴⁶⁴ TSAC, Final Report, above n 134, Recommendation 9.

⁴⁶⁵ *Ibid* Recommendations 32–46.

⁴⁶⁶ *Ibid* Recommendations 39, 40.

community correction order was the proposed legislative framework for the DWI court list in Victoria.⁴⁶⁷

4.2.43 Accordingly, if the DWI list was to use either the CMD approach (or expand CMD to include drink drivers), legislative changes will be necessary. There is also a need for a community-based sanction that allows for judicial monitoring. This could be achieved by amendment to the provisions for a probation order in the *Sentencing Act 1997* (Tas) or the introduction of a new community correction order (as detailed above).

4.2.44 Other issues raised by stakeholders in relation to developing a DWI list were primarily in relation to the need for appropriate resourcing for legal representation and for treatment services. Another matter of concern was the need to address transportation issues, particularly in geographically remote locations. In addition, both in the Law Society stakeholder meeting and in Vivian Hoy's submission, the need to address public perceptions was raised. Vivian Hoy observed that there may be a public perception that a therapeutic approach is 'soft on crime', that the program is too expensive and that offenders who break the law should be punished more severely than may be apparent with a therapeutic approach. In response, she stressed the need to explain to the Tasmanian community that dealing with any underlying issues will be confronting and onerous for many offenders and that public safety should be at the forefront of reform efforts. Similarly, the Salvation Army acknowledged that an order like a CMD requires a considerable investment from the individual as well as the community but that it represents value for money in comparison to the social and economic costs of imprisonment, and also because of the reduction in reoffending.

Recommendations

4.2.45 The model for the Drug Treatment (DWI) order proposed by the TLRI is dependent on the target audience for the order, and, as set out at [4.1], the TLRI's view is that the eligibility for the Drug Treatment (DWI) order should be high-needs/high-risk offenders for whom imprisonment would be the sentence imposed. Accordingly, the model recommended by the TLRI is a post-sentence model using a drug treatment order, amended to accommodate the eligibility criteria for drink driving offences, as the sentencing order to underpin the DWI list. While this does not preclude magistrates from deferring sentence to allow drink drivers to access treatment/rehabilitation services prior to sentence, it is the TLRI's view that because of the onerous nature of the order, the high level of risks and needs of the offenders, the need to have a capacity to monitor and enforce the conditions of the order by an appropriate body and direct the offender into treatment, it is more appropriate that the DWI operates as post-sentence option. In the Tasmanian context, a significant difficulty that arises in relation to deferred sentencing is the lack of an appropriate body to supervise and mandate compliance with the conditions of a pre-sentence order. There is no oversight by Community Corrections where treatment is a condition of a deferred sentence as there is no mechanism that enables this to occur, whereas, Community Corrections is able to supervise post-sentence orders.

4.2.46 The post-sentence model recommended by TLRI relies on an unactivated sentence of imprisonment (as is the current position with a DTO) rather than a non-custodial sentence. While feedback from stakeholders indicated that a model that depends on a determination that an unsuspended term of imprisonment is the only appropriate penalty (as required for a CMD order) may be unduly restrictive, the TLRI's view is that the DTO approach is the most appropriate model for the target cohort of the order (high-risk/high-needs repeat offenders for whom traditional criminal justice

⁴⁶⁷ See Richardson, above n 6, 17.

approaches have been ineffective). This DTO model provides a ‘top’ tier of intervention for these offenders rather than immediately requiring the offenders to serve a short period of imprisonment, where they are unlikely to be able to access the necessary rehabilitative services and support required. Further, as indicated at [4.1], the TLRI’s recommendation is that eligibility for the order should specify that an offender has three or more convictions for a drink driving offence. This reflects the New Zealand approach and also sentencing practice in Tasmania, where imprisonment would certainly be contemplated at this stage as a sentencing option. The use of an unactivated sentence of imprisonment coupled with a treatment component (as exists with the DTO) avoids difficulties that arise from the use of a community-based order that only allows for the sentence to be imposed that is proportionate to the offending with no capacity for treatment over a longer period. In contrast, under the DTO model, the period of imprisonment imposed reflects the culpability of the offender and the seriousness of the offence (and the length of imprisonment varies between offenders) but the treatment period may operate for up to two years (dependent on the progress of the offender through the phases of the program).⁴⁶⁸ The use of an unactivated period of imprisonment also allows for short periods of imprisonment to be imposed as a sanction for breaches of the order. This is a central component of the ‘swift, certain and fair’ approaches and DWI lists in other jurisdictions.

4.2.47 The TLRI also observes that there is already scope for magistrates to use community-based sentencing orders such as probation or community service orders, or suspended sentences of imprisonment combined with a probation or community service to direct an offender to take part in assessment and treatment for alcohol related issues, as well as to attend rehabilitative programs such as EQUIPS (Addiction) and the Sober Driver Program. These sentencing options will complement the approach recommended by the TLRI for the ‘hard-core’ drink drivers by providing a hierarchy of sentencing options for lower level offenders. The TLRI observes that a limitation of the current community-based sentencing options is that there is no provision for magistrates to impose judicial monitoring conditions and other special conditions to support the order such as curfew and alcohol prohibition. However, as noted in the Issues Paper, TSAC has recommended the introduction of an enhanced probation and community correction order (the CCO) and a Bill to establish such an order is currently before Parliament.⁴⁶⁹

Recommendations

6. The DWI model should be a post-sentence model using an amended drug treatment order as the sentencing order to underpin the Drug Treatment (DWI) order. Accordingly, the order should consist of a term of imprisonment which is not activated. This term would be the same length as if the court had not made the order. The order should also have a treatment and supervision component which operates for up to two years.
7. The provisions for a DTO in the *Sentencing Act 1997* (Tas) should be amended to accommodate DWI offenders and to enable the order to operate as a Drug Treatment (DWI) order within the current CMD list of the Magistrates Court.

⁴⁶⁸ In TSAC’s report, it was noted that of the 37 offenders on CMD orders as at 20 May 2015, the range of sentences imposed was from three to 18 months with a median sentence length of eight months: TSAC, Final Report, above n 134, 47.

⁴⁶⁹ *Sentencing Amendment (Phasing Out of Suspended Sentences) Act 2017* (Tas).

4.3 The conditions of the order

Position in other jurisdictions

4.3.1 The New Zealand scheme provides for different expectations at different phases of the program:

Phase One expectations include:

- engagement with a treatment readiness group if in custody;
- development of, and compliance with, a detailed treatment plan including a referral to any (medical or social) detoxification program as required; appropriate use of pharmacological support; and in all cases, use of a primary treatment program;
- engagement with 12-step meetings;
- regular and random testing (which continues throughout all phases) including the fitting of a Secure Continuous Remote Monitor (SCRAM) bracelet if directed;⁴⁷⁰
- regular reporting to the Case Manager and engagement with peer support workers as directed;
- fortnightly AODT Court appearances, or as determined by the AODT Court judge.

Phase Two expectations include:

- attendance at, participation in, and completion of programs detailed in the treatment plan;
- continued engagement with 12-step meetings;
- continued regular and random testing (it may be that any SCRAM bracelet would be removed during this phase);
- identification of personal/educational/vocational goals with steps taken to pursue them (for example, driver safety and/or working towards obtaining a driver's licence, literacy programs);
- regular engagement with voluntary community work;
- rebuilding family bonds where possible (which may also be stated in phase one);
- regular reporting to the Case Manager and engagement with peer support workers as directed;
- three weekly AODT Court appearances, or as determined by the AODT Court judge.

Phase Three expectations include:

- completion of all aspects of the treatment plan;
- continued engagement with 12-step meetings (which is likely to include having a home-group and a sponsor);
- continued regular and random testing (with removal of SCRAM bracelet if still in use);

⁴⁷⁰ This is discussed further at [4.7].

- further advancement of personal/educational/vocational goals with completion of relevant programmes;
- obtaining a driver's licence where appropriate;
- regular and significant engagement with voluntary community work;
- restorative justice meetings at judge's direction;
- clarification of reparation payments to be ordered at sentencing;
- engagement in suitable paid work or study;
- continued rebuilding of family bonds where appropriate;
- reporting to the Case Manager as directed;
- four weekly AODT Court appearances, or as determined by the AODT Court judge.⁴⁷¹

As the New Zealand approach is a pre-sentence model that relies on general bail legislation to allow conditions to be imposed, these expectations are set out in the court handbook and not in legislation.

4.3.2 In Victoria, the proposed DWI list was to be supported by a community correction order, a general sentencing order contained in the *Sentencing Act 1991* (Vic), which allows a court to impose a range of conditions including treatment and rehabilitation, supervision, prohibition on entering licenced premises, non-association orders, curfews and judicial monitoring.⁴⁷² In addition, a community correction order may contain special conditions such as testing for alcohol use and non-consumption of alcohol.⁴⁷³

4.3.3 In the United States, there is a ban on the use of alcohol by offenders dealt with in DWI courts,⁴⁷⁴ and offenders dealt with under the 24/7 Sobriety program model and the HOPE program model.⁴⁷⁵ Similarly, in New Zealand, participants are not able to consume alcohol whilst on the program and are tested for alcohol consumption. The approaches in both the United States and New Zealand rely on 12-step programs, such as those utilised by Alcohol Anonymous. In these jurisdictions, the focus is on abstinence rather than merely divorcing drinking from driving. Similarly, the drug court model proposed in Queensland relies on mandatory testing for both alcohol and drugs.⁴⁷⁶

4.3.4 Under the DTO, the *Sentencing Act 1997* (Tas) sets out the core and program conditions that attach to the order. Core conditions provide that the offender:

- must not, in Tasmania or elsewhere, commit another imprisonable offence;
- attend the court whenever it directs;
- report to a court diversion officer at a specified place within two clear working days after the order is made;

⁴⁷¹ Ministry of Justice, New Zealand, above n 369, 16–18.

⁴⁷² *Sentencing Act 1991* (Vic).

⁴⁷³ Freiberg et al, above n 2, 171.

⁴⁷⁴ NCDC, above n 258, Guiding Principle 4.

⁴⁷⁵ See [3.3].

⁴⁷⁶ Freiberg et al, above n 2, 239.

- undergo such treatment for the offender's illicit drug use problem as is specified in the order or from time to time as specified by the court;
- report to, and accept visits from a case manager or court diversion officers;
- give the offender's case manager at least two clear working days' notice before any change of address;
- must not leave Tasmania except with the permission, granted either generally or in a particular case, of the court;
- comply with all lawful directions of the court; and
- comply with all reasonable directions of the offender's case manager and court diversion officers concerning the core conditions and program conditions of the order.⁴⁷⁷

These conditions apply while the treatment and supervision part of the order is operating.

4.3.5 In addition, the court must add at least one of the following program conditions to the treatment and supervision part of the order:

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

The court must not attach more program conditions than it considers necessary to achieve the purposes of the order.⁴⁷⁸

What does the evidence say?

4.3.6 In imposing conditions, commentary suggests that is important not to burden an offender with an undue number of requirements. This may result in a disproportionate sentence and, further, the 'greater the number of conditions and their stringency may result in a greater number of breaches that may in turn result in an increased number of sanctions being imposed that may also be more severe'.⁴⁷⁹ Instead, to protect against net widening and sentence escalation, the conditions imposed

⁴⁷⁷ *Sentencing Act 1997* (Tas) s 27G(1).

⁴⁷⁸ *Ibid* s 27H(3).

⁴⁷⁹ Freiberg et al, above n 2, 70.

should not be ‘more numerous or onerous than they would be if treatment or rehabilitation had not been a purpose of the intervention’.⁴⁸⁰

4.3.7 In addition, evidence indicates that legal coercion can be effective to encourage an offender to enter into and remain in treatment. Legal coercion can be beneficial as it can provide a motivation for an offender to take part in treatment that he or she would not otherwise engage in — ‘the coercive influence exerted by the criminal justice system can indeed act as an effective catalyst for engagement with treatment services’.⁴⁸¹ Recognising that ‘engaging coerced clients in treatment is a task that requires great therapeutic skill’,⁴⁸² research shows that using legal coercion to direct an offender into treatment does not result in coerced clients underperforming relative to ‘others who access treatment from outside the criminal justice system’.⁴⁸³ This reflects the complexity of the relationship between coercion and motivation and that there are multiple sources of pressure for a person to take part in treatment for substance abuse. These sources include family, friends, welfare agencies, employers and health professionals, as well as legal pressure.⁴⁸⁴ Nevertheless, the challenge is to engage and retain participants in treatment programs. It appears that the key is the ability of the criminal justice system to encourage an offender to take part in treatment while at the same time having appropriate programs and skilled practitioners to ensure that the offender remains engaged and motivated to change.

4.3.8 In terms of alcohol bans, in other jurisdictions, the approach of DWI courts is to require sobriety and to impose monitoring of the ban via alcohol testing. Advocates of the DWI court model as a response to repeat drink drivers have asserted that that a “no alcohol” condition is appropriate for every alcohol or other drug-related offence [as is] a requirement for abstinence while in the alcohol program’.⁴⁸⁵ This is said to be linked to the success of DWI Courts.⁴⁸⁶ However, as noted, it is difficult to determine the features of a DWI court (or a drug court) that lead to success and it is not clear whether alcohol abstinence is, in fact, a key feature.

Consultations – views and issues

4.3.9 There was no support in the submissions received or in the meetings with stakeholders for a mandatory alcohol ban condition to form part of a response to repeat drink drivers, other than in the meeting with Community Corrections. ForensicClinic highlighted the significant medical risk that such a ban would pose to an individual with alcohol dependence. It also stressed other barriers to the implementation of an alcohol ban, such as the need for withdrawal and abstinence regimes that would require significant health inpatient and outpatient resources. ForensicClinic did support a requirement that participants in an individualised risk reduction program should be required to have a 0.00 blood alcohol reading at the time of each treatment session. Consultations with Forensic Mental Health Service indicated that a mandatory alcohol ban would be too difficult to monitor and was too

⁴⁸⁰ Ibid.

⁴⁸¹ Alex Stevens et al, ‘The Relationship Between Legal Status, Perceived Pressure and Motivation in Treatment for Drug Dependence: Results from a European Study of Quasi-Compulsory Treatment’ (2006) 12 *European Addiction Research* 197, 203.

⁴⁸² Andrew Day, Kylie Tucker and Kevin Howells, ‘Coerced Offender Rehabilitation – A Defensible Practice’ (2004) 10 *Psychology, Crime and Law* 259, 267.

⁴⁸³ Freiberg et al, above n 2, 132.

⁴⁸⁴ Poppy Rourke, John Howard and Kristy Martire, ‘Legal Mandates and Perceived Coercion in Residential Alcohol and Other Drug Treatment’ (2015) 22 *Psychiatry, Psychology and Law* 756, 756–758.

⁴⁸⁵ P Hora, ‘Tough on Crime is Not Smart on Crime: Evidence-Based Sentencing’ (Queensland Sentencing Advisory Council, Sentencing Seminar Series 2017) 34.

⁴⁸⁶ Ibid 41.

problematic as it sets individuals up for failure. Holyoake did not consider that a mandatory ban is appropriate but considered that in specific cases abstinence from alcohol may be warranted. It indicated that it supports a harm minimisation model, which does not demand abstinence, although for some clients this may be the only satisfactory approach. In relation to repeat drink drivers, it was stated that if the person had ‘committed a potentially catastrophic crime, one could argue that they have relinquished the same rights of choice as other Holyoake clients who have not been charged with this offence’. In contrast, Community Corrections thought that an alcohol ban was appropriate.

4.3.10 Other stakeholders indicated that they were concerned about the requirement for offenders to participate in a 12-step program because of its religious basis may mean that it is not appropriate for the needs of all offenders.

Recommendations

4.3.11 It is the TLRI’s view that, in structuring the order, core conditions as well as special conditions that are available under the amended DTO order will allow the court to tailor the order to meet the offenders’ rehabilitative needs. These include a range of conditions depending on what is most suitable to address the criminogenic and other needs of the offender.

4.3.12 Many of these requirements are relatively uncontroversial, however, as indicated, an issue exists in relation to the consumption of alcohol. In the Issues Paper, the TLRI sought feedback on whether a requirement for abstinence is appropriate and whether it should be mandatory for a DWI list program. This is the approach in other DWI and drug courts (that included alcohol). However, there was very limited support for this position in any of the submissions received from both legal and treatment perspectives. Nevertheless, the TLRI’s view is that an alcohol ban should be mandatory, at least at the initial stage of the order (phase one). The TLRI’s view is that an alcohol ban has a punitive component as well as a therapeutic role and may address community concerns about recidivist drink drivers (who would otherwise have been sent to prison) undertaking their sentence in the community and being allowed to drink. Further, repeat offending demonstrates that the person has not been able to separate drinking from driving in the past and that a period of enforced abstinence may promote rehabilitation and ensure community protection. It also reflects the approach that currently exists for offenders sentenced to a DTO. The TLRI acknowledges the concerns of treatment providers about the potential significant health risk to individuals from withdrawal from alcohol and therefore there should be scope within the order for the implementation of an alcohol ban to be managed under medical supervision and to include supervised detoxification programs. The TLRI’s view is that in subsequent stages of the order, the court should have the discretion to allow an offender to resume the consumption of alcohol if that is considered appropriate by treatment providers. This would allow for relapse and prevention planning to be implemented and monitored under supervision rather than allowing the offender to drink without any supervision at the end of the order. This reflects harm minimisation/risk management approaches.

4.3.13 An additional issue that needs to be addressed in the DWI program is the issue of transportation (Guiding Principle 8). The requirement for an offender to travel to attend testing, treatment meetings, court appearances and work creates considerable difficulty given that the loss of a driver’s licence is a mandatory sanction for drink driving. It is important that the DWI model makes it clear that the offender must not drive without a licence and that it encourages the offender to operate within the licensing system. Accordingly, the TLRI’s view is that the court should impose a condition that relates to driving, making it clear that there is a requirement that there be no driving in the

absence of a legal driver's licence.⁴⁸⁷ Further, while offenders need to be responsible for their own transport requirements, barriers to transportation need to be considered and the program should assist offenders in this regard by identifying available resources to address transport requirements. In the AODT Court pilot in New Zealand, judges are known for 'actively seeking to address perceived barriers to access treatment or other services (eg transport)' and it was noted that this created tensions with treatment that aims to build self-efficacy.⁴⁸⁸ In rural areas, it may be necessary to develop program requirements that take into account transport limitations, such as travelling for testing, education and counselling services.⁴⁸⁹ As discussed at [4.7], consideration should also be given to allowing the issue of a restricted licence/probationary licence with alcohol interlock requirements as part of the reward structure of the program.

Recommendations

8. In structuring the order, the core condition and special conditions that are available under an amended DTO will allow the Drug Treatment (DWI) order to be tailored to meet offenders' rehabilitative needs.
9. The court should impose a condition that relates to driving, with it being made clear that there is a requirement that there be no driving in the absence of a legal driver's licence.
10. An alcohol ban should be mandatory, at least in phase one of the order. However, the transition from alcohol use to abstinence should be implemented under appropriate medical supervision, and include supervised detoxification programs. The court should have a discretion to allow an offender to resume the consumption of alcohol if this is considered appropriate by treatment providers.

4.4 The referral and assessment process

Position in other jurisdictions

4.4.1 Generally, the approach adopted in other drug courts is to use a dual stage screening and assessment process.⁴⁹⁰ In New Zealand, a defendant is referred for an AOD assessment if, in a judge's view, he or she meets the eligibility criteria. This determination of eligibility is informed by information provided by Community Probation, police prosecution and defence counsel. AOD assessments are undertaken by Auckland Community Alcohol and Drug Services. The assessment is conducted by clinicians funded via the AODT Court treatment appropriation (under the responsibility of the Ministry of Health).⁴⁹¹ An AOD assessment contains the following information:

The defendant's AOD use patterns and history, dependency status (diagnosis), history of previous treatment, other behavioural addictions (eg gambling) and their relevance in relation to offending. There is also information regarding risk, mental health issues, medical history, whanau and social support (eg psychological function, education and employment, potential

⁴⁸⁷ Richardson, above n 6, 18.

⁴⁸⁸ Litmus, above n 286, 40.

⁴⁸⁹ NCDC, above n 258, Guiding Principle 8.

⁴⁹⁰ Freiberg et al, above n 2, 220.

⁴⁹¹ Ministry of Justice, New Zealand, above n 369, 13.

support persona and barriers to change), their motivational readiness to change, and recommendations as to potential treatment requirements and options.⁴⁹²

If the assessment identifies an AOD dependency, the judge will probably refer the defendant to the AODT court for a determination hearing. This is where the presiding AODT Court judge makes the final decision as to eligibility.⁴⁹³ This decision is informed by information provided by police, defence counsel and case managers. Eligibility is first discussed in the AODT Court pre-court team meetings, which defendants do not attend (but where they are represented by defence counsel).⁴⁹⁴

4.4.2 In the evaluation of the process of the AODT Court, the importance of quality AOD assessment was identified, and there has been ongoing dialogue between Community Alcohol and Drug Services and the AODT Court team to make sure that the reports are ‘tailored to inform decision-making in the court’.⁴⁹⁵ It was noted that even if an offender was not admitted to the AODT Court, the report was useful in sentencing and also for defence counsel in supporting the defendant to access AOD treatment via a different pathway.⁴⁹⁶

4.4.3 In Victoria, it was proposed that referrals would come from magistrates, prosecutors, Victoria Police and the Victorian Bar. Once a person was referred to the List, the magistrate would require them to undergo a community correction order assessment that would allow recommendations to be made about the conditions to attach to the order.⁴⁹⁷ All reports are peer reviewed and take up to six hours to write.⁴⁹⁸

4.4.4 Currently, in Tasmania, in assessing an offender’s suitability for a DTO, the following matters may be considered:

- the defendant’s
 - age;
 - social history and background;
 - history of drug use;
 - medical, psychological and psychiatric history and condition, including details of any treatment for drug or alcohol dependence;
 - educational background;
 - employment history;
 - financial circumstances;
 - special needs;
 - the circumstances of any other offences, known to the court, of which the defendant has been found guilty;

⁴⁹² Ibid.

⁴⁹³ Ibid 14.

⁴⁹⁴ Ibid.

⁴⁹⁵ Litmus, above n 286, 22.

⁴⁹⁶ Ibid 23.

⁴⁹⁷ Richardson, above n 6, 19.

⁴⁹⁸ Litmus, above n 286, 22.

- the extent of the defendant's compliance with any sentence currently in force; and
- any other relevant matters as the court may direct.⁴⁹⁹

Other relevant matters may include an assessment of the offender's pro-criminal or pro-social attitudes, motivation to change and an assessment of his or her current position within the cycle of change.⁵⁰⁰

What does the evidence say?

4.4.5 Research indicates that a key feature of successful criminal justice interventions for substance use, with successful programs is the 'early assessment of offenders to ensure the most appropriate intervention pathway is followed'.⁵⁰¹ A two-step process is desirable to screen offenders to determine eligibility, and then conduct a more comprehensive and thorough assessment 'to determine an offender's suitability for specific treatment types and levels of service intensity'.⁵⁰² In relation to DWI interventions, Guiding Principle 2 states that 'a clinically competent objective assessment of the impaired-driving offender must address a number of biopsychosocial domains including alcohol use severity and drug involvement, the level of needed care, medical and mental health status, extent of social support systems, and individual motivation to change'.⁵⁰³ This will allow a clinically sound treatment plan to be developed.

4.4.6 The Guiding Principles for DWI courts stress the importance of screening and risk assessment for DWI offenders given the likely different strengths and weaknesses of DWI offenders:

For example, some DWI offenders may have a high level of functioning, are able to maintain employment, have a relatively stable family environment, and a relatively lower level of criminogenic needs. As such, these offenders may require a different level of structure and support than a typical offender with different criminogenic needs.

Alternatively, some DWI offenders, particularly those with a poly substance abuse problem may require yet a different level of supervision as they progress through recovery. They may present with high criminogenic needs and have a profoundly poorer recovery environment at home or in the community. This may be the case because offenders have lost the support of family and friends, may not have a clean and sober environment in which to recover, or may not possess sufficient resiliency factors to complete treatment and probation without a higher level of assistance and supervision.⁵⁰⁴

4.4.7 Referrals to the DWI court might be made by the prosecution, defence, Tasmania Police or magistrates. Once a person has been referred to the list, an assessment needs to be made as to the offender's level of risk and the appropriate conditions to be imposed on the offender.

⁴⁹⁹ *Sentencing Act 1997* (Tas) s 27D(3), (4).

⁵⁰⁰ TSAC, above n 13, 48.

⁵⁰¹ Freiberg et al, above n 2, 173.

⁵⁰² *Ibid* 221.

⁵⁰³ NCDC, above n 258, Guiding Principle 2.

⁵⁰⁴ *Ibid* Guiding Principle 4.

Consultations – views and issues

4.4.8 In consultations with stakeholders and in the submissions received, the crucial nature of the assessment process was noted. Nicolle Ait Khelifa (private practitioner, psychiatrist (addiction speciality)) indicated that the initial assessment should be conducted by the most skilled people well versed in alcohol services. In her view, this should come from a government organisation and that the Alcohol and Drug Service would be best positioned. Holyoake supported the implementation of a specific alcohol and drug use assessment tool. It observed that it will be necessary to have suitable AOD experienced staff to provide the assessments. Consultation with legal stakeholders also identified the need for a rigorous assessment, undertaken by appropriately qualified staff, to identify needs and the best course to recovery. In this regard ForensiClinic submitted that it:

could make a valuable contribution to the success of a pilot program and longer-term success of DWI court list in Tasmania.

It is our intention to apply for funding in 2018 to enable us to undertake a large-scale project to:

- Design an evidence-based, well-researched screening risk assessment tool for legal practitioners/police/judiciary/court liaison staff/Community Corrections staff to assess recidivist drink drivers for eligibility for list and intervention programs.
- Design a pre and post intervention structured professional judgement assessment tool for monitoring the effectiveness of individualised risk reduction interventions.
- Design and implement individual risk reduction programs for offenders referred from the DWI court/list.
- Collate relevant data and evaluation of individualised risk reduction programs and evaluate and publish data.

4.4.9 It was also generally accepted that referrals to the DWI court could come from the prosecution, defence, Tasmania Police or magistrates. An issue that was raised in consultations with stakeholders about the current CMD program was the individual approaches taken by magistrates, with the consequence that there was inconsistency in the willingness of magistrates to refer to the list.

Recommendations

4.4.10 The TRLI recommends that referrals for the Drug Treatment (DWI) order should be able come from the prosecution, defence, Tasmania Police or magistrates.

4.4.11 The TLRI also recommends that there be a dual stage screening and assessment process. Screening should be undertaken using a screening assessment tool developed to inform the process to ensure consistency in decision-making between magistrates and to identify potentially eligible offenders based on a review of legal eligibility criteria, a preliminary assessment of dependency and a risk of reoffending assessment. It is important that any offender who meets the screening eligibility criteria and wishes to participate in the DWI list program should be referred for a suitability assessment to determine his or her 'suitability for specific treatment types and levels of service intensity'.⁵⁰⁵ This addresses a weakness identified in the current DTO, where an offender is only referred for an assessment if the 'court is considering make a drug treatment order'.⁵⁰⁶ As outlined at

⁵⁰⁵ Freiberg et al, above n 2, 221.

⁵⁰⁶ *Sentencing Act 1997* (Tas) s 27D.

[4.4.4], under the *Sentencing Act 1997* (Tas) s 27D(2), many factors are considered in relation to the suitability of offenders for a DTO. These include factors relating to AOD use patterns and history, dependency status (diagnosis), history of previous treatment, other behavioural addictions (eg gambling) and their relevance in relation to offending. It also canvases information regarding risk, mental health issues, medical history, social support (eg psychological function, education and employment, potential support persons and barriers to change), and their motivational readiness to change. This can provide the basis for the assessment for the Drug Treatment (DWI) order. However, in the implementation of the pilot, feedback should be sought from suitable experts in relation to the appropriateness of the existing criteria to assess the eligibility of DWI offenders. The assessment should be conducted by experienced and appropriately qualified health practitioners.

Recommendations

11. Referrals for the Drug Treatment (DWI) order should be able to be made by the prosecution, defence, Tasmania Police and magistrates.
12. A dual stage screening and assessment process should be adopted.
13. Screening should be undertaken using a screening assessment tool developed to inform the process to ensure consistency in decision-making between magistrates and to identify potentially eligible offenders based on a review of legal eligibility criteria, a preliminary assessment of dependency and a risk of reoffending assessment.
14. It is important that any offender who meets the screening eligibility criteria and wishes to participate in the DWI list program should be referred for a suitability assessment to determine his or her suitability for specific treatment types and levels of service intensity.
15. The requirements of a drug treatment assessment order contained in the *Sentencing Act 1997* (Tas) s 27D(2) should provide the basis for the suitability assessment for DWI offenders. However, feedback should be sought from suitable experts in relation to the appropriateness of the existing criteria to assess the eligibility of DWI offenders.
16. The assessment should be conducted by experienced and appropriately qualified health practitioners.

4.5 Services that need to be available as part of treatment and rehabilitation

Position in other jurisdictions

4.5.1 In New Zealand, interventions that AODT Court participants can access include:

- treatment-readiness sessions while on custodial remand;
- residential addictions treatment;
- intensive day programs;

- specialist drink driving programs; and
- other specialist AOD treatment and community-based support services.⁵⁰⁷

In addition, detoxification and pharmacotherapies are available as part of the program.⁵⁰⁸

4.5.2 In Victoria, it was proposed that a person who participated in the list would be subject to a comprehensive treatment plan. The types of services that were proposed to be offered were those suggested by the Ten Guiding Principles: motivational enhancement therapy, cognitive-behaviour interventions, evidence-based pharmacological treatments, continuing care/aftercare, relapse prevention training, specified participant competencies to be achieved at each phase of treatment and participation in an organised recovery support program (eg 12-step self-help).⁵⁰⁹

What does the evidence say?

4.5.3 Freiberg et al have observed that key features of successful court-based interventions include ‘an adequate period of treatment that allows time for behaviour change while not inducing treatment fatigue’, ‘high-quality case management to assist in addressing clients’ broader social and health issues’ and ‘availability of a range of treatment options’.⁵¹⁰ It is stated that ‘drug courts work more favourably than alternative programs because their non-adversarial therapeutic approach motivates participants to engage with treatment for periods of time long enough to activate behavioural change’.⁵¹¹ The treatment needs to be evidence based and best practice.⁵¹²

4.5.4 The development of a criminal justice intervention in response to substance use also needs to be informed by an understanding of it as a chronic health condition.⁵¹³ Research has shown that: recovery is a long-term process, will likely entail relapses, and frequently requires multiple episodes of treatment; no single treatment modality is appropriate for everyone and so individualised treatment plans that can be modified as needed are important; expectations for drug treatment participants in terms of program compliance and progression should differ, depending upon their individual situation(s) and stage of program participation; not all participants will progress at the same pace and the drug court structure must therefore provide the flexibility to address the individual needs of each participant; court-based interventions need to provide a continuum of treatment that assures patients access to needed levels and intensities of services, as and when they need them; and effective treatment must address the multiple needs of the individual, both substance addiction specifically and ancillary services, with particular focus on ‘criminogenic factors’.⁵¹⁴

4.5.5 Based on Guiding Principle 2, the type of interventions used need to be based on research that demonstrates the effectiveness of treatment practices and should form part of a comprehensive

⁵⁰⁷ Ministry of Justice, New Zealand, *Alcohol and Other Drug Treatment Court Handbook* (2014) 10.

⁵⁰⁸ *Ibid* 22–23; Litmus, above n 286.

⁵⁰⁹ Richardson, above n 6, 20. These are based on the *Ten Guiding Principles for DWI Courts*, Guiding Principle 3, see NCDC, above n 258.

⁵¹⁰ Freiberg et al, above n 2, 173.

⁵¹¹ *Ibid* 262.

⁵¹² *Ibid*.

⁵¹³ *Ibid*.

⁵¹⁴ Jeffrey Kushner, Roger Peters and Caroline Copper, *A Technical Assistance Guide for Drug Court Judges on Drug Court Treatment Services* (Bureau of Justice Assistance Drug Court Technical Assistance Project, 2014) 5.

treatment plan for the particular offender. The types of services suggested by the Ten Guiding Principles include:

- Motivational approaches — these focus on ways to engage substance users in considering, initiating, and continuing substance abuse treatment while at the same time, discontinuing their use of alcohol and other drugs.
- Cognitive-behavioural therapy (CBT) — this has been recognised as a factor that is critical in reducing recidivism.
- Pharmacological treatments — these include naltrexone and campral (acamprosate), which have both been demonstrated to be effective pharmacological treatments when used in conjunction with psychosocial therapies.
- Aftercare — this is a significant predictor of long-term success and should involve at least monthly contacts, either in person or by telephone.
- 12-step self-help/manual aid approaches — these include alcoholics anonymous.

4.5.6 An analysis of the research literature (prepared in relation to drug courts) has found that a successful drug court uses ‘best-practice and evidence-based treatments, provided by agencies that share the non-adversarial and therapeutically-inclined philosophy of the drug court, but who respect the court’s obligation to manage and respond appropriately to non-compliance’.⁵¹⁵ The length of treatment should be no shorter than best practice (90 days) but should aim for a continuum of treatment over a period of nine and 12 months.⁵¹⁶ Treatment plans (in terms of both intensity and duration) should be individualised to meet client needs.⁵¹⁷

4.5.7 Research indicates that, in addition to substance use treatment, an effective criminal justice response must address an offender’s criminogenic needs as ‘drug court programs require integrated treatment responses that recognise drug treatment as just one component of the treatment matrix aimed to address a more complex series of criminogenic needs’.⁵¹⁸ Case management that allows for the ‘coordination of services that best help individuals meet their specific needs and goals’ has also been shown to improve the criminal justice response by improving treatment retention, reducing employment problems and improving family functioning.⁵¹⁹

Consultations – views and issues

4.5.8 In Tasmania, the Sober Driver Program, discussed at [2.4], is a psycho-educational program run by Community Corrections. Community Corrections also runs EQUIPS (Addiction). Other government community-based services include Alcohol and Drug Services (counselling, detoxification and pharmacotherapy) and Forensic Mental Health. Services are also provided by non-government organisations such as the Salvation Army (including the Day Program, the Bridge Program, the Residential Program, After Care and Outreach), City Mission (Missiondale, Serenity House), Holyoake (Gottwanna, Get Real (Youth) program), Headspace/The Link, Anglicare, and the

⁵¹⁵ Freiberg et al, above n 2, 263.

⁵¹⁶ Ibid.

⁵¹⁷ Ibid.

⁵¹⁸ Ibid 267.

⁵¹⁹ Ibid 268.

Tasmanian Aboriginal Centre. Individualised mental health plans can be developed to assist with psychological counselling through services such as ForensiClinic.

4.5.9 In the Issues Paper, the TLRI sought feedback on whether service providers currently offer programs that would be suitable for drink driving offenders, and currently have the capacity to provide treatment and support services in Tasmania to integrate and collaborate with a DWI court pilot. The TLRI also asked if there are any issues that may arise in making existing services available to recidivist drink drivers as part of any DWI court program.

4.5.10 In its submission, the ATDC provided detailed information on the treatment of people with a substance use disorder related to alcohol who commit repeat drink driving offences. This information is based on the experience of community sector organisations (CSO) in Tasmania. It was reported that that CSOs regularly work with this cohort, and based on this experience the key messages are that:

(1) there is no one size fits all approach — the ADTC highlighted the myriad of issues that present along with an alcohol use disorder which means that treatment is often about finding out what is going on underneath an alcohol use disorder and also finding a person's motivation for change. This requires the adoption of a person-centred approach and holistic assessments to achieve a profile unique to each client to allow underlying issues to be identified.

(2) staff employ an eclectic range of tools and approaches, including one to one counselling and group therapy using clinical approaches such as motivational interviewing, cognitive behaviour therapy, and mindfulness. Underpinning this is the idea of 'harm reduction' with the focus not necessarily on achieving abstinence, but rather on reducing harms associated with substance use. Whether the goal is abstinence or the reduction of harm through decreases in drinking levels, will depend on the presenting issues. Residential rehabilitation services employ a therapeutic community model.

(3) Specific drink driving safety measures are incorporated into treatment approaches. This includes readiness for change, education sessions, exploration of consequences.

(4) There is little difference in treatment mandated to voluntary clients. CSOs regularly work with mandated clients and suggested overall treatment approaches are not different but require more 'front end' work to enable a client to become ready for treatment through motivational interviewing. There are potential problems with group work for mandated clients if they are not ready but they can work within the group.⁵²⁰

Some workers reported that some mandated clients were more motivated to change due to the prospect of custodial sentences. This was especially true for those who had never been to prison. It was also important that there is a lower proportion of mandated to voluntary clients in groups.

(5) CSOs conduct evaluations on treatment outcomes and report 'success' defined as abstinence or reductions in drinking levels and change to drink driving behaviour.

(6) Any further increase in treatment places in CSOs will require careful and strategic investment. Current funding does not meet demand and it is long recognised that pathways and capacity for accessing withdrawal services is a barrier to streamlined treatment provision across the AOD sector. There are difficulties with access to mental health treatment and access to GPs who bulk bill and who are also equipped to work with complex comorbid alcohol and

⁵²⁰ This reflects research that indicates that treatment outcomes are not worse for offenders who attend treatment programs as a result of legal coercion instead of voluntarily, see TSAC, above n 13, [2.4.1].

other drugs and mental health presentations. There may be a need to develop specific drink driving programs.

4.5.11 ForensiClinic highlighted the need for additional funding to be made available, as the current funding pathways that are available under Medicare are not sufficient to enable the individualised risk reduction programs that would be beneficial. The need for appropriate funding was raised in many submissions and by stakeholders in consultation meetings. Both stakeholders and the submissions received highlighted the need for an individualised program to compliment the sober driver program. Holyoake indicated that it provided therapeutic services for offenders on community-based orders in Tasmania without any dedicated funding and that it would not have the capacity to take on more clients without appropriate funding. Other stakeholders raised concerns about the lack of staff with the necessary expertise to treat alcohol use issues.

4.5.12 The availability of clinical detoxification services and residential rehabilitation was raised as in submissions and consultations. Other concerns raised were in relation to the availability of services in the North and North-west of Tasmania. The wait lists and the unsuitability of available treatment options for particular offenders were raised as reasons why offenders failed to comply with existing drug and alcohol programs. It was noted by several stakeholders that there is a need for a more 'wrap around service' that assists clients in 'navigating the system', develops organisational skills to attend appointments, and addresses transportation difficulties. It was also noted that there is a need for services to be culturally appropriate for Aboriginal offenders.

4.5.13 ForensiClinic also highlighted the need for communication between service providers, the judicial system and other stakeholders. The need for coordinated responses between AOD treatment services and the court was also raised in FARE's submission. The Salvation Army also highlighted the need for effective planning and communication/collaboration between agencies

Recommendations

4.5.14 Based on the submissions received and recommendations made in relation to the Queensland Drug Court, the TLRI recommends that 'individual drug treatment plans should be developed by suitably qualified and trained personnel working within a specialist alcohol and other drug service. Drug treatment location, length, setting and modality should be decided based on clinical indications and best-practice principles in the provision of drug treatment'.⁵²¹ The precise treatment services to be offered will need to be determined as part of the implementation of the DWI list program pilot. However, the TLRI's view is that treatment services should be provided predominantly from within a health framework and that there is scope for services to be provided by government and non-government service providers. There is also scope for offenders to be directed to participate in the Sober Driver Program and EQUIPS (Addiction), where this is appropriate for the offender. Treatment must be evidence based and effective with alcohol dependent individuals.

4.5.15 There is also a need for a coordinated approach to the provision of treatment services through case management, as well as access (where appropriate) to evidence-based treatment programs that address all of an offender's criminogenic needs.⁵²² In addition, adopting the model of a Drug

⁵²¹ Freiberg et al, above n 2, Recommendation 35.

⁵²² Ibid 269.

Treatment (DWI) order, will allow a multidisciplinary team to review progress, and oversee or deliver legal, treatment and supervision services.⁵²³ This is discussed further at [4.7].

4.5.16 The TLRI stresses that the existence of community partnerships will be crucial for the success of the pilot to allow offenders to access the individualised treatment that is required. The TLRI also acknowledges that there is a need to address the funding requirements created by any expansion in demand for community-based programs addressing the issue of alcohol abuse.

Recommendations

17. Individual drug treatment plans should be developed by suitably qualified and trained personnel working within a specialist alcohol and other drug service.
18. Drug treatment location, length, setting and modality should be decided based on clinical indications and best-practice principles in the provision of alcohol treatment.
19. Treatment services should be provided predominantly from within a health framework and there should be scope for services to be provided by government and non-government service providers.
20. There should be a coordinated approach to the provision of treatment services through case management, as well as access (where appropriate) to evidence-based treatment programs that address all of an offender's criminogenic needs.
21. It is necessary to address the funding requirements created by any expansion in demand for community-based programs arising from a Drug Treatment (DWI) order addressing the issue of alcohol abuse and other treatment services.

4.6 Program phases

Position in other jurisdictions

4.6.1 The AODT Court pilot in New Zealand uses a three phase model with the length of the program varying depending on the needs of the participant and lasting between 12–18 months.⁵²⁴ Feedback on the operation of the pilot has observed that participants with EBA offences tend to graduate within 12 months.⁵²⁵ In New Zealand, identified advancement criteria allow an offender to advance a phrase in the program with the milestones 'not necessarily [being] linked to treatment time frames' with each phrase anticipated to take between four and six months.⁵²⁶ The milestone advancement criteria are:

Phase One:

- attendance and participation in agreed treatment programs;

⁵²³ Ibid 232.

⁵²⁴ Ministry of Justice, New Zealand, above n 369, 15.

⁵²⁵ Litmus, above n 286, 28.

⁵²⁶ Ministry of Justice, New Zealand, above n 369, 16.

- satisfactory attendance at other aspects of the treatment plan (for example, 12-step meetings, peer support group meetings);
- acknowledgement of the extent of the AOD dependency problem, and a demonstrated commitment to live an AOD free lifestyle;
- no unexcused absences from scheduled services or court-required appointments for at least 14 consecutive days; and
- a minimum of 30 consecutive days of demonstrated sobriety.

Phase Two

- progress with the treatment plan;
- satisfactory attendance at other aspects of the treatment plan (for example, 12-step meetings, peer support group meetings);
- progress with other courses or programs, including voluntary community work;
- evidence of continuing commitment to living an alcohol and drug-free lifestyle;
- no unexcused absences from scheduled services or court-required appointments for at least 14 consecutive days; and
- a minimum of 60 consecutive days of demonstrated sobriety.

Phase Three:

- completion of treatment plan;
- satisfactory attendance at relapse prevention/recovery based supports (such as 12-step meetings, fellowships, and peer support group meetings);
- appropriate progress with other personal/educational/vocational goals;
- evidence of clear commitment to living an alcohol and drug-free lifestyle;
- engagement in fulltime work or study or suitable community-based activity;
- no unexcused absences from scheduled services or court-required appointments for at least 14 consecutive days; and
- a minimum of 180 consecutive days of demonstrated sobriety.⁵²⁷

4.6.2 Based on the models of DWI courts in the United States and the model recommended for implementation in Victoria, DWI courts use a three-staged program leading to graduation:

- Phase I — most intensive phase, which lasts three to six months;
- Phase II — Education Period, which lasts six to nine months;
- Phase III — Self-Motivation Phase, which lasts three to six months.⁵²⁸

In the United States, this means that successful participation will typically be undertaken over 12 to 18 months.⁵²⁹

⁵²⁷ Ministry of Justice, New Zealand, above n 369, 16–18.

⁵²⁸ Richardson, above n 6, 21.

4.6.3 Drug court models, including CMD in Tasmania, also rely on the phased approach with phase one aimed at stabilisation, phase two at rehabilitation and phase three at reintegration and relapse prevention.⁵³⁰ In developing guidelines for the structure of the program design for a drug court in Queensland, it has been recommended that this be guided by:

- (a) a shared understanding within the drug court team that stabilisation will take considerably longer for some participants and that premature graduation to a higher phase can be detrimental to treatment.
- (b) the decision to graduate a participant from stabilisation to rehabilitation should take into account the health, criminal justice and social domains likely to affect active and motivated engagement in both drug use and criminogenic/criminal thinking treatments.⁵³¹

What does the evidence say?

4.6.4 Research suggests that outcomes for drug courts are significantly better ‘when they have a clearly defined phase structure and concrete behavioural requirements for advancement through the phases’.⁵³² Phase advancement needs to be based on ‘the achievement of clinically important milestones that mark substantial progress towards recovery’.⁵³³

Consultations – views and issues

4.6.5 In consultations with stakeholders and in the submissions received, support was expressed for a phased approach for participants engaged in the DWI list program. However, Holyoake raised concerns about some aspects of the phased approach that exist in other jurisdictions:

Does a two-year time frame for all clients seem excessive? Each client will have different needs and not all will require the same interventions for the same period of time. This time frame would certainly be appropriate for a chronic ice user, but may not routinely be required for all offenders using alcohol or other drugs. Will there be some flexibility here?

The phased plan outlined in the paper has some restrictions which may set the participants up to fail:

- Required consecutive days of demonstrated sobriety. Relapse in drug and alcohol rehabilitation is common and to be expected. What will be the consequences of a breach of this criterion? Punishment or additional support?
- Engagement in full time work or study or suitable community based activity. Will the participants be offered support from employment agencies to fulfil this criterion?
- Attendance at other aspects of the treatment plan (for example 12-step meetings, peer support group meetings). It is important to ensure that any such meetings are evidence-based.

4.6.6 Other stakeholders also raised concerns about the requirement for attendance with the 12-step programs as an expectation in the Australian context.

⁵²⁹ Ibid 21.

⁵³⁰ See Magistrates Court of Tasmania, above n 239; Freiberg et al, above n 2, 259–260.

⁵³¹ Freiberg et al above n 2, 261.

⁵³² Ibid 259.

⁵³³ Ibid.

Recommendations

4.6.7 THE TLRI recommends that the Drug Treatment (DWI) order should adopt the same three-phase approach (stabilisation, rehabilitation and reintegration) as applies for the DTO with each phase having clear objectives and expectations that need to be met in relation to behavioural change.⁵³⁴ These criteria can be based on the criteria for the DTO and can be developed by the Reference Group in consultation with stakeholders in the development of the DWI list pilot, but need to be informed by the Tasmanian context.

Recommendations

22. The Drug Treatment (DWI) order should adopt a three-phase approach (stabilisation, rehabilitation and reintegration) with each phase having clear objectives and expectations that need to be met in relation to behavioural change.

23. These criteria can be based on the criteria for the DTO and can be developed by the Reference Group in consultation with stakeholders in the development of the DWI pilot.

4.7 Supervision and judicial monitoring

Position in other jurisdictions

4.7.1 In New Zealand, the AODT Court team consists of the AODT Court judge, case manager, court coordinator, defence counsel and police prosecutor.⁵³⁵ The case manager is employed by the Ministry of Health and is responsible for co-coordinating specialist AOD treatment and other services. The case manager retains ‘an ongoing and current overview of each participant’s stages in the treatment process (including treatment progress and drug testing results etc)’.⁵³⁶ Court coordinators are employed by the Ministry of Justice and coordinate specialist services and manage relationships with the judiciary, professional service providers, legal practitioners, prosecutors, court users and various community groups. They maintain the AODT Court database and report to the AODT Court team.⁵³⁷ Each participant is represented by a specialist AODT Court defence counsel and self-represented defendants cannot apply to enter the AODT and defendants who are represented by other counsel, will be represented by AODT Court counsel if offered a place in the AODT Court.⁵³⁸ AODT Court defence lawyers provide rostered services under the Duty Lawyer Scheme.⁵³⁹ The police prosecutor is actively involved in recommending appropriate sanctions and incentives, providing information on violations, and ensures public safety is always a primary focus and brings any information that may impact on this to the attention of the AODT Court.⁵⁴⁰ Other people who contribute to the AODT Court include AOD clinicians, testing providers, treatment providers, Community Advisory Group, Community Probation, Court Registry Officers, employers, peer

⁵³⁴ Ibid 261.

⁵³⁵ Ministry of Justice, New Zealand, above n 369, 6.

⁵³⁶ Ibid 7.

⁵³⁷ Ibid.

⁵³⁸ Ibid 7–8.

⁵³⁹ Ibid 7.

⁵⁴⁰ Ibid 8.

support workers, victims, and victim advisors.⁵⁴¹ Supervision is provided by the case manager (treatment) and the police.

4.7.2 In New Zealand, incentives and sanctions used by the AODT Court include:

Incentives

- verbal praise and recognition in court;
- being moved to the front of the daily 'list' in the AODT Court (A-team designation);
- formal recognition of consecutive negative AOD tests (30 days tag; six, nine and 12 month medals);
- formal recognition of attendance at 12-step meetings;
- formal recognition of progress with treatment/rehabilitation goals;
- graduation to the next phase with a certificate of progress;
- longer periods between court appearances;
- assistance with access to personal development, cultural, pro-social, educational or work-related opportunities not normally available or publically funded.

Sanctions

- verbal correction in court;
- assignment to the end of the court list;
- production of a piece of work (eg written) focusing on the behaviour which led to the sanction;
- apologies (where appropriate) in writing or verbally;
- increased or longer attendance requirements at a suitable treatment agency;
- increased reporting to case managers;
- curfews;
- more regular appearance in AODT Court;
- more frequent random AOD tests;
- participation in services in and for the community;
- stand-down or short remand in custody where behaviours raise risks of reoffending or exit from AODT Court.⁵⁴²

4.7.3 In the Victorian model for a DWI list, it was proposed that a participant would be supervised by Community Corrections Victoria, with judicial monitoring imposed as a condition of a community correction order. It was intended that the Victorian list would involve a 'small cohort of 2–3 magistrates who have training and expertise in the therapeutic approach to judging and alcohol and/or

⁵⁴¹ Ibid 9.

⁵⁴² Ibid 19.

drug addiction'.⁵⁴³ It was proposed that the DWI court team include, 'as a minimum a judicial officer, a prosecutor, a defence lawyer (legal aid), a DWI Court coordinator, a treatment provider, a probation officer and a law enforcement officer'.⁵⁴⁴ Under the proposed model for the program, the following sanctions and rewards were suggested:

| Rewards | Sanctions |
|---------------------------------------|---|
| Verbal praise/encouragement | Verbal warning |
| Advancement to the next Program phase | Demotion to an earlier phase |
| Decreased supervision | Increased supervision |
| Decreased court appearances | Increased court appearances |
| Reduced drug or alcohol testing | Increased drug or alcohol testing |
| Gift/voucher given | Imposition of a curfew |
| Reduced unpaid community work | Unpaid community work |
| Successful Program completion | Termination of participation in the Program |

It was noted that it was not proposed for periods of incarceration to be used as a sanction because that power does not exist under the CCO.⁵⁴⁵

4.7.4 Under the current CMD order the following rewards and sanctions are used to encourage compliance with the order:

| Rewards | Sanctions |
|---|---|
| Verbal praise/encouragement | Verbal warning |
| Removal of program conditions | Addition of program conditions |
| Variation of core or program conditions to reduce the frequency of treatment, the degree of supervision, the frequency of testing and the type or frequency of other programs | Variation of core or program conditions to increase the frequency of treatment, the degree of supervision, the frequency of testing and the type or frequency of other programs |
| Reduction of community work | Imposition or increase of community work |
| Reduction of the amount of imprisonment | Imposition of a period of imprisonment |
| Cancellation of the order | Cancellation of the order |

If an offender has failed to comply with a condition of a drug treatment order, other than by committing an offence punishable by a term of imprisonment exceeding 12 months, the court may order that the custodial part of the drug treatment order is activated for a specified period, of not less than one day and not more than seven days.⁵⁴⁶ The offender will serve any activated period of imprisonment, once the period exceeds 13 days.⁵⁴⁷ Transition through the stages of the program and the removal or reduction of curfew periods are other rewards that may be used for offenders.⁵⁴⁸

⁵⁴³ Richardson, above n 6, 22.

⁵⁴⁴ Ibid 23.

⁵⁴⁵ Ibid.

⁵⁴⁶ *Sentencing Act 1997* (Tas) s 27M.

⁵⁴⁷ Ibid s 27N.

⁵⁴⁸ Information provided by Tristan Bell, email 29 February 2016.

4.7.5 In the evaluation of a drug court model for Queensland, the following team members were identified as reflecting best practice standards for drug courts: judicial officer, program coordinator, prosecutor, public defence representation, community supervision officer, alcohol and other drug representative and law enforcement officer. However, it was noted that there is no evidence that suggests a particular drug court team model is better than any other.⁵⁴⁹ In the recommendations made by the evaluation, it was noted that the ‘non-adversarial and inter-disciplinary approach of the drug court [is] one of its key features’, and the recommendation was made that each Drug Court established in Queensland should have ‘representation from each of the key agencies – courts, corrections, health, legal aid, and police’.⁵⁵⁰ In light of the understanding that the ‘right judicial officers [being] appointed to the Drug Court [is] critical to the success of a drug court’, it was recommended that Drug Court magistrates should be selected on the basis of having the requisite skills and attributes required to undertake a therapeutic jurisprudence role and recruited to the court on a voluntary basis.⁵⁵¹

What does the evidence say?

4.7.6 In the Ten Guiding Principles, case management is identified as a key feature of a DWI court, defined as the series of inter-related functions that provide for a coordinated team strategy and seamless collaboration across the treatment and justice systems. Case management ensures that:

- (1) Clients are linked to and guided through relevant and effective services;
- (2) All service efforts are monitored, connected and in synchrony; and
- (3) Pertinent information gathered during assessment and monitoring is provided to the ensure drug court team in real-time.⁵⁵²

Similarly, Freiberg et al have stressed that a key feature of successful drug court programs is ‘strong collaboration and communication between specially-trained magistrates, alcohol and other drug service providers and other relevant stakeholders at the local level’.⁵⁵³ The Guiding Principles note that ‘preliminary indications [are] that the team case management approach takes on heightened significance in the DWI court arena where alcohol, as opposed to illicit substances, tends to be the primary drug of choice’ as denial is more deeply ingrained and tougher to overcome than in illicit drug dependent populations.⁵⁵⁴

4.7.7 Supervision is also specified as a guiding principle of DWI courts given the danger posed by offenders who drive when intoxicated.⁵⁵⁵ It is stated that due to the public safety risks, ‘DWI offenders must be monitored through every method possible. This includes utilising technology such as ignition interlocks, car impounds, global positioning devices, in-home electronic surveillance that has photo capable alcohol testing equipment or trans-dermal alcohol detection devices’.⁵⁵⁶ These methods are to be used in conjunction with personal surveillance, and testing.

⁵⁴⁹ Freiberg et al, above n 2, 232.

⁵⁵⁰ Ibid 236.

⁵⁵¹ Ibid 248.

⁵⁵² NCDC, above n 258, Guiding Principle 7.

⁵⁵³ Freiberg et al, above n 2, 173.

⁵⁵⁴ NCDC, above n 258, Guiding Principle 7.

⁵⁵⁵ Ibid Guiding Principle 4.

⁵⁵⁶ Ibid.

4.7.8 The Ten Guiding Principles recommend that the DWI court team consist of a judicial officer, a prosecutor, a defence lawyer, a DWI court coordinator, a treatment provider, a probation officer and a law enforcement officer under the leadership of the judicial officer (Guiding Principle 6). Research has confirmed that judicial monitoring is a key feature of court-based solution-focused approaches.⁵⁵⁷ Participants should be seen regularly by the same judicial officers. Further, research shows that ‘the attitude and approach of the judicial officer can significantly influence the outcomes of an entire drug court program’.⁵⁵⁸ Jones and Kemp report that the ‘drug court judge appears to be curial to the drug court rehabilitation process. The formation of strong interpersonal bonds that appears to underpin this effect is consistent with the therapeutic jurisprudential principles upon which drug courts are based’.⁵⁵⁹

4.7.9 Traditionally, the criminal justice system has relied on punishment of negative behaviour and has rarely used rewards and incentives to promote positive behaviour.⁵⁶⁰ As noted, a feature of drug court and DWI models (and other problem-oriented courts) is the use of positive reinforcement of desirable behaviour as well as the use of punishment for negative behaviour. Immediate consequences for negative behaviour are important because they demonstrate to the offender and the community that offenders will be held accountable for their conduct.⁵⁶¹ The Ten Guiding Principles stipulate that:

- the DWI court team should provide positive and negative reinforcement of conduct (whichever is appropriate) as soon as practical after it occurs;
- the DWI court magistrate, in consultation with the DWI court team, must provide evidence-based incentives and sanctions to respond to participant conduct as soon as practicable after it occurs.⁵⁶²

These principles accord with understandings about the effectiveness of swift, certain and fair sanctions in modifying behaviour, which underpins programs such as the 24/7 Sobriety program and the HOPE program. Research has shown that, to be effective, sanctions must be certain and swiftly applied, but that sanction severity ‘is likely to be the weakest contributor to behavioural change’ and that ‘there is relatively little evidence to suggest that the imposition of harsh sanctions in a drug court program improves individual or court-level outcomes’.⁵⁶³

4.7.10 Rewards are a key feature of problem-oriented courts, and as noted in the Maryland Guidelines, ‘DUI/DWI treatment courts should identify and incorporate the strengths and past successes of the participants and build upon them. The program should constantly look for new ways to encourage participants to succeed’.⁵⁶⁴ Research has ‘demonstrated better outcomes for participants

⁵⁵⁷ M Edgley, ‘Addressing the Solution-Focused Sceptics: Moving Beyond Punitivity in the Sentencing of Drug-Addicted and Mentally Impaired Offenders’ (2016) 39 *University of New South Wales Law Journal* 206, 213.

⁵⁵⁸ Freiberg et al, above n 2, 246.

⁵⁵⁹ C Jones and R Kemp, ‘The Strength of the Participant-Judge Relationship Predicts Better Drug Court Outcomes’ (2014) 21 *Psychiatry, Psychology and Law* 165, 165.

⁵⁶⁰ Maryland Drug Courts, above n 376, 11.

⁵⁶¹ *Ibid* 12.

⁵⁶² *Ibid* 23 summarising Guiding Principle 4.

⁵⁶³ Freiberg et al, above n 2, 254.

⁵⁶⁴ Maryland Drug Courts, above n 376, 11.

who are rewarded for their compliance and success in treatment'.⁵⁶⁵ Best practice indicates that the court should provide rewards at least on an equal basis to the imposition of sanctions.⁵⁶⁶

Consultations – views and issues

4.7.11 In the Issues Paper, feedback was sought on whether an offender who makes progress in complying with the order should be able to obtain a driver's licence or a restricted licence subject to an interlock condition. Feedback was also sought about other suggestions for sanctions and rewards that may be applied to offenders for compliance or non-compliance with the program. Stakeholders were also asked about the monitoring of any alcohol ban, and the most appropriate means to monitor such a ban and any problems that may arise.

4.7.12 Mixed views were expressed in submissions and in consultations in relation to providing access to a driver's licence as a reward with a DWI list program. The DPP did not consider that this was appropriate given that it raises fairness issues in that it would benefit those individuals who were able to attend court regularly, for example those who are able to find transport to court, do not work full time, do not have obligations as caregivers or do not study full time. In addition, the DPP noted that the cost of installing an interlock is prohibitively expensive for many offenders. The fairness of allowing one category of offenders to have access to a restricted licence (when this is not more generally available) and the cost of interlocks as a barrier to installation were raised as significant issues to such a proposal in other responses. In contrast, ForensiClinic considered that access to a licence should be an available reward and that the decision to grant a licence could be informed by the proposed risk assessment tool utilised to monitor meaningful individual risk reduction, not just by program attendance. ForensiClinic stated that such 'incentives for progress may assist with motivation during the intervention program, and contribute positively to community safety'. Gerald Waters also considered that being allowed to drive with an interlock, should be used as a compliance reward.

4.7.13 Other rewards and sanctions proposed by stakeholders included less frequent testing. FARE suggested that this be done in line with the use of the colour categories in the HOPE program, so that offenders progressed through the colours with different conditions for drug testing. In terms of sanctions, Gerald Waters proposed that a SCRAM bracelet be used as a sanction and FARE suggested that the DWI list potentially use the sanctions and rewards used by HOPE. These include:

- early termination and early discharge (for those demonstrating compliance, up to three years can be removed from their sentence);⁵⁶⁷
- technical violations with no aggravating circumstances (such as a missed appointment where the offender contacts his/her probation officer) might result in a non-jail sanction (this might include spending the day in the courthouse cell block and no overnight stay rather than being checked into jail);⁵⁶⁸

4.7.14 Stakeholders also indicated that the integrity of the order requires that conditions be monitored and that there be swift responses to their breach. In terms of a method of monitoring

⁵⁶⁵ Freiberg et al, above n 2, 254; Long and Sullivan, above n 2.

⁵⁶⁶ Freiberg et al, above n 2, 254.

⁵⁶⁷ It is noted that probation terms are typically five years, Hawken et al, above n 326, 42.

⁵⁶⁸ Ibid 43.

alcohol use, alcohol testing via a SCRAM bracelet was supported by some stakeholders. Other stakeholders stressed the need for random testing.

Recommendations

4.7.15 The TLRI's view is that the Drug Treatment (DWI) order should be supported by a DWI team consisting of a multidisciplinary group of professionals with representatives from the court, community corrections, health, legal aid and the police. The structure for these roles can be based on the current administrative arrangements that exist for the DTO. Judicial officers play a key role in the DWI list participants' successful completion of DWI list programs. Specialist DWI list magistrates should therefore be appointed who are experienced in handling drink driving matters, have a good understanding of addictions and a genuine interest in therapeutic jurisprudence. The TLRI recognises that there is already expertise of this kind among Tasmanian magistrates, and recommends that the Drug Treatment (DWI) order should be situated within the DTO list structure. A written agreement should be signed by the team members in relation to information sharing and confidentiality. The protocols developed for the CMD order could be adapted for this purpose.

4.7.16 The TRLI's view is that rewards for compliance and sanctions for non-compliance are key features of the Drug Treatment (DWI) order. Participants need to know the consequences of non-compliance, and breaches need to be followed up promptly with sanctions that are swiftly imposed. There needs to be consistency in the views expressed by the DWI team members about responses to non-compliance that reflect the policy and philosophy about the use of sanctions and rewards.⁵⁶⁹ There should be a focus on rewards and acknowledgement of progress rather than an overly punitive approach focusing on punishment for non-compliance. As acknowledged by Freiberg et al, 'the court philosophy should be guided by evidence-based behavioural science techniques that favour incentivising compliant behaviour over the sanctioning of non-compliant behaviour'.⁵⁷⁰

4.7.17 The schedule of sanctions and rewards can be based on the existing structure for the DTO order and should be settled in conjunction with the Steering Committee in the development of the pilot program. The rewards and sanctions need to be clearly communicated to participants. Based on research evidence, it is the TLRI's view that treatment relapses should not be punished by the court but should be met with treatment adjustment given that 'punitive responses to a temporary lapse in treatment will more likely than not undermine the treatment alliance and weaken the court's capacity to engage and motivate behavioural change'.⁵⁷¹

4.7.18 The TLRI considers that there is merit in exploring the granting of driving privileges as a reward for compliance. This is one of the biggest potential rewards that could be used to encourage compliance and rehabilitation. This would also enable the offender to be supervised and to participate in appropriate rehabilitation/treatment programs during the time when the offender is legally able to drive. It would provide a strong incentive for compliance with the order and encourage offenders to operate within the licencing system. It also reflects research findings which have shown that interventions like interlocks are more effective if combined with other interventions directed towards long-term behavioural change.⁵⁷² In this way, this approach addresses community safety issues in the short and longer term. It also allows for greater integration of the judicial and administrative

⁵⁶⁹ Freiberg et al, above n 2, 258.

⁵⁷⁰ Ibid Recommendation 33.5.

⁵⁷¹ Ibid 258.

⁵⁷² See [2.4].

responses to drink driving as occurs in some other jurisdictions.⁵⁷³ However, this is a highly controversial issue, as highlighted in the submissions received by the TLRI, with concerns raised about the need for there to be consistency in approach with other drink driving offenders (who do not participate in the DWI list or who are not able to afford an interlock, for example). Nevertheless, some stakeholders supported the use of a driving licence as a possible reward within a supervised DWI list structure.

4.7.19 Licence disqualification is a primary response to drink driving and aims to provide community protection (by removing the ability to drive) and to act as a deterrent. As discussed at [2.4.25], research has shown that licence disqualification/suspension is generally the most effective penalty for drink driving for these purposes.⁵⁷⁴ However, there are limits to the effectiveness of disqualification for some offenders and some repeat offenders continue to drink drive and many have driven without a licence.⁵⁷⁵ In the TLRI/TILES study, most of the offenders were convicted of offences that related to breaches of no alcohol requirements reflecting their drink driving offending history (either their status as disqualified or unlicensed drivers or their number of prior convictions in a specified period, or in breach of the conditions of their licence.⁵⁷⁶) In the Victorian context, research has found that many individuals decide not to take part in the interlock process and instead keep driving without a licence and without an interlock.⁵⁷⁷ Accordingly, VSAC suggests that a new pathway is desirable to maximise community protection so that in appropriate cases it should be possible to:

- require offenders to confront and address their underlying alcohol problem at an early stage; and
- increase the likelihood that offenders will remain in the licensing scheme and as a consequence be subject to an alcohol interlock condition.⁵⁷⁸

It was argued that ‘this is more likely to protect the community than the current pathway, which does not effectively encourage offenders to address any underlying alcohol problems and, in many cases, results in offenders continuing to drive outside of the licensing scheme and without an interlock’.⁵⁷⁹ VASC proposed that the court should have greater discretion in relation to the disqualification periods and to allow offenders to apply for a restricted licence subject to an interlock condition.⁵⁸⁰

4.7.20 Similarly, in Tasmania, under the current drink driving penalty structure, it is arguable that there is a disconnect between the policy objectives of community protection underlying the sentencing structure for drink driving offences and the interlock scheme, and its practical effect on offender rehabilitation. Instead of relying on long periods of disqualification for repeat drink drivers followed by an administrative scheme that requires the use of an interlock as a condition of re-licensing to secure community safety and offender rehabilitation, it may be preferable to deploy, in a coordinated manner, treatment, court supervision and interlocks in conjunction with probationary or restricted licences. While the TLRI notes that any move to provide greater discretion and access to

⁵⁷³ See [2.4.19] for discussion of jurisdictions where a court can impose an interlock condition.

⁵⁷⁴ See Terer and Brown, above n 32; Warner, above n 56, 397.

⁵⁷⁵ VSAC, above n 255, 59.

⁵⁷⁶ See TLRI above n 70, 19.

⁵⁷⁷ VSAC, above n 255, 59.

⁵⁷⁸ Ibid.

⁵⁷⁹ Ibid.

⁵⁸⁰ Ibid 60.

restricted licences is likely to be controversial and generate concerns about fairness and consistency, the TLRI recommends that this approach warrants consideration and trial with embedded evaluation after a set period to assess its effectiveness and fairness in practice.

4.7.21 Absent any legislative change that would grant the court greater discretion in relation to the period of disqualification and/or the grant of restricted licences, there remains the possibility that some offenders eligible for the DWI list may be able to apply for a licence while still under the supervision of the court (depending on the blood alcohol reading and the length of the disqualification imposed). As noted at Table 2-3, the minimum disqualification period for a repeat offender with a blood alcohol reading of 0.05 or more but less than 0.1 is six months which increases to 12 months for an offender with a blood alcohol reading of 0.1 or more but less than 0.15. Accordingly, a DWI magistrate may be able to sentence an offender to a period of disqualification that is likely to be less than the treatment component of the order and the offender may be issued with a probationary driver's licence that is subject to a zero alcohol requirement as well as a driver interlock condition following the disqualification period.⁵⁸¹ In this context, the TLRI's view is that the DWI List Reference Group should consider how the administrative licencing scheme and the criminal justice system could be made more complementary. This will require the involvement of the key stakeholders, including the Department of State Growth.

4.7.22 In addition, it is necessary to provide for alcohol and drug testing of offenders to monitor abstinence. As Freiberg et al write, 'drug testing is an essential feature of any drug court program and is almost universally recognised as key to both individual-level and court-level success'.⁵⁸² Research shows that drug testing needs to be frequent and random.⁵⁸³ Therefore, adequate monitoring will be required to maintain the credibility of the DWI court and to ensure 'certainty' of detection. Hobart Pathology currently conducts urinalyses on all CMD participants for a range of illicit substances in addition to analyses to detect alcohol on request.⁵⁸⁴ There is currently no funding provided specifically for alcohol testing in Tasmania.⁵⁸⁵ Accordingly, funding would need to be provided for testing for alcohol to be included in a DWI court process. It will also be necessary to ensure that the procedure for alcohol testing implemented is appropriate and effective for drink drive offenders. Tasmania Police currently monitors compliance with any alcohol bans that have been imposed on offenders who are subject to a DTO by breath testing them when checking on compliance with curfews. However, there are difficulties in monitoring an alcohol ban placed on drink drivers because alcohol remains in the body for a relatively short period of time (compared with other drugs).⁵⁸⁶ This means that more frequent testing is required than for offenders currently supervised under CMD orders.

4.7.23 Possible models of cost-effective testing include testing an offender two times a day, using a driver interlock device, or using random and unexpected testing, as suggested by Guiding Principle 4 (on paydays, during football games, early in the morning, or two hours after probation officers make their last check at offenders' homes). It may be possible for an offender to be required to report daily for breath testing. A technological solution that is pursued in New Zealand is the testing of offenders

⁵⁸¹ See *Vehicle and Traffic (Driver Licensing and Vehicle Registration) Regulations 2010* (Tas) regs 22(10), 24.

⁵⁸² Freiberg et al, above n 2, 238.

⁵⁸³ *Ibid* 239.

⁵⁸⁴ Information provided by Liz Moore, email 31 August 2015.

⁵⁸⁵ Information provided by Michelle Lowe, email 20 March 2017.

⁵⁸⁶ This concern was recognised by Gregg and Chetwin in their review of the AODT in New Zealand, see Gregg and Chetwin, above n 363, 88.

through the use of SCRAM bracelets (which provide constant monitoring for alcohol) and random breath testing, which is conducted five times over a two week period.⁵⁸⁷ There are only limited SCRAM bracelets available for use in New Zealand and so only selected offenders are monitored using these devices, with the removal of the device being viewed as a sign of trust by the court and a reward.⁵⁸⁸ In South Dakota, SCRAM bracelets were initially used to monitor offenders who were geographically remote from regular testing locations and now are used for a wide array of offenders.⁵⁸⁹ However, the New Zealand experience indicates that SCRAM bracelets are not without difficulties given that they operate through a cellular network and issues have been identified in relation to ‘participants’ failing to correctly set up base stations and modems, interference and the power supply to the base station being unplugged’.⁵⁹⁰ In response, there has been a move to try to download the data directly from the SCRAM bracelet during clinic attendance and it is indicated that this change will ‘achieve cost savings, as the base stations and modem would not need to be set up in participants’ homes and they would not longer be able to abscond with or destroy the equipment’.⁵⁹¹

4.7.24 It is the TLRI’s view that if an alcohol ban is imposed on an offender, it should be effectively monitored by frequent and random testing. In the development of the precise framework of the pilot Drug Treatment (DWI) order, the most appropriate method of testing participants should be decided by the Reference and Steering Group in consultation with other stakeholders.

4.7.25 An additional issue raised in consultations related to the potential disclosure of unlicensed driving and/or drink driving during case management while an offender is subject to a Drug Treatment (DWI) order. This disclosure is problematic as it immediately raises considerable public safety concerns and in this respect differs from a disclosure of illicit drug use under the current DTO arrangement (separate from any offending). The TLRI sought assistance from the New Zealand AODT Court officers in relation to how such an issue would be managed in that jurisdiction and the following response was provided:

We acknowledge that further use and/or offending is a possibility whilst in a Drug Court and encourage our participants to be open, honest and transparent with the Court in relation to this. If such information comes to light, we encourage the AODT Court defence counsel, prosecution and other team members to work collaboratively with each other to find a solution that manages the risk to public safety whilst also considering the most therapeutic outcome for the participant in the circumstances.⁵⁹²

The TLRI, similarly, recognises the need to respond to such disclosures in a way that manages the risk posed to public safety within the therapeutic framework.

Recommendations

24. The Drug Treatment (DWI) order pilot should be supported by a DWI team that comprises a multidisciplinary group of professionals with representatives from the court, community corrections, health, legal aid and the police.

⁵⁸⁷ Ministry of Justice, New Zealand, above n 369, 24.

⁵⁸⁸ Gregg and Chetwin, above n 363, 90.

⁵⁸⁹ Loundenberg et al, above n 332, 1.

⁵⁹⁰ Litmus, above n 286, 87.

⁵⁹¹ Ibid.

⁵⁹² Judge Lisa Tremewan, email 14 August 2017.

25. Judicial officers will play a key role in the Drug Treatment (DWI) order participants' successful involvement in the programs. Specialist therapeutic magistrates who have a good understanding of addictions and a genuine interest in therapeutic jurisprudence should therefore be appointed. The TLRI recognises that there is already expertise of this kind among Tasmanian magistrates, and that the Drug Treatment (DWI) order could be accommodated within the existing therapeutic framework of the court.
26. Participants need to understand the consequences of non-compliance, and breaches need to be followed up promptly with sanctions swiftly imposed.
27. There needs to be consistency in the views expressed by the DWI team members about responses to non-compliance that reflect the policy and philosophy about the use of sanctions and rewards.
28. There should be a focus on rewards and acknowledgement of progress rather than an overly punitive approach focusing on punishment for non-compliance.
29. The schedule of sanctions and rewards can be based on the existing structure for the DTO order and should be settled by the Reference Group in the development of the Drug Treatment (DWI) order pilot.
30. Consideration should be given to a review of the penalty structure for drink driving offences, in particular access to restricted licences and better integration of the driver interlock scheme with the criminal justice response. This should be considered in consultation with key stakeholders, including Tasmania Police and the Department of State Growth.
31. The alcohol ban needs to be effectively monitored by frequent and random testing.

4.8 Evaluation

Best practice

4.8.1 Evaluation of the DWI model adopted is one of the Ten Guiding Principles. A criticism of many reviews of DWI courts has been the failure to adopt scientifically rigorous research designs.⁵⁹³ The Maryland Guidelines suggest that several types of evaluation should be used, including:

- process evaluation — documenting how the DWI court is currently operating and comparing that with how it is meant to be operating. The range of questions that may be asked for a process evaluation are set out in Table 4-3;
- outcome evaluation — assessing the effect of the DWI court on the lives of participants after they have left the program, as compared with outcomes associated with more traditional criminal justice processing; focusing on a wide range of outcomes for participants (for example, abstinence, employment, family relationships), for the criminal justice system (recidivism, criminal case processing efficiency) and for the larger community. A range of questions that may be asked for an outcome evaluation are set out in Table 4-3;

⁵⁹³ Miller et al, above n 212.

- cost analysis — comparing costs and benefits to help determine whether the program warrants sustained or increased funding and considering how the DWI court compares with the costs of other sentencing options as well as other social costs.⁵⁹⁴

Table 4-3: Questions that can be addressed as part of a process and outcome evaluation

| Process evaluation questions | Outcome evaluation questions |
|---|---|
| What are the main components or activities delivered as part of a program? | To what extent has the program achieved its stated objectives? |
| Is the program currently operating or has it been implemented as it was originally designed (ie program fidelity)? | Did the program make a difference in terms of the problem it sought to address? |
| What are the characteristics of the problem, places and/or people being targeted by the program? | What outcomes that have been delivered as a result of having implemented the program? |
| Are the intended recipients of a program accessing the services being provided, do they remain in contact with the program and does the program meet the needs of participants? | What impact has the program had in the short term on participants' knowledge, attitudes, skills or behaviour? Are these outcomes sustained over time? |
| What is the nature and extent of stakeholder involvement in all stages/aspects of the program? | What longer term outcomes have been delivered, including the impact on crime rates and community safety? |
| Is the program consistent with best practice in terms of its design and implementation? | Who else benefits from the program, such as program staff, stakeholders and government? |
| What factors impact positively or negatively upon the implementation or operation of the program? | Were there any unintended consequences or outcomes from the program? |
| How appropriate are the governance arrangements, operating guidelines and where applicable, legislative framework in supporting the operation of a program? | Which program activities or components contributed to the short and long-term outcomes that have been observed? |
| What is the cost associated with the operation of the program? Is the program adequately resourced? | What external factors impacted positively or negatively on the effectiveness of a program and the outcomes that were delivered? |
| How efficient has the program been in delivering key activities? | What changes could be made to the program to improve its overall effectiveness? |
| What improvements could be made to the design, implementation and management of the program? | What are the financial benefits of a program relative to the costs associated with its operation (return on investment)? |

Source: A Morgan and P Homel, *Evaluating Crime Prevention: Lessons from large-Scale Community Crime Prevention Program* (Trends and Issues in Crime and Justice, No 48, Australian Institute of Criminology, 2013) 3.

4.8.2 Accordingly, clear objectives or aims for a DWI list must be established to allow for evaluation and to provide guidance in interpreting the legislation.⁵⁹⁵

Position in other jurisdictions

4.8.3 The AODT Court in New Zealand aims to reduce reoffending, decrease alcohol and other drug use and dependency, moderate the use of imprisonment, have a positive effect on offenders' health and rehabilitation, and be cost-effective.⁵⁹⁶ In relation to the proposed Victorian DWI list, it was stated that 'the aim of a DWI Court is not necessarily to divert a person from prison but to find a more effective way to deter future offending and protect the community through treatment rather than incarcerating the person'.⁵⁹⁷

⁵⁹⁴ Maryland Drug Courts, above n 376, 8, 19.

⁵⁹⁵ Freiberg et al, above n 2, 196.

⁵⁹⁶ Ministry of Justice, New Zealand, *Alcohol and Other Drug Treatment (AODT) Court Pilot*.

⁵⁹⁷ Richardson, above n 6, 14.

4.8.4 In Victoria, the legislative purposes of the drug court order attach to the order and are to: (1) facilitate the rehabilitation of the offender by providing a judicially-supervised, therapeutically-oriented, integrated drug or alcohol treatment and supervision regime; (2) take account of an offender's drug or alcohol dependency; (3) reduce the level of criminal activity associated with drug or alcohol dependency; and (4) reduce the offender's health risks associated with drug or alcohol dependency.⁵⁹⁸ Further, the legislation provides that if considering making a DTO, the Drug Court must regard the rehabilitation of the offender and the protection of the offender (achieved through the offender's rehabilitation) as having greater importance than the other purposes set out in s 5(1).⁵⁹⁹

4.8.5 Similarly, the legislative purposes of the DTO in Tasmania attach to the order and are to: (1) to provide an alternative sanction to imprisonment;⁶⁰⁰ (2) through treatment, to facilitate the offender's rehabilitation and reintegration into the community; (3) to reduce the incentive for the offender to resort to criminal activity; and (4) to reduce risks to the offender's health and well-being.⁶⁰¹

4.8.6 In New South Wales, the objectives of the Drug Court are set out in legislation as follows: (1) to reduce the drug dependency of eligible persons and eligible convicted offenders; (2) to promote the re-integration of such drug dependent persons into the community; and (3) to reduce the need for such drug dependent persons to resort to criminal activity to support their drug dependencies.⁶⁰²

4.8.7 The recommendation for the drug court model in Queensland couched its objectives in the following terms:

Reflecting the therapeutic jurisprudential framework that underpins a drug court, the legislative objectives of the Act or provisions establishing the Queensland Drug Court program should focus on the individual-level benefits of participation in the drug court program. In particular, to:

- facilitate the rehabilitation of eligible persons by providing a judicially-supervised, therapeutically-oriented, integrated drug or alcohol treatment and supervision regime;
- reduce the drug or alcohol dependency of eligible persons;
- reduce the level of criminal activity associated with alcohol and other drug dependency;
- reduce the health risks associated with alcohol and other drug dependency of eligible persons; and
- promote the rehabilitation of eligible persons and their re-integration into the community.⁶⁰³

Consultations – views and issues

4.8.8 There was general support expressed by stakeholders in relation to having comprehensive evaluation built into a Tasmanian DWI list program.

⁵⁹⁸ *Sentencing Act 1991* (Vic) s 18X(1).

⁵⁹⁹ *Ibid* s 18X(2).

⁶⁰⁰ It is noted that this is not reflected in the operation of the DTO as the custodial part of the DTO requires a sentence of imprisonment to be imposed. Accordingly, a DTO is not a true alternative sanction to imprisonment but is another way of serving a prison sentence.

⁶⁰¹ *Sentencing Act 1997* (Tas) s 27C.

⁶⁰² *Drug Court Act 1998* (NSW) s 3.

⁶⁰³ Frieberg et al, above n 2, 198.

Recommendations

4.8.9 The TLRI recommends that the DWI list be monitored, evaluated and open to modification in response to the evaluation findings. It is the TLRI's view that it is important that comprehensive evaluation is built into any model adopted in Tasmania to determine: (1) which offenders achieved the best outcomes; (2) which interventions produced the best outcomes; and (3) which interventions worked for which categories of offender. It is necessary to evaluate short-term outcomes as well as longer-term outcomes.⁶⁰⁴ There should also be a process and cost analysis evaluation conducted. It is also necessary to ensure that an appropriate management information system is in place to allow for necessary data to be captured to enable evaluation/monitoring to take place.

4.8.10 In identifying the objectives of the DWI list, the TLRI has drawn on approaches in other jurisdictions, and recommends that the legislative objective of the DWI list include to:

- facilitate the rehabilitation of offenders by providing a judicially-supervised, therapeutically-oriented, integrated alcohol treatment and supervision regime;
- reduce the level of criminal activity associated with alcohol use disorder, in particular drink driving; and
- reduce risks to offenders' health and well-being.

Recommendations

32. The Drug Treatment (DWI) order pilot should be monitored, evaluated and be open to modification in response to the evaluative findings.

33. The legislative objectives of the Drug Treatment (DWI) order should include to:

- facilitate the rehabilitation of offenders by providing a judicially-supervised, therapeutically-oriented, integrated alcohol treatment and supervision regime;
- reduce the level of criminal activity associated with alcohol use disorder, in particular drink driving; and
- reduce risks to offenders' health and well-being.

4.9 Sustainability, resources and funding

Position in other jurisdictions

4.9.1 It is noted that in 2011, the New Zealand government committed to a \$10 million investment package for AOD assessments and interventions. This included the establishment of the AODT Court five-year pilot with funding of \$1.93 million, with additional funds provided from 'proceeds of crime' and the criminal justice initiative 'Drivers of Crime' program to 'purchase' extra treatment beds. There was an expectation that agencies would absorb additional operational costs.⁶⁰⁵ In the final evaluation, it was observed that the resources required to operate the court were significantly under-

⁶⁰⁴ NCDC, above n 258, 37.

⁶⁰⁵ Gregg and Chetwin, above n 363, 17.

estimated with NZ Police and treatment providers indicating that the AODT Court design is not sustainable without additional funding allocation.⁶⁰⁶

4.9.2 In New Zealand, the development and oversight of the pilot is supported by a Steering Group, which consists of national level representatives from the justice and health sectors (Ministry of Justice, Policy, New Zealand Police, the Police Persecution Service and the Police Policy Group, judiciary, Ministry of Health, Mental Health Service Improvement and the Department of Corrections), chaired by the Ministry of Justice, District Courts' representative.⁶⁰⁷ The Steering Group exists 'to ensure the project delivers an AODT Court model in accordance with cabinet's directive, ensure integration between organisations, oversee the implementation of the court, provide effective project steering and maintain budget oversight'.⁶⁰⁸ Based on the experience in New Zealand and other jurisdictions that have established a drug court, in Queensland, it was recommended that a 'Steering Group should be established to provide ongoing strategic oversight of the Drug Court and its implementation. The Steering Group should involve representation of all key government agencies involved in supporting the Drug Court'.⁶⁰⁹ In the Tasmanian context, a Steering Committee was established for the MHDL, which consisted of representatives from the Magistrates Court, the Department of Justice, Mental Health Services, the University of Tasmania (Faculty of Law) and Tasmania Police.⁶¹⁰ The terms of reference for the MHDL Steering Committee included: managing the consultation for the development of the MHDL pilot; managing the evaluation of the pilot; considering mechanisms to enhance collaboration of the justice and health systems; subject to the evaluation, considering mechanisms for extending the duration of the pilot or making the program a permanent feature of the justice system, and assessing best practice models/strands of the operation of the pilot.⁶¹¹

4.9.3 In New Zealand, the AODT Court is also supported by a Community Advisory Group (CAG) that consists of various community representatives who meet regularly to provide practical support for the work of the court and also provide input to the court.⁶¹² It consists of a member with community interests in AOD recovery, a road safety advocate, representation from the legal profession, from philanthropic organisations, treatment providers, professional, academic and business interests, the LGBTQI community, representatives of different ethnic and cultural backgrounds as well as a representative of victim support.⁶¹³ The purposes of the Community Advisory Group are to:

- provide support and opportunities for the work of the AODT Court;
- provide a meaningful opportunity for the AODT Court to be informed by the input of the wider community; and
- play a role in informing the wider community about the purposes and processes of the AODT Court.⁶¹⁴

⁶⁰⁶ Litmus, above n 286, 38, 112.

⁶⁰⁷ Litmus, *Process Evaluation for the Alcohol and other Drug Treatment Court* (Interim Report, 2015) 26.

⁶⁰⁸ Ibid.

⁶⁰⁹ Freiberg et al, above n 2, 281.

⁶¹⁰ Newitt and Stojcevski, above n 407, 15.

⁶¹¹ Ibid 16.

⁶¹² Ministry of Justice, New Zealand, above n 369, 10.

⁶¹³ Litmus, above n 607, 27. LGBTQI stands for lesbian, gay, bisexual, transgender, queer, questioning and intersex.

⁶¹⁴ Ibid 30.

4.9.4 In evaluations of the AODT Court, the CAG has been identified as playing ‘a key role in its ability to engage across the community and to build understanding about the AODT Court, in particular that it is not an easy option for offenders’.⁶¹⁵ It is involved in fundraising to fund incentives provided to participants (for example zoo passes, supermarket vouchers, driver licence fees), has used its own networks to find community work and housing for AODT Court participants and has a role in informing the public about the operation of the court.⁶¹⁶

What does the evidence say?

4.9.5 Secure, stable and dedicated funding has been identified as a critical need of DWI courts.⁶¹⁷ As Richardson has acknowledged in the Victorian context, it is necessary to identify ‘existing resources that would [be] available to the ... List through the Community Corrections Service, any geographical constraints for service provision and availability, and the associated costs of resources’.⁶¹⁸ Guiding Principle 10 (as discussed above) recommends that the sustainability of a DWI court depends on:

- strategic planning;
- written agreements with key stakeholders which provide operational stability, clear agreements, and interagency commitments;
- clearly identified program costs;
- a diversified funding plan; and
- regular evaluations of the effectiveness of the plan.⁶¹⁹

A legislative basis for the DWI list is also important for its long-term viability.

4.9.6 Community acceptance has also been identified as a crucial factor in the establishment and longevity of a DWI court, including recognition of the benefits of a problem-oriented approach.⁶²⁰ This involves the engagement of the media, particularly ‘the engagement of journalists with crime journalism specialisation in educating and promoting attitudinal change within the community’.⁶²¹

Consultations – views and issues

4.9.7 In the Issues Paper feedback was sought in relation to whether a community advisory group should be established as part of the process of developing a Tasmanian DWI list, and who should serve on such a group. The creation of a community advisory group was supported by stakeholders with suggestions for appropriate members of the group identified as follows:

- Legal professionals, including a magistrate or former magistrate
- Road safety groups

⁶¹⁵ Ibid.

⁶¹⁶ Ibid.

⁶¹⁷ Maryland Drug Courts, above n 376, 23.

⁶¹⁸ Richardson, above n 6, 25.

⁶¹⁹ Ibid 25, summarising the Ten Guiding Principles.

⁶²⁰ Bartkowiak-Théron and Henning, above n 4, 8.

⁶²¹ Ibid.

- Tasmania Police
- Treatment providers
- AOD ‘expert’ academic
- Victim support
- Offender.

Holyoake expressed an interest in participating in the community advisory group. Gerald Waters, based on his experience in New Zealand, expressed the view that it would be desirable to have representation from those with a background in fundraising and community liaison as well as representatives of cultural minorities. He indicated that fundraising is an important function for the CAG groups as well as identifying opportunities for Court participants to reintegrate into their communities successfully. The CAG would optimally have links to employment and training opportunities and include representatives from community groups involved in the arenas of health and accommodation.

Recommendations

4.9.8 The TLRI’s view is that the Drug Treatment (DWI) order should have a legislative basis and, in accordance with the Ten Guiding Principles, should have commitment from its key stakeholders to ensure sustainability, collaborative partnerships and interagency engagement with the order.⁶²²

4.9.9 In addition, the TLRI notes that the Drug Treatment (DWI) order will require the allocation of additional resources to agencies that support the operation of the order, including the Magistrates Court, police, Community Corrections, government and non-government health and treatment providers, and legal aid.

4.9.10 The TRLI also recommends the establishment of a Steering Group and a community advisory group to help guide the process of developing and implementing the Drug Treatment (DWI) order pilot.

Recommendations

34. The Drug Treatment (DWI) order should have a legislative basis.

35. Appropriate additional resources should be allocated to agencies that support the operation of the Drug Treatment (DWI) order.

36. A Steering Group, with representation from relevant key government agencies, should be established to provide strategic oversight of the Drug Treatment (DWI) order pilot and its implementation.

37. A Community Advisory Group representing a diverse range of relevant interests should be established to promote community engagement in, and to provide support for, the operation of the Drug Treatment (DWI) order.

⁶²² NCDC, above n 258, Guiding Principle 10.

Appendix A: Survey of responses to drink driving

| Jurisdiction | Program | Pre/post sentence | Main features | Evaluation | Legislation |
|--------------|---|---|--|---|--|
| Victoria | Drink Disqualified Driver List (proposed) | Post sentence | <p>≤ 2 years</p> <p>Uses community correction order which allows a court to include unpaid community work, treatment and rehabilitation, non-association, residence restrictions, supervision, place or areas exclusions, curfew, alcohol, exclusion, bond and judicial monitoring.</p> <p>Based in a Magistrates Court in regional Victoria.</p> <p>Can be combined with driver interlock device.</p> <p>This is a requirement for re-licensing and for repeat drink drivers, this is managed by the court.</p> | | <i>Sentencing Act 1991</i> (Vic) Part 3A |
| | Victorian Drug Court – Drug Treatment Order | Post sentence | <p>≤ 2 years</p> <p>Two parts: a treatment and supervision part and imprisonment part. Program conditions include substance testing, detoxification, educational/vocational/employment programs, health assessment, non-association, residence restrictions.</p> <p>Based at Dandenong Magistrates Court.</p> | <p>Court deals with around 60 offenders a year.</p> <p>Individuals completing a DTO are less likely to reoffend and experience higher levels of employment than those with similar criminal and AOD related circumstances.⁶²³</p> <p>Significant improvements in the rate and severity of offending by the DVC cohort compared to counterparts in mainstream system.⁶²⁴</p> | <i>Sentencing Act 1991</i> (Vic) Part 3 Subdivision (1C) |
| | Drink Driver Education Program | Administrative requirement for re-licensing | <p>8 hours</p> <p>Independent of sentencing system but an administrative requirement prior to re-licensing for some offenders.</p> | | |

⁶²³ Victorian Alcohol and Other Drug Association (VAADA), *Drug Court in Victoria: Evidence and Options*, Position Paper (2013) 2.

⁶²⁴ KPMG, *Evaluation of the Drug Court of Victoria: Final Report* (2014) 4.

Appendix A

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| NSW | Magistrates Early Referral into Treatment (MERIT – Alcohol) | Pre-plea | 3 months Voluntary but court monitors progress through the use of bail conditions. Treatment that can include case management, psychological interventions, residential rehabilitation, referral to other services. | Reduce reoffending ⁶²⁵ Completers had substantially lower rates of reoffending than non-completers. There was also reduced psychological distress and improved physical and mental health. ⁶²⁶ High level of judicial satisfaction. ⁶²⁷ Funded under the National Health Care Agreement. | Local Court Practice Note Crim 1 <i>Bails Act 1978</i> (NSW) s 36A |
| | Traffic Offender Intervention Program | Post-conviction/pre-sentence Imposed as condition of s 11 adjournment (allows court to adjourn sentencing for up to 12 months so that offender can demonstrate rehabilitation). | Majority of participants are drink drivers but generally not high range offenders. ⁶²⁸ Purpose is to reduce reoffending by providing skills and information for offender to develop positive attitudes and safer behaviour when driving. | 10.5% of offenders who took part in program committed a traffic offence in the 2 years following the commencement of the program (but did not compare with those who did not complete program or did not take part at all). ⁶²⁹ | <i>Criminal Procedure Regulation 2010</i> (NSW) Pt 8 |

⁶²⁵ R L Lulham, 'The Magistrates Early Referral into Treatment Program: Impact of Program Participation on Re-offending by Defendants with a Drug Use Problem' (Crime and Justice Bulletin No 131, NSW Bureau of Crimes Statistics and Research, 2009) 8–9.

⁶²⁶ M Howard and K Martire, 'Magistrates Early Referral into Treatment: An Overview of the MERIT program as at June 2011' (Attorney-General and Justice, Crime Prevention Issues No 2, 2012); M Passey, et al, 'The Magistrates Early Referral into Treatment (MERIT) Pilot Program: Court Outcomes and Recidivism' (2007) 40 *Australian and New Zealand Journal of Criminology* 199.

⁶²⁷ L Barnes and P Poletti, *MERIT: Magistrates Early Referral into Treatment Program – A Survey of Magistrates* (Judicial Commission of NSW, Monograph 24, 2004) 50.

⁶²⁸ Attorney-General and Justice, NSW, *Traffic Offender Intervention Program 2009 – 2011* (Evaluation Report, 2013) 8.

⁶²⁹ P Rourke and C Jones, 'Risk of Reconviction among Traffic Offenders Who Commence the Blacktown Traffic Offender Program' (NSW Bureau of Crime Statistics and Research, Bureau Brief No 81, 2012) 7.

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|------------|-----------------------|--|--|--|---|
| | Sober Driver Program | Post sentence. Placed on a bond (good behaviour bond or suspended sentence) with condition that complete program | <p>Program for repeat drink drivers convicted of two or more offences within five years (category 1) or offenders who have been convicted of a single serious drink driving offence and offenders who have been convicted of a repeat drink driving offence after more than five years and less than 10 years (category 2). In addition, category 2 offenders, must meet at least one of the following criteria: the offender admits or suggests that they regularly drink and drive without being detected by police; the offender's pattern of alcohol consumption continues to place them at risk and/or the offender's LSIR is *24 or greater.⁶³⁰</p> <p>Aim to reduce recidivism by assisting to separate drinking from driving.</p> <p>Delivered through Corrective Services.</p> | <p>Reduced rate of recidivism for those who participated compared to a comparison group who did not participate in the program.⁶³¹</p> <p>Repeat offenders who lose their licence though a major alcohol-related offence are subject to a mandatory alcohol interlock program. This is imposed by the magistrate. If an offender does not enter or complete the interlock, the disqualification is for at least five years.</p> | <p><i>Crimes (Sentencing Procedure) Act 1999</i> (NSW) s 9, 12, Pt 8</p> <p><i>Road Transport Act 2013</i> (NSW) s 209, 211</p> |
| Queensland | Under the Limit (UTL) | Pre-conviction or post-sentence | <p>6-week program</p> <p>Imposed as part of probation order.</p> <p>Focuses on separation of drinking and driving and also aims to reduce alcohol consumption.</p> <p>If imposed as part of the sentence, the cost of the program is paid as part of or instead of a fine.</p> | <p>Reduce drink driving by 55% among high-risk serious offenders who complete the program.⁶³²</p> <p>Significant reduction in drink driving re-offence rates for multiple offenders completing the program compared with a comparison sample.⁶³³</p> | <p><i>Penalties and Sentences Act 1992</i> (Qld) Pt 5 Div 1 (Probation Orders)</p> |

⁶³⁰ Department of Justice, above n 374. LSIR is an assessment tool used to identify an offender's needs and risks in terms of recidivism.

⁶³¹ Mazurski, Withaneachi and Kelly, above n 145.

⁶³² V Siskind et al, 'The Impact of the "Under the Limit" Drink Driving Rehabilitation Program on Traffic Safety: An Outcome Evaluation of "Under the Limit"' (Australian Bureau of Transport, Report CR 186, 2000).

⁶³³ Sheehan et al, above n 185, 4.

Appendix A

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| ACT | Court Alcohol and Drug Assessment Service (CADAS) | Pre-sentencing and post-sentencing (can be a condition of a Good Behaviour Order) | <p>This can include counselling, residential rehab, pharmacotherapy, education, case management and supported accommodation.</p> <p>Also provides assessment and treatment for the Alcohol Interlock Program. Court must refer people to CADAS for assessment prior to sentencing if have been convicted of 2 or more alcohol-related disqualifying offences within the previous 5 years.⁶³⁴</p> <p>There is mandatory alcohol interlock for repeat offenders, who can apply for a probationary licence with an interlock after serving at least one half the period of disqualification. An offender cannot obtain a probationary licence unless they have complied with treatment, referral or monitoring required by the court.</p> | | <i>Crimes (Sentencing) Act 2005 (ACT) s 13 (Good Behaviour Orders)</i> |
| Western Australia | | | Driver interlock commenced October 2016. Mandatory for some drink drive offenders, including repeat drink drivers (on re-licensing) | | |
| South Australia | UR Choice | | <p>Mandatory for drivers aged 16–25 who have learner’s permit or provisional licence disqualified. Not drink driving specific.</p> <p>Mandatory for some drink drive offenders, including repeat drink drivers (on re-licensing).</p> | | |
| Northern Territory | Back on Track Program | Pre-licence reinstatement requirement | Also mandatory driver interlock for some drink drive offenders, including repeat drink drivers (on re-licensing). | Offenders with a BAC of .15% or more or multiple offences or had refused to supply a sample and had successfully completed the DDE course had a reoffending rate of 16%. ⁶³⁵ | |

⁶³⁴ Alcohol, Tobacco and Other Drug Association ACT, *Police and Court Drug Diversion Service (Alcohol and Drug Services, ACT Health)* <<http://directory.atoda.org.au/diversion-service-alcohol-and-drug-service/>>.

⁶³⁵ B Dwyer and A Bolton, ‘Dying for a Drink: Drink Driver Education as Part of the Northern Territory’s Response to Road Crashes involving Alcohol’ (Paper presented at Road Safety Conference – Research, Policing and Education, Wellington, NZ, 1998).

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|-------------|---------------------------------------|--|---|--|--|
| New Zealand | Alcohol and Other Drugs Court (Pilot) | Post plea of guilty/pre-sentence (uses bail) | <p>Aims to reduce reoffending, reduce alcohol use, reduce the use of imprisonment, positively impact on the defendant's health and wellbeing and be cost-effective.</p> <p>Time period between 12–18 months.</p> <p>Successful graduation is a significant mitigating factor.</p> <p>Eligible if charged with third or subsequent drink drive offence in aggravated form, AOD dependency and high-risk of reoffending.⁶³⁶</p> <p>Can also be issued with driver interlock licence sentence, a zero licence sentence or an indefinite disqualification.</p> | | |
|-------------|---------------------------------------|--|---|--|--|

⁶³⁶ See Gregg and Chetwin, above n 363.

Appendix B: TLRI/TILES study

The data were collected from the Magistrates Court of Tasmania 2008–9 to 2013–14 for the following offences:

- Drive under the influence of alcohol, *Road Safety (Alcohol and Drugs) Act 1970* (Tas) s 4
- Drive a motor vehicle while exceeding the prescribed alcohol limit, *Road Safety (Alcohol and Drugs) Act 1970* (Tas) s 6(1)
- driver not holding a licence with alcohol in body, *Road Safety (Alcohol and Drugs) Act 1970* (Tas) s 6(2)
- convicted within any 10-year period of three or more offences under the Act arising from at least three separate occasions, *Road Safety (Alcohol and Drugs) Act 1970* (Tas) s 6(3)

In this period, there were 21 222 finalised defendants with 730 who received an immediate custodial sentence (either a partial sentence or a determined term of imprisonment). There were 393 offenders who received a partially suspended term and 337 who received a sentence of imprisonment with a determined term.

In the 730 instances where a custodial sentence was received, the sentences were as follows:

| <i>Range of principal penalty</i> | <i>Imprisonment with partially suspended term</i> | <i>Imprisonment with determined term</i> |
|-----------------------------------|---|--|
| <3 months | 25 | 110 |
| 3 – < 6 months | 193 | 124 |
| 6 – <12 months | 147 | 71 |
| 12 – <18 months | 23 | 23 |
| 18 – <24 months | 3 | 7 |
| 24≥ | 2 | 2 |

This sample of offenders was intended to comprise 10% of drink drive offenders who were given a custodial sentence, either partially suspended or a determined term as identified from the CRIMES Department of Justice database. However, one of the cases included in the sample was sentenced in 2002 and was subsequently excluded from the study. This case involved a male, aged 40–44 who was sentenced in Hobart to imprisonment for ≥ 24 months.

Ten per cent of offenders were selected from each of the following sentence terms:

| Sentence terms | Number of offenders |
|-----------------------|----------------------------|
| < 3 months | 14 |
| 3 < 6 months | 34 |
| 6 < 12 months | 19 |
| 12 < 18 months | 4 |
| 18 < 24 months | 1 |

The sample was proportionally representative in terms of gender, age group and location:

Gender: Males = 63 Female = 9

Location: Hobart = 44

Launceston = 17

Devonport = 5

Burnie = 2

Other = 4 (Huonville, Smithton, St Helens, Wynyard)

Age group: 15–19 = 2

20–24 = 12

25–29 = 8

30–34 = 14

35–39 = 13

40–44 = 7

45–49 = 7

50–54 = 2

55–59 = 7

65+ = 2