Foundation for Alcohol Research & Education

Responding to the Problem of Recidivist Drink Drivers: Tasmania Law

August 2017

STOPPING HARM CAUSED BY ALCOHOL

About the Foundation for Alcohol Research and Education

The Foundation for Alcohol Research and Education (FARE) is an independent, not-for-profit organisation working to stop the harm caused by alcohol.

Alcohol harm in Australia is significant. More than 5,500 lives are lost every year and more than 157,000 people are hospitalised making alcohol one of our nation's greatest preventive health challenges.

For over a decade, FARE has been working with communities, governments, health professionals and police across the country to stop alcohol harms by supporting world-leading research, raising public awareness and advocating for changes to alcohol policy.

FARE is guided by the World Health Organization's (2010) *Global strategy to reduce the harmful use of alcohol* for stopping alcohol harms through population-based strategies, problem directed policies, and direct interventions.

If you would like to contribute to FARE's important work, call us on (02) 6122 8600 or email info@fare.org.au.

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Introduction

The Foundation for Alcohol Research and Education (FARE) welcomes the opportunity to make a submission to Issues paper no 23: *Responding to the Problem of Recidivist Drink Drivers* (Issues paper) released by the Tasmania Law Reform Institute (TLRI).

Drink driving is one of the main causes of road fatalities and injuries in Australia. Alcohol impairs judgement, reduces coordination, and affects decision-making ability. Between 20 and 30 per cent of drink drivers reoffend and disproportionately contribute to road trauma due to their repeat offending and high blood alcohol concentrations (BAC).[1]

In 2006, the cost to the community of a single fatal car crash was approximately $2.6 million, while the cost of hospitalisations was approximately $266,000 each.[2] Research from 2014 shows that 58 per cent of drivers report drinking and driving, and 72 per cent reported they had driven at least twice in the previous year after consuming alcohol.[3]

Recidivist drink drinking is not unique to Tasmania and responses that aim to address the issue have been trialled for some time. Since the early 2000s initiatives have been undertaken across the United States that target recidivist drink drivers, this includes the South Dakota Sobriety 24/7 project and the Hawaiian Opportunity Probation and Enforcement (HOPE) project. These projects are based on Swift, Certain and Fair (SCF) approaches. These aim to increase compliance with sentencing conditions by informing offenders that any breaches of conditions will be met with swift, certain and fair sanctions. The sanctions are made clear to offenders when they enter the program and these are applied evenly across similar offences/offenders. FARE has advocated for a project based on these models to be piloted within an Australian jurisdiction since 2014, it appears opportune that Tasmania could lead on this issue.

The effectiveness of any drink driving measures is the perception to drivers that their behaviour will be detected and that they will be sanctioned if they have committed an offence. The HOPE and South Dakota Sobriety 24/7 projects are good examples of this approach working.

Additionally, it is critical that the proposed court/list work closely with existing alcohol and drug (AOD) treatment services to ensure that referrals are made quickly, that reporting is optimised and that services are not overwhelmed by increased demand. Access to treatment, through the recidivist drink driving program, may act as a preventive health measure as there is an almost 20 year delay from the time someone develops an alcohol use disorder (AUD) to the time when they seek treatment in Australia.[4] That is two decades untreated. For those in their forties and fifties their drinking behaviour is a pattern that commenced in their early twenties and has continued over time. Intervening early in the course of an AUD can reduce the harm currently being experienced and prevent further harm from occurring. Treatment also improves health, improves psychological wellbeing, and community participation and decreases criminal behaviour.[5]

The Issues paper, prepared by TLRI, is a comprehensive body of work and thoroughly investigates the issue and responses available. FARE acknowledges this substantial work. While FARE has chosen to answer the questions from the Issues paper in groups, some questions are outside FARE's area of expertise and so comment has not be provided for these.

Evidence of need for a Driving While Intoxicated (DWI) court/list

1. **Do you consider that there are limitations in the current responses to the problem of repeat drink driving? If so, please outline your concerns.**
2. **Do you think that a DWI court/list should be established in Tasmania?**
3. **If you think a DWI court/list should be established in Tasmania, do you think that a preliminary pilot DWI court/list would be an appropriate approach to the establishment of the court/list.**

The research presented in the Issues paper outlines that there are sufficient number of cases for a DWI court or list to be established in Tasmania.

A preliminary pilot of two years appears to be an effective approach in establishing a DWI court/list. This should be evaluated to determine its effectiveness as well as any impacts on rates of imprisonment, results of drug and alcohol testings including numbers failed, numbers of breaches, information on further offences and other crimes such as property damage and family violence for example.

Pre- or post-sentence options for the DWI court/list

4. **If a problem-solving approach is adopted in Tasmania to recidivist drink-driving should it apply pre-sentence or post-sentence?**
5. **If it applies post-sentence, should it rely on an unactivated sentence of imprisonment (as with Court Mandated Drug (CMD)) or should the problem-solving approach operate by using conditions that can be attached to a community-based sentencing order (as with the Victorian model) or should both options be available?**
6. **If the order relies on an unactivated sentence of imprisonment, should the CMD order be expanded to allow for alcohol related offences (that is, should the DWI list be made part of the CMD order) or should a problem-solving approach to repeat drink-driving be established as a stand-alone DWI court/list (separate from CMD)?**
7. **Are there any issues you can foresee that arise from any of these approaches that will need to be addressed in the implementation of the model?**

Overall, the post-sentence option appears to be the strongest option to pursue. This means that the court imposes a sentence of imprisonment which is then not activated. Imprisonment is used as the ultimate sanction for non-compliance. Thus, the treatment of the activation of the prison sentence acts as a motivator to the offender. A table outlining the positives and negatives of each approach (pre- and post-sentence models) is include in Attachment A.

There are already examples operating in Tasmania that are post-sentence, as the Issues paper notes that the Court Mandated Drug (CMD) Diversion program operates as post-sentencing. In addition, the proposed Drink Disqualified Driver List in Victoria[6] would operate post-sentence and have community-based sanctions. These include conditions such as unpaid community work, supervision orders, non-association orders, residence restrictions, place or area exclusions, curfews, alcohol exclusions, treatment and rehabilitation and judicial monitoring. Rewards for progress and sanctions for non-compliance are proposed.

The need for legislative reform for a post-sentence option does not appear to be an insurmountable obstacle. The Issues paper notes that the Tasmania Government has expressed its commitment to sentencing reform and a key action of the *Tasmania Alcohol Action Framework* is 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" (Page 15).[7]

Post-sentencing also allows judges the ability to adopt swift, certain and fair approaches that have been successful in the South Dakota Sobriety 24/7 and HOPE projects. The swift and certain approach follows the argument that: *"If punishment is swift and certain, it need not be severe to be efficacious. If punishment is uncertain and delayed, it will not be efficacious even if it is severe".*[8]

Swift and certain sanctions create strong and predictable deterrents. Studies have found that there is a close relationship between the perceived risk of apprehension and self-willingness to engage in crime.[9] Justice projects that directly target alcohol-related offences through swift and certain punishment have been effective in reducing crime.[10] Furthermore, addressing the person's alcohol use is associated with marked improvements in other life outcomes that are often risk factors for family violence, such as improved financial situation, fewer legal problems, and higher participation in education and the workforce.[11] Swift and certain responses improve the perception that a sanction is fair and this in turn helps shape behaviour.[12,13]

Questions five and six are outside FARE's area of expertise, although there appears to be merit in having both options available to be able to use the unactivated sentence as well as conditions that can be attached to a community-based sentencing order. It also seems clear that the CMD should include alcohol-related offences.

Eligibility criteria for DWI court/list

8. **What type and level of recidivism should eligibility criteria stipulate? Should first time offenders be included? In what circumstances?**
9. **In this regard, should there be minimum and/or maximum limits for the number of offences committed?**
10. **Should the DWI court's jurisdiction include DWI-related death or serious personal injury cases?**

These questions are outside of FARE's area of expertise and therefore have not been answered.

Alcohol use disorders and comorbid conditions

11. **What severity of alcohol abuse should be stipulated by the eligibility criteria?**
12. **Should offenders with co-morbidity issues such as illicit drug dependence or mental health problems be eligible to participate in DWI court programs?**
13. **Should offenders with any particular criminal history be excluded, such as offenders with prior convictions for crimes involving personal violence?**

In terms of criteria to be eligible for the DWI court/list, the term 'alcohol abuse' no longer exists. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) published by the American Psychiatric Association in 2013 merged the two previous disorders (alcohol abuse and alcohol dependence) into a single disorder: alcohol use disorder (AUD) with mild, moderate, and severe sub-classifications.[14] The presence of at least two symptoms is an indication of an AUD. This classification of an AUD could be used as part of the eligibility criteria as it would encompass individuals with mild, moderate and severe AUDs. Appropriate treatment plans could then be developed based on the level of severity.

The original HOPE model began as a pilot to reduce probation violations by drug offenders and others at high risk of recidivism, under the high-intensity supervision of First Circuit Judge Steven Alm and local Probation Officers. [15] It targeted offenders at high risk of reoffending and those with a history of recidivism, particularly drug offenders but also including those with the most serious criminal histories and those that the system is committed to monitoring closely (for example sex offenders and family violence offenders). These participants were identified through risk assessment tools that looked at criminal history, substance abuse, family and marital relationships, personal companions, attitudes and employment. The model aimed to address the failure to comply with conditions, as well as the long delays in response to probation violations, where typically offenders would accumulate a long list of violations before action was taken.

Therefore, it appears from the information from the HOPE model that offenders with comorbid issues as well as those with convictions for crimes including personal violence should not be excluded from the DWI court/list.

Alcohol bans

14. Do you consider that an alcohol ban should be a mandatory condition for all offenders or for any particular type of order (for example, CMD/stand-alone drink-driving orders)?

15. Alternatively, do you consider that the court should have a discretion to impose an order to ban alcohol use if appropriate taking into account the vulnerabilities of the offender and his or her treatment requirements?

16. Do you agree that referrals to the DWI court could come from the prosecution, defence, Tasmania Police or magistrates?

FARE does not support that alcohol bans be a mandatory condition for all offenders. Alcohol bans should only be enacted where they are relevant to the offending behaviour. Alcohol bans require careful consideration, because for individuals with alcohol use disorders or alcohol dependence, an abrupt reduction in alcohol intake may result in alcohol withdrawal syndrome. This can be a life threatening condition.[16] People suffering from acute alcohol withdrawal, or those at high risk of developing acute alcohol withdrawal, should be admitted to hospital for medical care.[17]

In order to determine the relevance of alcohol to the offending behaviour, information about consumption and evidence of intoxication should be collected at the time of arrest. This data should be collected consistently for all offenders.

Alcohol bans may be appropriate if done in conjunction with alcohol-treatment programs. Referrals to treatment services need to be undertaken quickly and the candidate needs to be willing to attend. There also needs to be effective arrangements to coordinate responses between AOD services and the courts.

FARE agrees that referrals to the DWI court should be able to come from prosecution, defence, police or magistrates.

Impacts on treatment services in Tasmania

17. **Do you have any observations or comments to make in relation to the assessment process for eligibility and/or the eligibility criteria?**

18. **What issues arise in making existing services available to recidivist drink drivers as part of any DWI court program?**

19. **Are there any gaps in treatment and rehabilitation services currently available for recidivist drink drivers? Are they able to access treatment currently?**

20. **Do you agree that a phased approach for participants engaging in a DWI list is desirable?**

Treatment is an important part of any response to alcohol and other drug harm in the community. It has been proven effective in reducing the demand for alcohol and other drugs through decreasing consumption, improving health, reducing criminal behaviour, improving psychological wellbeing, and participation in the community.[18]

It is important that referrals to treatment are undertaken quickly. To be effective there needs to be arrangements in place to coordinate responses between AOD treatment services and the court.

A validated screening tool should be used to establish which participants may have an alcohol use disorder, this includes the Alcohol Use Disorders Identification Test (AUDIT) and the Clinical Institute Withdrawal Assessment for Alcohol – revised version (ClWA-Ar). These tests should be undertaken by appropriately qualified staff.

Unfortunately, the community sector as a whole is plagued by a struggle to meet demand, with an overwhelming majority (80 per cent) of sector services reporting that they were unable to meet demand. The largest gaps are in areas of the greatest need.[19] Over half (56 per cent) of services delivering AOD treatment are in the community sector. A key factor in insufficient service provision is the lack of adequate and sustained funding.

It is therefore possible that current alcohol and drug treatment services available in Tasmania will be overwhelmed by recidivist drink drivers referred to services. This in turn would increase the wait times for those wanting to use the service and make it harder for people to access treatment. Treatment services need to be appropriately resourced to ensure that this does not occur.

An investigation should be undertaken to identify the potential gaps in services currently available, the wait times and options for overcoming these. The pilot of the recidivist drink driving court should not go ahead until these issues are examined and corrected.

A phased approach for participants entering the DWI list seems logical and appropriate.

Compliance with conditions and sanctions

21. **Should an offender who makes progress in complying with the order be able to obtain a driver's licence or a restricted licence subject to an interlock condition?**

22. **Do you have any other suggestions for sanctions/rewards that may be appropriately applied to offenders for compliance or non-compliance with the program?**

The HOPE model offers suggestions on reductions in sanctions that can be studied for the Tasmanian situation. When an individual enters the HOPE program they are assigned a colour, which requires them to call the hotline each morning and appear at the probation office before 2pm (if their colour

has been selected). In the first two months, a probationer is randomly tested for alcohol and drugs six times per month. After these two months they are assigned a new colour. This new colour, depending on their testing results and whether they have complied with their set conditions, is associated with less regular alcohol and drug testing. This process allows the probationer to easily recognise their progress through the system and how well they are complying with what is expected from them.

Other modifications and lessening of sanctions include (noting these have not yet been formally evaluated):

1. Early termination and early discharge:

    → for those demonstrating a history of compliance, up to three years can removed from their sentence.

2. Technical violations, with no aggravating circumstances:

    → probationers who have been compliant for a long time can be granted a non-jail sanction, meaning instead of jail they spend the day in the courthouse cell block.

3. The most common violations no longer receive an escalation of sanctions:

    → probationers are spared from the accumulation of sanctions and the negative impacts these had; and this was found to work against behaviour change goals and rehabilitation.[20]

It may also be worth investigating and trialling the ability for an offender to regain a driver's licence and/or having a restricted licence subject to interlock fitting. This would enable those who require a driver's licence in their occupation to continue their employment.

However, caution needs to be applied as studies from the United States found that re-arrest rates increase once interlock devices are removed.[21] Offenders who sit out the interlock period by having their licence suspended should be required to undertake a screening and brief intervention program and, if hazardous or harmful alcohol use is indicated, they should be referred to evidence-based treatment. These offenders should also be required to undertake education and rehabilitation programs to support efforts to achieve a sustained change in their drinking and driving behaviour.[22]

The duration of the performance period could be scaled up in accordance with the BAC reading at the time of the offence. For example, offenders with a BAC of 0.10-0.149 could be required to complete a performance period of a minimum of six months, whereas an offender who had a BAC reading of 0.15 and above could be required to complete a minimum performance period of 12 months.

Should participants reoffend once they have completed the program, they should lose their licence and be required to undertake treatment for their alcohol use and be referred to other services where appropriate. The reinstatement of their licence should only occur after a minimum of two years has passed and they have completed alcohol and any other treatment required.

Additionally, ignition interlock may not be feasible for all vehicles, and drink driving regulations should refer to driving or operating any vehicle whether boat, car, motorbike or bicycle. Like road safety, maritime safety should be considered a public health issue. In Tasmania, you are required to carry a boat licence to drive a vessel and must have a blood alcohol limit of less than 0.05 and 0.00 for a commercial vessel. [23] The type of vehicle may need to be considered by TLRI.

Alcohol monitoring

23. How should an alcohol ban be monitored? For example, do you consider that the use of a Secure Continuous Remote Monitor (SCRAM) bracelet is desirable? Should random testing be utilised and if so, how frequently might this occur and/or in what circumstances? What problems do you foresee in relation to monitoring alcohol use and how might these problems be solved?

Secure Continuous Remote Alcohol Monitoring (SCRAM technology) is effective in monitoring an individual's alcohol consumption but it will not assess and understand the reasons why that person is drinking. This, therefore, does not address therapeutic principles that are recommended in the Issues paper. Additionally, it does not address the reasons why an individual may be using alcohol and/or other drugs and the impact this is making on their lives including repeat drink driving and other offences.

A criticism of programs like HOPE is that the focus is on reducing recidivism and compliance with conditions rather than rehabilitation or treatment. However, the 2016 evaluation outlines that treatment and rehabilitation feature heavily within HOPE. Offenders can be triaged to the drug court, they can request a referral to treatment at any time and those with multiple violations may be mandated to intensive treatment. Therefore a continuum of court supervision now exists, and includes:

1. Routine probation (no random drug testing)

2. HOPE probation (for those not performing under routine probation)

3. Drug Court (reserved for those in need of more-intensive services or at risk of failing HOPE).

The evaluation outlines the differences between HOPE and drug courts are the role of the judge and the role of treatment stating:

> *In a drug court, probationers appear regularly before the judge for status hearings. Under HOPE, probationers appear before a judge (or hearings officer, in some implementations) only if they have violated a term of their probation. This has significant implications for caseloads and costs. The intensive judicial supervision in drug courts constrains the caseloads drug court judges can manage. Under HOPE, probationers appear before a judge only in response to violations. As a consequence, a dedicated HOPE court could manage multiple thousands of probationers (the HOPE court in Honolulu currently oversees approximately 2200 HOPE probationers, with one nearly full-time and one part-time judge, and is anticipated to oversee 3000 HOPE probationers when operating at scale), whereas the typical drug court has a smaller capacity (typically fewer than 100 cases). HOPE does not mandate formal treatment for every participant. Rather, HOPE relies on the results of regular random drug testing and probationer requests for treatment referrals to indicate treatment need. Probationers who are able to remain drug free on their own are not required to enter a drug treatment program, reserving intensive service provision (intensive outpatient or residential treatment) for those who do need help. (Page 19)*

Randomised alcohol and other drug testing should occur. Research from the HOPE program and HOPE-like programs identify random testing as an essential element.[24] This is because the onus is on the on offender to remain alcohol and drug free. This testing is part of the 'fair' approach of the SCF techniques, in that it is applied fairly to all offenders. From the literature, the binary nature of these conditions appears to be important in ensuring compliance.

Over time HOPE and other similar programs have included other binary conditions have been added such as the failure to attend counselling appointments, court appearances or hearings, failure to attend behaviour management programs, failure to attend or complete AOD treatment services. Failure to do these things should result in swift, certain and fair sanctions being applied.

Evaluation

24. Do you agree that comprehensive evaluation needs to be built into any model adopted in Tasmania?

It is important that comprehensive evaluation is built into the model. The collection and reporting mechanism should be determined before the pilot commences. It is vital that data is collected in a consistent and meaningful way.

The information and data collected should be made publicly available to allow governments, not-for-profits and researchers to measure effectiveness. This also allows for comparison with other jurisdictions. Follow up research should be undertaken to assess the effectiveness of the DWI court/list and outcomes for the offender population over time.

Attachment A: Comparison of pre- and post-sentence models

Pre-sentence model	Post-sentence model
Overview: • sentence is deferred until the offender completes programs • uses bail provisions to direct offenders to complete relevant programs • aims to address the underlying cause of the offending and is informed by principles of therapeutic jurisprudence.	**Overview:** • sentence is suspended until offender completes programs • uses sentencing conditions to direct offenders to complete relevant programs • allows for a hierarchy of sentencing options to address repeat drink drivers and application of SCF principles.
Positives: • does not require legislative change to implement • aims to address the underlying cause of offending and is informed by principles of therapeutic jurisprudence • presents an opportunity to intervene early in a potential career of offending • the offender is likely to comply with orders to avoid a custodial sentence, offenders are also more likely to develop positive relationships with the court and participate in programs in an attempt to influence their sentence or avoid custody • breaches do not result in formal sanctions; this allows for more flexibility in response and recognises that relapse for alcohol and drug use is common.	**Positives:** • the sentencing conditions and obligations are proportionate to the offence committed • the sentencing conditions reflect the coercive nature of order: such as the need to attend and complete treatment, and be subjected to monitoring • allows flexibility in judicial sentencing in that conditions – such as adding or removing programs, the frequency of treatment, and degree of supervision – may vary and change over time • similar models exist in other states and the Tasmanian Sentencing Advisory Council recommends that the Court Mandated Diversion (CMD) Drug Treatment Order include alcohol as well as illicit drugs.
Negatives: • described as an inappropriate use of bail. Bail principles are the right to liberty and presumption of innocence; therefore, undertaking regular court appearances, alcohol and drug treatment, random drug testing are more appropriate as conditions of a sentence • failure may result in harsher sentences as failure to comply is an additional offence resulting in further punishment • the actual sentence is unknown until the end of the deferral period; this can be a deterrent to compliance • courts are unable to impose short periods of imprisonment for breaches as the offender has not yet been sentenced.	**Negatives:** • requires legislative change, however the Government has committed to sentencing reform and new sentencing options • uses suspended sentence which the Government has committed to abolishing • does not encourage positive relationship with court: a pre-sentence model encourages an offender to develop positive relationships with the court, as they feel they have influence over the final sentence • offers little flexibility as sanctions are formal in nature • participants can be reluctant to engage with treatment orders, as they do not associate themselves with being 'drug users'.

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