DRUG AND ALCOHOL NURSES OF AUSTRALASIA CONFERENCE
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"ESTABLISHMENT OF DRUG COURTS"

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It is a great honour for me to have been asked to speak to such a distinguished gathering this afternoon, especially to spruik a topic close to my heart: the establishment of special court proceedings to deal with criminal offenders who are dependent on alcohol or other drugs.

This meeting is, of course, being held on the lands of the Ngunnawal and Ngambri peoples, the Traditional Owners of the lands, who have never ceded sovereignty over them. I pay my respects to their Elders; past, present and emerging. I welcome all Aboriginal and Torres Strait Islander people here present. I commit myself to personal acts of reconciliation.

As you have heard, I am currently a retired judge of the ACT Supreme Court but returned to duty to supervise the Drug and Alcohol Sentencing List, which is, in effect, our version of a Drug Court as many of you would know it. I have a long history of involvement in drug rehabilitation groups, including being, for 20 years, the Chair of the Board of one.

I think that it is useful to start with some context on the origins of abused drugs and hope that it will help. Many of you will know the history of heroin. With the banning of opium in the 19th Century, the principal illegal drug in Australia earlier last century was heroin, as well as cannabis. Heroin was first synthesised by the acetylising of morphine in 1874 by an English chemist, but it was only commercialised in 1898 after a Chemist employed by Bayer, a German pharmaceutical company, independently synthesised it. Bayer then started the commercial production of heroin, marketing it as a substitute for morphine and as a cough syrup. Ironically, it was introduced to avoid the dependence on morphine and advertised as "non-addictive". How wrong that was! Further irony is found in the fact that the name "heroin" was based on the German word "heroisch" meaning "heroic, strong". The birth of heroin shares some similarity with cocaine, which also gained its popularity after it became a prescribed medicine.

Soon, the downside of heroin and other drugs became clear and, in 1914, America restricted its use to medical practitioners prescribing it as a treatment for addiction, but then, in 1924, banned it altogether. Other countries were slower to follow - Australia in 1953 and the UK in the 1960's.

I can recall my father, an obstetrician and gynaecologist before he became a medical administrator, telling my siblings and I how he prescribed heroin to help women in childbirth; he felt that, for this purpose, it was a great drug.

Though it did become a recreational drug, its use was more limited in Australia until

the Vietnam War exponentially increased its use. It has been said that 20% of US servicemen subsequently identified themselves as heroin addicts. I have not been able to find any statistics of the Australian situation.

Its prohibition, and the prohibition of other drugs, led to many people finding themselves in court, either for illegal possession, use, sale or manufacture of drugs or for the offences they committed as a result of their dependency, mainly offences of dishonesty. Though some could continue to work while using drugs, especially cocaine, many could not and so, to feed their habit, had to resort to criminality of dishonesty offences.

The criminalisation of drug addicts was, in large part, because the response to the negative social effects of drug abuse was a criminal justice one. Thus, President Nixon announced a "War on Drugs" in 1971, emphasising that "drug abuse" was public enemy number one. Australia followed suit, though without actually declaring war! The war was conducted primarily with prohibition, interdiction of production and supply and more severe penalties for producers, traffickers and consumers.

Even then, however, health practitioners with expertise in this area were concerned about the criminal justice prism through which drug use was seen, rather than, as they preferred, as a medical or public health issue. Nevertheless, while most of the war was conducted by police and criminal courts, medical and health practitioners supported organisations which flourished to try and help to heal the issue in a way that the criminal justice system did not.

Apart from cannabis, and some use of MDMA/Ecstasy; steroids (among exercise enthusiasts); and LSD; the major drug of dependence other than heroin was then methylamphetamine. It was synthesised in 1873 by a Japanese chemist and became very popular during World War II to keep the troops awake. It reached epidemic proportions in America, but its use did not really become popular in Australia until the 1990's. Because of its properties, it widened the range of offences committed by users from generally being offences of dishonesty, committed by heroin users, to introducing more aggressive and violent offences.

In Australia, the problems created by the dependency on illegal recreational drugs really became significant in the late 1970's and early 1980's.

Courts began experimenting with alternatives. They could see the problems that the criminal justice system was creating - the merry-go-round of the same offenders appearing time and time again, with imprisonment having little effect. It was obvious traditional, punitive custodial methods were not addressing the underlying cause of drug dependency.

I was heavily involved with a number of judicial officers, in the late 1970's and 1980's, in using a method which had been approved by the High Court. The Court would defer the sentence of an offender while they underwent drug rehabilitation in a residential facility, with the promise that no jail time or a lesser sentence will be imposed on successful completion. It was a rudimentary version of the Drug Court, though at that time, we did not really know much about such an innovation.

There began to be recognition, however, that the issue was really a public health problem. Thus, in 1985, the National Campaign against Drug Abuse (now the National Drug Strategy) adopted a policy of harm minimisation, with three objectives: demand reduction; supply reduction; and harm reduction. There was some movement in the courts at or before this time. For example, New South Wales created a diversion program as early as in 1977, though I can find little information about it.

The ACT has been very active in this space and followed up with various programs over the years. It did introduce, in the late 1970's or early 1980's, a methadone maintenance program at the then Woden Valley Hospital. Then, in 1992, it followed South Australia in creating "on the spot fines", that is expiation notices, called Simple Cannabis Offence Notices, which allowed payment of a fine to avoid charges in court. Later, in 2000, it created the Court Alcohol and Drug Assessment Service (CADAS), which is a pre-sentencing assessment and post-sentence treatment option. In 2001, a Police Early Intervention and Diversion Scheme was introduced to allow offenders to avoid charges if they submitted to rehabilitation. In 2011, a Youth Alcohol and Drug Court was created within the Children's Court, but as a pre-sentence option, though it includes some judicial supervision as well as treatment.

Despite this activity, the ACT did not similarly establish a Drug Court like NSW did in February, 1999, which was the first in Australia. We were quite slow, compared to the growth of Drug Courts in the USA. The first Drug Court was established there in 1977 in New York, but it was part of the more severe approach then being enacted in that State. The establishment of the first Drug Court as we know them was in 1989 in Dade County, Florida. It is now estimated that there are over 4,000 Drug Courts in America.

As you will know, Australia now has a Drug Court in all the mainland States. Our immediate past Chief Justice, Helen Murrell, was appointed here from the District Court of New South Wales, where she had been the first Drug Court judge. As a result, she established a task force in the ACT in 2017, headed by Justice Burns, to look at the establishment of a Drug Court here. The task force included a wide variety of stakeholders, health officials, corrections services officers, police, lawyers, court administrators and policy officers. It consulted widely and visited a number of Drug Courts, producing a report a year or so later, which recommended the establishment of such a Court, as well as some useful indicators of how this could be done.

Unlike any other Australian Drug Court, however, the ACT did not establish a Drug Court, but established a program and list within the Supreme Court. It is fair to say that, in the ACT, where there is no intermediate court, like the District Courts and County Court of the mainland States, the Supreme Court does have jurisdiction over many offences that, in those jurisdictions, would normally be dealt with by the intermediate court. Nevertheless, the process here is somewhat different from the other courts, the first being that it is not a separate court and a list within the Supreme Court. Here, the process is called the Drug and Alcohol Sentencing List,

hence with the apparently sexy title of “DASL”, bringing some “razzle DASL” to the Supreme Court. The DASL was established by change in legislation in 2019 and the first participants entered the program in December 2019.

The first judge was an Acting Judge of the Supreme Court, actually until then the Chief Magistrate, Lorraine Walker, who was appointed to establish the List and who created many of the procedures and protocols. As an interim, a judge was then appointed from the resident judges of the Supreme Court until I was appointed, also an Acting Judge of the Supreme Court, from 1 July 2020.

The program has some interesting differences from other Drug Courts. For example, any judge of the Court can make a Treatment Order and can, theoretically, preside over the supervision of that Order. However, in practice, while judges of the Court other than the List judge do make Treatment Orders, it is logistically impossible for them then to engage in the relevant supervision. Thus, when they make the Order, they refer the matter into the List for the judge in charge, currently myself, to exercise the supervision.

A further issue is that, while there a number of the indictable offences for which a Treatment Order can be made, most offences are often dealt with in the Magistrates Court which is unable to make a Treatment Order and, accordingly, more offenders are committed to the Supreme Court so as to access the Treatment Order.

There are other differences in the operation of the List from those of most of the Drug Courts elsewhere in Australia. These include that the List here:

(a) includes offenders dependent on alcohol, as well as illicit drugs, though the Queensland Drug and Alcohol Court also does;

(b) includes offenders who are convicted of offences of violence;

(c) serves a far smaller caseload than courts in other jurisdictions. Currently, including a couple of “inactive cases”, where orders have been made but the offender has absconded, there are presently only 35 participants in the program; and

(d) Canberra Health Services plays a leading role in case management, with the support of ACT Corrective Services, whereas, in many other jurisdictions, the court or correctional services manage supervision and compliance with support from the health team.

This last point is important, for the contribution of the two perspectives, the therapeutic view from the health team members and the criminal justice perspective from the corrections members, provides a very helpful and dynamic discussion in the regular conferences that precede the also regular court reviews of the participants. The two perspectives are, however, by no means inconsistent or contrary to each other, but the diversity in views allows for a more informed approach and is both unique and valuable.

In addition, the involvement of clinical personnel can be very important. While often

lawyers think that they have a monopoly of running a criminal justice system, the clinicians can provide an immensely important perspective - and information - that is highly relevant and important. While the List does not have a permanent nurse in its team, its first Co-ordinator was one and helpfully made her information known on relevant issues. She has recently been working on assessing prospective participants and provided a helpful in-service lecture on urinalysis.

Of course, the establishment of the List was a significant undertaking as the whole structure had to be created in an environment using the invaluable learning of other courts, as well as refashioning these models to address the particular situation of the program. Further, of course, while some counselling was provided from within the government's health services, outside providers had to be contracted to provide both residential and community based programs. We were fortunate in Canberra, where we had a thriving ATODA sector, with a wide range of active, established and enthusiastic services.

While our program is still quite small, unexpectedly the number of residential treatment options for which contracts had been let was insufficient for the demand. This may well have been a function of the wider range of offences for which an offender was eligible for a Treatment Order to be made and the fact that offenders from both the Magistrates Court and the Supreme Court could be referred into the program.

Then, the protocols and structure for operation had to be created in the birth of the List to ensure that the principles of Drug Courts could be best achieved. This also required a culture shift, especially in the conduct of the lawyers, whose adversarial approach had to be abandoned for a more collegial approach, at least in the conduct of the regular review of participant's progress. Indeed, it has, interestingly, led to some more sceptical opinions from defence lawyers and some more lenient approaches of prosecutors in the confidential conference from time to time. The key element of a Drug Court is that, using a non-adversarial approach, prosecution and defence counsel promote public safety while protecting participants' due process rights. Here, this has been met and, in my view, exceeded.

One of the important aspects of this approach is the opportunity for the participant to interact directly with the judge and not have, in effect, to speak through his or her lawyer. One participant described the best thing about the program as "being able to talk to the judge. When you've got a lawyer in court, but you've got to do the talking for yourself. I think it's really good to get up there and be able to talk. Gives you those skills to be able to communicate properly".

Despite this, one of the huge problems of the List is the challenges that it creates in being a court, but, in a sense, not a court. Thus, the regular judicial reviews of the progress of participants are conducted with much informality. This can be problematic when controversy arises. Ordinarily, disputes in court are resolved with formal evidence that is given under oath or affirmation. This is inappropriate at the regular informal reviews. Thus, information in relevant updates on the participants is provided from case managers (both health and corrections officers), police and others at the confidential conference before the Court opens. This can be, for

example, about association with anti-social persons. But given the informal channels information is received through, it causes an issue of what to do if the participant states the information is wrong.

A simple and common situation arises in relation to the really important issue of urinalysis testing, which is a critical mechanism to ensure the integrity of the program. One of the key components of the Drug Court is that abstinence is monitored by frequent testing. Thus, when a urinalysis test comes back positive for illicit drugs or alcohol the question arises: what to do when the participant denies using such substances? We do know that urinalysis is not 100% accurate. The first thing we do is send the sample for confirmatory testing to a pathology laboratory. If it then comes back with a confirmed positive result for unapproved substances, but the participant denies taking any, it still presents a problem. You can imagine the range of excuses: it is left over from drugs I admitted taking 10 days ago and I have not used since; it must have been in some medication or food I am consuming; my drink was spiked; I was with some drug users and I must have ingested the smoke passively while they were using drugs (especially for cannabis, but even methamphetamine, which can be smoked). I have even had one participant suggest that he drank out of a drug user's glass after the user had drunk out of it.

Despite the unlikelihood of the validity of most of such excuses, how a court resolves this issue without calling expert evidence (possibly from both sides) that the drug does not stay in the system for that long (except, of course, cannabis, which last for about 4 weeks or possibly more), or that medication or food does not result in a positive result, or you cannot passively ingest a sufficient amount of drug to produce a positive result is a big issue. We do not have the time or resources to engage in such fact-finding exercises. A blanket refusal to accept any such issues, especially where there could be some truth (e.g. drink spiking) would not comply with the requirement for individualised justice.

It is true that urinalysis is not the only indicia of return to (or continuation of) drug use and that other matters, such as behaviour on presentation for appointments, or evading testing for apparently good, but not always justified, reasons will build a picture of confirmation, but we still have the difficult issue of denial. Yet, of course, it would be unworkable if any denial were to be regarded as sufficient to prevent an appropriate decision to be made about such an issue.

We have now made it clear that the breach of obligation is when the urinalysis test is positive: that is, the participant is expected not only to cease taking alcohol or other drugs but also to avoid situations where he or she can be exposed to drug use indirectly (to the extent that this could affect the test) or to avoid situations where drink spiking or other contamination could occur.

Similarly, the problem also arises from a test showing low levels of creatinine, which is some evidence of flushing in order to dilute the urine evidence of drug use. While drinking before the test is a way to assist in being able to urinate, which some people find a problem, there are others (like having a running tap nearby or pressure on the coccyx). Nevertheless, we do not want people not to drink, but low levels of creatinine do show much more than just a few glasses of water before the test.

Thus, we are moving towards holding that a sufficiently low creatinine level will be counted as positive test unless a medical report is provided showing that some other explanation, such as problems with kidney function, is or is very likely to be the cause.

Two other areas of concern may be of interest here. A really big problem for the program is homelessness. Some Drug Courts make having a permanent residence a precondition to entry to the program. I have resisted this, as it seems to me to be discriminatory in an unacceptable way. Nevertheless, it can be a major challenge. Of course, when the program begins with residential drug rehabilitation, there is no immediate problem, but the transition at the end of that program can then be problematic. Fortunately, two of the residential facilities have transition arrangements, but that is also a temporary solution as that becomes unavailable and, on graduation, it would be a waste of the program for the graduate to be returned to homelessness, which creates high risks of returning to crime, if not alcohol or other drug use.

The other area is mental health. We have, fortunately, long moved beyond the problems the mental health and drug sectors had about co-morbidity, where one would not deal with the other and vice versa, which left many people in difficulties. Many such participants have trauma and other mental health issues in their background, which may indeed have been causal to drug addiction. While supports for participants to address such mental health issues is provided, it is not central to the offerings available. Nevertheless, an increased availability of support for these issues is also important. Another key component of Drug Courts is to integrate alcohol and other drug treatment services with justice system case processing. This is an area of need and current debate.

It has been very helpful that, despite its youth, the List has been the subject of two evaluations: an interim evaluation and a full final report. I am delighted to say that, of the ten key components of a Drug Court, the List has completely achieved four; mostly achieved four others; and partly achieved two. While that shows we can do better, this is a score card of which I think the team can be justly proud, given the short time we have had to settle in and show what can be done.

Acting Justice Richard Refshauge