Victorian Alcohol and Drug Association
211 Victoria Parade, Collingwood 3066
p. 03 9412 5600 f. 03 9416 2085
vaada@vaada.org.au
www.vaada.org.au
ABN 19 039 293 679

9 December 2022

Sentencing Advisory Council
e. contact@sentencingcouncil.vic.gov.au

Sentencing Deferrals

The Victorian Alcohol and Drug Association (VAADA) welcomes the opportunity to contribute to this consultation.

As peak body for the Victorian alcohol and other drug (AOD) sector, we are acutely aware of the entrenched systemic flaws evident with the justice system, generating excessive yet in many cases preventable harm through imprisonment.

Beyond the growing human cost, in both preventable victimization and the exacerbation of vulnerabilities through repeated incarceration, the financial burden of imprisonment is competing with resourcing for services which are more effective at reducing offending. The system as it stands applies resources to punish people while providing little at the front or back end of the sentence. The dire consequences of this neglect are surging recidivism rates and increasing harm to the community, including those imprisoned.

There is a dire need for systemic reform across the correctional system, which includes the development and enhancement of pragmatic evidence informed innovations to address the vulnerabilities which contribute to offending.

We will not be commenting on the sentencing aspect of the consultation. We will reflect on the current challenges with AOD support for people in the correctional system and how this aligns with a potential further enhancement of sentencing deferrals. Please see our response to a relevant selection of the questions in the *Consultation Paper* below.

2. What, if any, are the current barriers to using sentence deferrals in appropriate cases? What changes would you propose to overcome those barriers, and why?

From the perspective of the AOD service system, limitations in sector capacity amounting to increasing wait times for treatment are a barrier to sentencing deferrals where AOD is a priority.

During the pandemic, AOD treatment agencies across the state were surveyed by VAADA on matters relating to wait times and the length of queues for AOD treatment.

These surveys were administered in September 2020 and January, July and December 2021 to funded AOD treatment providers across the state.

The number of people waiting for treatment on any given day for AOD treatment increased from 2345 (September 2020) to 4088 (December 2021), amounting to a 71% increase in waitlist length during the pandemic.

The mean and median wait times for most funded AOD treatment types increased through 2021, with residential services acutely impacted due to the social distancing aspects of the COVID-19

restrictions. State wide data indicates that capacity in residential AOD services contracted by approximately 20% during the restrictions. At the start of 2022, during the omicron wave, a number of residential withdrawal services had to temporarily close down due to COVID-19 infected staff, service users and/or people in isolation.

In addition to these stressors, the pandemic led to increased AOD related harm, especially alcohol related, with the impact of the pandemic likely to continue to increase demand for AOD treatment.

More recently, preliminary data obtained through a recent survey of AOD agencies indicates that there has been an uptick in the number of agencies putting funded AOD program waitlists temporarily on hold, effectively closing the waitlist so people cannot access that program. This occurs when demand reaches peak levels, and agencies do not have the capacity to support those waiting for treatment due to the sheer number of people in the queue.

These data indicating increasing sector capacity challenges during the pandemic heightens the pre-existing acute demand issues that predated COVID-19. Research indicates that there are approximately 500,000 Australians who, each year, are not accessing AOD treatment despite having clinical need across Australia[1].

These tensions in sector capacity amidst escalating demand must be considered when reflecting on any programmatic reform which will generate greater demand for AOD treatment services. The architects of such reform must be cognizant of current wait times and how this will sit within an expanding sentence deferral program.

We note from the *Consultation Paper* that drug offences as the principal offence account for only 9% of deferral cases and note that any expansion would potentially increase this ratio. We note also that many offences involving AOD, either as a primary or secondary offence, are non violent and often involve a range of vulnerabilities. We note that there are a number of populations which, for various reasons, do not engage with the voluntary AOD sector and often have their first engagement in with the forensic system. Prioritising means of engaging these populations to minimise their interaction with the justice system, whether through deferred sentences or other means such as diversion, should need to be progressed.

We recommend that system planning activities be undertaken to forecast the potential demand implications of increasing the scope of sentence deferrals to ensure that service access is not further limited for existing voluntary and forensic clients, or those who may have AOD support being a factor in a deferred sentence.

4. Are there reforms that could be made to sentence deferrals that could reduce the disproportionate effect of the criminal justice system on marginalised groups? If so, what reforms would you propose, and why

AOD treatment provides a return on investment through reducing future AOD related harms including law and order issues and associated interventions and acute health issues at a rate of $7 for every dollar spent[2]. Greater returns of up to $27 can be achieved through various harm

[1] Ritter, A, Chalmers, J & Gomez, M. 2019. Drug Treatment: The Application of an Australian Population-Based Planning Model. Jan; Sup 18:42-50. doi: 10.15288

[2] National Institute on Drug Abuse. 2018. Principles of Drug Treatment: a reach based guide.

reduction measures[3], many which are hobbled through justice interventions and the continuing criminalization of various substances.

Increasing of sentencing deferrals to enable greater access to AOD treatment and allow that to impact upon the disposition of a potential sentence is a worthwhile consideration. However, it needs to be acknowledged that people are not always in an ideal situation to benefit from treatment. They may be at a stage in their life where trauma and compounding factors, including anxieties relating to justice interventions, are counterproductive to attaining a positive approach to engaging in treatment. People in this situation should not be unduly penalized for not being 'treatment ready'. This also speaks broadly to the efficacy of justice related therapeutic interventions as well as the broader principles of deterrence, which, for some people who are not ready to engage in treatment, may not be effective in achieving recovery and therefore reducing the likelihood of re-offending. People should not be penalized for failing to take full advantage of a deferred sentence or by otherwise not being able to capitalize on all available interventions.

We note the *Consultation Paper* which reflects on the need to account for the arduous nature of some of the interventions which may be triggered through a deferred sentence and that the effort and imposition of these interventions should be given weight at sentencing.

We note also that legal process can generate further anxiety and the provision of a deferred sentence needs to be weighed up against the benefits of concluding the matter sooner.

5. Should the current legislative purposes of sentence deferral in section 83A(1A) of the Sentencing Act 1991 (Vic) be amended? If so, what changes would you recommend, and why?

There is a pressing need for an explicit statement ensuring that the treatment and means to reduce harm relating to AOD dependence is noted as a protected attribute and prioritised throughout the sentencing process. There should be no delays or hurdles with regard to access opioid replacement therapy and neither should there be any restrictions or penalties on accessing lifesaving health services such as the Medically Supervised Injecting Room. Saving lives should be the key priority.

8. Is there scope to increase or improve the use of judicial monitoring during sentence deferrals? If so, how?

The backlog in Court cases is indicative of the need to ensure that the judicial members are not hindered unnecessarily. However, programs such as the Drug Court, which have intensive judicial oversight, have some success on a range of fronts relating to positive outcomes for the participant and the broader community. We note however, that the Drug Court is available in cases where there is a guilty plea and therefore presents different circumstances to situations availing a deferred sentence.

It may be preferable if therapeutic supports were options for certain candidates of a deferred sentence. The nature and role of this support would need further investigation, but should not result in a punitive overlay to their supervision.

[3] National Centre in HIV epidemiology and clinical research. 20019. Return on investment 2: evaluating the cost-effectiveness of needle and syringe programs in Australia 2009. Department of Health and Ageing.

10. Are there any improvements that could be made to the availability of support services and programs for people whose sentence has been deferred? If so, what do you propose, and why?

We have earlier highlighted the capacity and demand challenges facing the AOD treatment sector that adversely impact service user access. We have noted that in some cases the demand is so acute that services have to temporarily put their waitlists on hold, effectively closing access to the program until they can manage existing demand.

Irrespective of the legislative and regulatory structure of deferred sentences, people should not be adversely penalised for being unable to access an overburdened system.

Any meaningful change to the application of deferred sentencing which impacts the AOD treatment system should generate additional capacity to meet demand. This raises a broader issue with regard to workforce recruitment, where currently agencies report that recruitment and retention of suitably skilled AOD workers is a priority challenge. This is further exacerbated by the pending growth in the mental health sector, which will likely see many skilled AOD workers transition to the mental health sector, that will likely be viewed as more secure with better remuneration and greater career advancement opportunities. Innovations such as sentence deferrals need to account for the future planning of tomorrow's AOD workforce.

11. Should offenders receive a written deferral plan outlining what they have agreed to do during the deferral period, and the potential consequences of not engaging positively with those requirements?

Any deferral plan should account for the nature of AOD dependency, where relapse is common and most people will have to engage support multiple times before reaching their recovery goals. Punishing people for failing to adhere to a plan which has an expectation of abstinence is setting people up to fail.

13. To what extent should the requirements imposed on an offender during a sentence deferral be taken into account at sentencing?

We have made some comment on this issue in question 10 and 11 above. People should not be penalised for not succeeding in a therapeutic AOD related program given AOD dependency is a chronic relapsing condition. We note that favourable outcomes achieved through engagement with support services should have weighting, as this would improve the prospects of rehabilitation and reduced the likelihood of reoffending.

14. If an offender has engaged positively with the conditions of their deferral, should rehabilitation become the primary purpose of sentencing?

Rehabilitation is the most cost effective way to achieve community safety. Rehabilitation leads to a reduction in offending behaviour and greater social inclusion and community involvement from people released from prison. Rehabilitation often involves successfully linking people into support services, improving or repairing family issues and increasing engagement in education and/or employment.

Sentencing should seek to prioritise rehabilitation and in doing so, ensure that people have access to the supports necessary to have the best chance to achieve that goal.

Sentencing deferrals, accompanied by accessible services, would assist many people and reduce community risk going forward. With positive achievements throughout the deferred sentence noted in the sentencing disposition, sentencing deferrals may be part of the broader solution in addressing the critical and enduring failures of our justice system.

Thank you for the opportunity to contribute to this consultation.

Should you have any queries, please contact Dave Taylor on dtaylor@vaada.org.au