UNSW SYDNEY | Australia's Global University

Mandatory alcohol and drug treatment: What is it and does it work?

Thu Vuong, Alison Ritter, Caitlin Hughes, Marian Shanahan, Liz Barrett

Bulletin No. 27 — March 2019

Drug Policy Modelling Program,
Social Policy Research Centre, UNSW Sydney

http://doi.org/10.26190/5cc258e2a385c

Background

Mandatory (or compulsory) treatment is a tool often reached for by governments during moments of alcohol and/or illicit drug crises. It has come to the fore as a potential policy panacea in recent times in response to ongoing concern about the rise of crystal methamphetamine ("ice") use, regional concerns over alcohol abuse, and the desire to address alcohol and other drug (AOD) problems in young people.

However, in public debate there is a significant lack of clarity about what mandatory treatment is, who benefits from it, and how it might be implemented. In addition, there is confusion about the existing evidence-base and the extent to which mandatory treatment is an effective and cost-effective approach for people with AOD problems.

The aim of this bulletin is to:

1. Provide an overview of the various models of mandatory treatment currently used in Australia and internationally
2. Summarise the evidence base for each of these models
3. Assess the relative merits of the different types of mandatory treatment models, especially their effectiveness in addressing AOD problems.

What is mandatory treatment?

AOD treatment is the provision of services and supports to enable someone to reduce or cease problematic AOD use. The main forms of treatment include withdrawal, psycho-social counselling and support, residential rehabilitation, and pharmacotherapy maintenance. AOD treatment also includes one or more elements of case management, continuing care, and holistic attention to the person's health, social and psychological needs.

Mandatory treatment compels someone to treatment through one of two mechanisms:

1. Involuntary treatment: where the individual has no choice or say in the matter
2. Coerced treatment (sometimes referred to as forced choice): where individuals can choose between a criminal justice sanction and a treatment program, as a means to obtain a lesser criminal justice sanction.

There is considerable variety in the ways in which mandatory treatment is implemented both in Australia and internationally, with substantial differences in the target group, the levels of legal coercion, and whether consent needs to be given [1, 2]. Referral pathways and treatment options correspondingly vary.

Both in Australia and internationally, models of mandatory treatment broadly fall into 5 categories (explored in greater detail in table 1):

1. Court-mandated treatment
2. Drug courts
3. Compulsory prison-based treatment
4. Civil commitment
5. Centre-based compulsory rehabilitation (specific to East and Southeast Asian countries).

In Australia, referrals to all except one of the models are through the criminal justice system.[1] Compulsory prison-based treatment, court-mandated treatment and drug courts all target people who have committed criminal offences that are either directly due to drug use (e.g. drink driving, drug dealing) or are indirectly related, including offences committed to support substance use (e.g. burglary), or crimes committed under the influence (e.g. assault). These interventions primarily seek to reduce reoffending, as well as eliminate problematic AOD use.

In Australia, civil commitment is the only referral pathway into mandatory treatment for people with AOD problems outside of the justice system. It is only an option for people who are assessed as being at extreme risk of harming themselves or others, and whose decision-making capacity is considered to be compromised due to substance use. Civil commitment interventions are relatively short (generally between 7 and 28 days) and seek to ameliorate immediate and significant harm.

1 There are a number of non-mandatory programs in the Australian justice system (e.g. family courts and police diversion) where referrals to AOD education or a one-off AOD assessment and/or brief intervention may be provided. See [3] for more detail.

There are no mandatory systems currently operating in Australia that compel someone with AOD problems into treatment if significant and immediate harm (such as loss of life) is not present, and if they are not in contact with the justice system. One previous model, the Alcohol Mandatory Treatment Program (AMTP) in the Northern Territory (NT), was discontinued due to high costs with no discernible program outcomes.

Internationally, models that compel treatment for illicit drug use only (i.e. where there are no other associated crimes or harms) are known as centre-based compulsory rehabilitation. However, they are subject to fierce criticism over concerns that such systems impinge on civil liberties and human rights, and they constitute a punitive rather than treatment-based approach to drug use and people who use drugs.

Why mandatory (rather than voluntary) systems of treatment are used

Systems of mandatory treatment may be an appealing option in order to spread the benefit of AOD treatment (i.e. cessation or reduced use and reductions in related harm) to people who may be unable or unwilling to address their AOD problems. Given high costs to society of substance use including human suffering and negative impacts on health and wellbeing [4], addressing AOD use is seen to have broader benefits beyond the individual. For some, crime is a particular concern given the well-documented link between AOD problems and criminal behaviours [5–7].

Mandatory treatment is not without controversy however, with such programs raising a number of ethical and motivational concerns including how much the state should impose on civil liberties [8] and whether individuals need to both recognise their problem and want treatment for the treatment to be successful [9]. In addition, a wealth of health research raises the undeniable link between problematic AOD use and broader social determinants of health, such as poverty, trauma and abuse. This raises questions of how and if treatments need to address underlying drivers of AOD use if they are to be successful in the long term [10].

Table 1 Models of mandatory AOD treatment

Type	Description	Program jurisdictions	Target group/ eligibility	Target outcomes	Program details
Coerced treatment models					
Court-mandated treatment	Court-mandated treatment programs are usually designed to respond to offenders brought before the courts on minor drug or drug-related matters, (covering an assortment of offences, but typically property, driving and fraud offences) that are related to their drug use.	Operates across all states and territories in Australia.	People who have committed minor drug or drug-related criminal offences and have a recognisable drug problem.	Reduced reoffending Reduced drug use and related harm	The typical court mandated program in Australia is 3–6 months. Treatment can be community-based or residential, albeit most have a strong emphasis upon counselling. Most are pre-plea and conducted while an offender is on bail.
Drug courts	Drug courts are specialised courts that only deal with offenders who have entrenched histories of offending (usually serious offending), drug dependencies (often polydrug use), and who face imprisonment if they do not comply with program orders.	Drug Courts are located in NSW, VIC, SA, QLD and WA. The ACT has committed to establishing a new Drug and Alcohol Court in 2019.	People who have committed criminal offences serious enough to warrant imprisonment, which are deemed to be caused by underlying drug dependency/ies.	Reduce drug dependency Promote re-integration into community Reduced reoffending	A drug court is a 12–24-month program involving a dedicated judicial officer or magistrate appointed specifically to hear drug-related matters and a broader support team involving a clinical nurse, police, legal aid and others. Treatment offered can be community or residential-based. Drug courts regularly screen for AOD use and may also require electronic monitoring and home detention. They also provide services that seek to target broader health and social needs e.g. employment services.
Involuntary treatment models					
Compulsory prison-based treatment	Compulsory prison-based treatment programs are rare internationally. Most existing prison-based AOD treatments in Australia, England, Wales, Canada and New Zealand are all voluntary, albeit with negative consequences attached to failure to attend.	NSW only: The NSW Compulsory Drug Treatment Program (CDTP).	Repeat drug-related male offenders.	Cessation of drug use Reduced reoffending	The CDTP allows the NSW Drug Court to order sentenced, repeat, drug-related offenders to the Compulsory Drug Treatment Correctional Centre (CDTCC) – a purpose built complex – for comprehensive drug treatment and rehabilitation. The model of drug treatment and rehabilitation is abstinence-based, and the treatment is clearly compulsory – there is no consent and no appeal. The program includes at least 6 months closed detention and 6 months semi-detention.

Type	Description	Program jurisdictions	Target group/ eligibility	Target outcomes	Program details
Civil commitment (involuntary treatment detention due to harm to self/others)	Civil commitment is often imposed compulsorily on people who are heavily dependent on alcohol and/ or drugs where this is necessary as a matter of urgency, to prevent them harming themselves and/or other people.	Civil commitment legislation for substance dependence exists in NSW, VIC, TAS and the NT. At time of writing WA and SA are actively considering legislation.	People with severe substance dependence who are at risk of serious harm and whose decision-making capacity is considered to be compromised due to their substance use.	Removal of risk of harm Improved psycho-social wellbeing	Detention and treatment lengths vary between jurisdiction but are generally short-term (between 7 and 28 days). Referrals can generally be through a variety of people (e.g. family member). Assessments are undertaken by an accredited medical practitioner, with admission usually then approved by a court. Generally considered an option of last resort.
Centre-based compulsory rehabilitation in East and Southeast Asian countries	In many East and Southeast Asian countries, people who use illicit drugs (who are not necessarily dependent on drugs) can be compelled to be detained in a compulsory rehabilitation centre for up to two years, without either consent or due process.	Not applicable to Australia. This approach is common in 9 countries in East and Southeast Asia: Cambodia, China, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Thailand, and Vietnam.	People who use illicit drugs.	Reduced drug use in population as a whole	Rehabilitation is abstinence-focused. The approaches adopted are unsupported by scientific evidence: forced labour work or shaming, and harsh physical punishment for individuals who relapse. The objective is to provide a punitive approach to scare people from using illicit drugs again and to deter people from trying illicit drugs in the first place.

Research findings on the effectiveness of mandatory treatment schemes

Drawing on high-quality research, evaluations and seminal papers with a focus on Australian studies, the evidence on the effectiveness of mandatory treatment schemes was examined. A summary of this research is available in Appendix A. The findings are:

1. **There is limited research that directly tests the effectiveness of mandatory treatment in reducing AOD use or dependence in the long-term (i.e. after the life of the treatment program)**

In the short-term and while a participant in the program, evidence, particularly from coerced treatment programs (court-mandated programs and drug courts), shows some reduced AOD use and/or dependence [11–14].

2. **There are significant gaps in the research on the effectiveness of civil commitment programs**

It is impossible to draw conclusions on the impact of civil commitment models in Australia as there is little reliable evidence of the effectiveness of this treatment approach. There is a much greater volume of research and more robust research on the coerced treatment models associated with the criminal justice system.

3. **Evidence has shown some success in all coerced models at reducing reoffending, particularly drug courts, but this success is variable from program to program**

As models of coerced treatment are all attached to the criminal justice system in Australia, the focus of research is primarily on reduced reoffending. Level of engagement was found to be a critical success factor in this regard, with studies of drug courts and court-mandated treatment finding people who finish the treatment programs were more likely to not reoffend [11, 14–19]. The biggest predictor of program retention and success was the level and quality of social supports provided such as housing, education and healthcare access [20]. Drug court programs were more likely to provide these supports than other criminal justice models.

4. **Coerced treatment models were found to be cost effective, involuntary treatment programs were not**

Although limited, there was some evidence that court-mandated treatment and drug courts are cost effective interventions, with savings accruing where they are successful in avoiding or reducing a prison sentence, and/or when broader measures like reduced reoffending are taken into consideration [21–23]. By comparison, it has been argued that NSW's compulsory prison-based program and the former Alcohol Mandatory Treatment Program in the NT are both costly interventions with no accompanying evidence that the programs achieved their aims [8, 24].

5. **Centre-based rehabilitation programs that seek to address problematic AOD use without adjacent criminal offences or risk of significant and immediate harm have little supporting evidence and stray into complex moral territory**

Evaluations of international models of centre-based compulsory rehabilitation found that drug use was likely to increase after program release [25]. They have also been heavily criticised by international organisations for human rights abuses [26, 27]. Although the one Australian example (AMTP) had a radically different framework, civil liberties concerns were raised about the program, including the racially discriminatory nature of its application; and the program was not successful in reducing AOD use [24].

Appendix A: Summary of research on mandatory AOD treatment programs

Court-mandated treatment

Australia has a long history of employing court-mandated treatment programs in all states and territories, albeit with much program diversity [3]. While there have been many process evaluations conducted on these programs, outcome evaluations have been more limited, with 10 outcome evaluations on court-mandated treatment programs from seven Australian states and territories (of which one was a national evaluation) [15, 16, 21, 22, 28–31]. It is important to note that while all 10 outcome evaluations measured changes in reoffending (i.e. impact on criminal behaviours), only two evaluations measured changes in drug use.

Of the available evidence on program impact of drug use, the findings are mixed. An evaluation of the Pre-sentence Opportunity Program (POP) in Western Australia (WA) found that while on the program, participants reduced their drug use across most drug categories. However, no conclusions could be drawn about the longer-term success of the program in reducing drug use due to high attrition rates and lack of participants available for post-program follow-up [11].

An evaluation of the Magistrates Early Referral into Treatment program (MERIT) in New South Wales (NSW) found significant reductions in self-reported drug use, including polydrug use, among participants who had completed the program. However, decreases in the use of heroin and methamphetamine were also related to significant increases in the use of cannabis [11]. Evaluators also noted significant improvements in respondents' social functioning and health status, with improvements in psychological health more pronounced than physical health [21].

Evidence on re-offending rates are also ambiguous. Some studies found no difference in the offending rates of program completers and non-program completers, while others have found that program completion is significantly associated with lower levels of offending following program commencement [11]. The NSW MERIT evaluation by the Bureau of Crime Statistics and Research (BOCSAR) for example, found completion of MERIT significantly reduced the number of defendants committing any offence by 12 percentage points [15]. A more recent study found that MERIT participation had no significant effect on the likelihood of reconviction within 12 months, but those completing the program were 50 percent less likely to re-offend within one-year [16].

Two evaluations (NSW and WA) found that court-mandated programs can save money in the criminal justice sector, particularly in terms of reduced sentences given to program completers [21, 22]. Savings also resulted from reductions in reoffending and hospitalisations. E.g. MERIT in NSW produced an estimate of an annual net benefit of $16,622 per program completer in 2003 [11].

Drug courts

There has been sustained interest in and a number of evaluations of Australian drug courts [17]. This includes 12 outcome evaluations conducted in five Australian states and territories (NSW, Queensland, South Australia, Victoria and WA) from the period 2002 to 2014 [13, 14, 18, 19, 30–37]. One of these evaluated the Youth Drug and Alcohol Court in NSW [14], while the remainder evaluated adult courts.[2]

2 The Crime Research Centre included juveniles in its offending and cost benefit analysis but no separate results for juveniles were presented [30].

The most common outcome measured in drug court evaluations was reoffending, with strong evidence that drug courts programs are successful in reducing reoffending rates. A review of 12 experimental or quasi-experimental impact evaluations of Australian drug courts found that drug courts reduce the incidence of reoffending, as well as the frequency and the seriousness of subsequent offending, more than conventional sanctions [17].

Remaining engaged in, and successful completion of a drug courts program was a significant factor in reducing drug-related reoffending, and deemed to be a reliable indication that the program was meeting its objective of reducing drug-related offending in both youth and adult models [14, 18, 19]. A systematic review of international drug court programs found that the average reoffending rate among youth program participants (43.5%) is lower than those of non-participants (50%) [38].

One of the biggest predictors of program retention and program success is the extent to which programs are adequately resourced to meet other underlying needs of the offenders, including access to housing, financial services and financial counselling, mental health and dental care, employment and education services. This is one reason that many Australian drug courts now purchase housing for use by drug court clients [20].

Where drug use was measured (five evaluations) results were generally positive, with most showing some level of use decline (e.g. in frequency) during program participation [12-14], although there was some evidence of substitution effects (an increase in cannabis use) in one evaluation [13]. None of the evaluations measured long-term drug use in participants, so it is unclear whether the benefits of any drug court programs are sustained [20].

Some drug court evaluations have shown positive impacts on health status, social functioning and, in some cases, employment [11]. Evaluation of the NSW Drug Court showed there were improvements in mental health, physical health, general health and reductions in bodily pain [12]. However, the NSW Youth Drug Court evaluation was more mixed and found an increase in the level of unemployment among program participants over time ,and a slight decrease in participants' physical and mental health status [14].[3]

Four evaluations (2 of NSW, 1 of Victoria and 1 of WA) assessed cost and benefits of drug courts in Australia. The most rigorous study found that while drug courts might be more expensive than traditional court processes, overall, they were more cost effective when outcomes such as reduced reoffending were taken into account [23].

Compulsory prison-based treatment programs

NSW is the only Australian jurisdiction that is currently implementing a compulsory prison-based drug treatment program (the Compulsory Drug Treatment Program - CDTP). An evaluation of the program was undertaken in 2008 predominantly relying on participant interviews and urine samples of people in the first three stages of the program (during which time they are detained in a purpose-built facility[4]) [39]. The evaluation found it was difficult to draw any conclusions about the overall effectiveness of the CDTP due to a lack of comparison group. However, conclusions that were drawn include:

3 The study did note that at the time of program commencement, the majority of respondents indicated that their health was excellent, very good or good.

4 The Compulsory Drug Treatment Correctional Centre (CDTCC)

- Although the majority (95.7%) of drug tests conducted during the study were classified as 'non-prescribed drug free', illegal and non-prescribed drugs were detected in at least one of the drug tests for the majority of participants
- 80 of the 95 participants (84%) perceived their admission to the Program as voluntary despite the mandatory nature of the program. This, along with positive comments from the participants, led evaluators to believe that offenders in the program genuinely wanted to change their behaviour
- Significant improvements were found for outcome measures of mental and physical health.

CDTP is reportedly a costly intervention, based on budget figures from NSW of $6 million funding from 2005 to 2007, and capital costs of $3.5 million [40]. Strict eligibility criteria mean that few qualify for the program [8], potentially explaining why the minimum security facility that houses the program had not been at full capacity in the four years to 2013 [40].

Accordingly, it has been argued that the CDTP is a very expensive approach that "will only have a minimal impact on overall recidivism and crime in the community even if it has a substantial impact on participants' drug use and recidivism" [8]. No official costing and cost-effectiveness work has been done [41].

Civil commitment

While there is an existing literature in relation to civil commitment for mental health reasons [42–44], it is much more limited in the case of AOD civil commitment programs. Program reviews have consistently reported the lack of research on civil commitment in non-offender populations, with conclusions often largely drawn from expert opinions, stakeholder interviews, case studies, and anecdotal reports [45, 46]. Based on the results from these reviews, there is no reliable evidence to date of the effectiveness of this treatment approach.

Published research on active AOD civil commitment programs in Australia (in Victoria, NSW and Tasmania) is not yet available. However, practitioners within the NSW Involuntary Drug and Alcohol (IDAT) program have reported that at 6-month post-treatment, relapse to previous levels of drinking occurred in 11 patients (27.5%); five (12.5%) were lost to follow-up; 13 (32.5%) were abstinent and seven (17.5%) continued to drink alcohol but at a reduced amount and frequency [47]. Death was reported for four patients (10%). This work was based on a small sample (n=40 patients), and without a comparison group.

Unlike programs in Victoria (VIC) and NSW, the discontinued Alcohol Mandatory Treatment Program (AMTP) in the NT did not target those at immediate risk of severe harm. Instead, the program provided for the mandatory commitment into treatment of individuals who had been taken into protective custody for public intoxication more than three times over a two-month period, and who had committed no other crimes.

The only evaluation of this program by PricewaterhouseCoopers (PWC) found there was no statistically significant difference between those who had been in the program and those who had not in terms of hospital admissions, and that "most" participants were re-apprehended "multiple times" by NT police upon leaving the program [24]. Lack of data hampered a thorough evaluation of cost effectiveness, but PWC felt that program costs of approximately $18m/year were high, especially given the lack of discernible outcomes.

PWC found that the program did provide short-term health benefits associated with the comprehensive assessment of people who entered the AMTP, such as providing

access to dental care. However, the evaluation found that most people in the program were significantly disadvantaged and experiencing a range of complex issues, including homelessness, trauma, economic marginalisation, racism and discrimination. Ninety-seven percent of people admitted into the program identified as Indigenous, which PWC noted led to external criticism of the program being racially discriminatory [24].

PWC concluded that policies and programs that seek to address problematic alcohol consumption are most likely to be successful if they seek to address causal factors, including the social determinants of health [24].

Centre-based rehabilitation (CBR) (East and South East Asia)

In a number of East and Southeast Asian countries, compulsory treatment mostly consists of residential, long-term and abstinence-based treatment in facilities that resemble prisons, located in remote areas. In countries such as China, Vietnam, Thailand, Malaysia, Cambodia, Laos, Myanmar and the Philippines, it is still the most dominant approach in dealing with people who use illicit drugs [26]. CBR is processed through an administrative order for illicit drug use behaviours, rather than a legal order through the criminal justice system designed for drug-related offenders, as is the case in most developed countries.

The 'rehabilitation' strategies in compulsory centres focus mainly on moral teaching, basic health care services, 'cold turkey' detoxification, and forced labour work (in the belief that labour work will directly aid in drug dependency treatment, for example, by sweating out toxins) [26]. People who use drugs who have broken the law (by using illicit drugs) can be compelled to be detained in a compulsory rehabilitation centre for up to two years without either consent or due process [1, 48].

There have been two published evaluations of this approach. Wegman et al. [25] found that opioid-dependent individuals in compulsory rehabilitation centres in Malaysia are significantly more likely to relapse to opioid use after release, and sooner, than those treated with evidence-based treatments such as methadone. Vuong et al. [49] found that compared to compulsory rehabilitation, community-based voluntary methadone treatment in Vietnam is both less expensive and more effective in achieving drug-free days.

International observers have expressed significant concerns with these programs, including their use of forced labour, shaming and harsh physical punishment [26, 27]. Many commentators have criticised the approach of CBR and questioned the legitimacy of calling it 'treatment', suggesting the term 'detention' should be a more appropriate term [50–53].

References

1. Pritchard, E. K., Mugavin, J., & Swan, A. J. (2007). *Compulsory treatment in Australia: a discussion paper on the compulsory treatment of individuals dependent on alcohol and/or other drugs*. Canberra: Australian National Council on Drugs.
2. Stevens, A., Berto, D., Heckmann, W., Kerschl, V., Oeuvray, K., Ooyen van, M., Steffan, E., & Uchtenhagen, A. (2005) Quasi-Compulsory Treatment of Drug Dependent Offenders: An International Literature Review, *Substance Use & Misuse, 40*(3), 269–283. doi: 10.1081/JA-200049159
3. Hughes, C., & Ritter, A. (2008). *A summary of diversion programs for drug and drug-related offenders in Australia*. Sydney: National Drug and Alcohol Research Centre.
4. Collins, D. J., & Lapsley, H. M. (2008). *The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05*. Canberra: Commonwealth of Australia.
5. Ross, J., Teesson, M., Darke, S., Lynskey, M., Ali, R., Ritter, A., & Cooke, R. (2005). The characteristics of heroin users entering treatment: findings from the Australian treatment outcome study (ATOS). *Drug and Alcohol Review, 24*(5), 411–418. doi: 10.1080/09595230500286039
6. Kosten, T. (2002). Commentary: Commitment for substance abuse-current judicial interventions. *Journal of the American Academy of Psychiatry and the Law, 30*(1), 46–48.
7. Anglin, M.D., & Speckart, G. (1986). Narcotics use, property crime, and dealing: Structural dynamics across the addiction career. *Journal of Quantitative Criminology, 2*(4), 355–375.
8. Hall, W., Lucke, J., & Wales, N. S. (2010). *Legally coerced treatment for drug using offenders: ethical and policy issues*. Sydney: NSW Bureau of Crime Statistics and Research.
9. DiClemente, C. C., Bellino, L. E., & Neavins T. M. (1999). Motivation for change and alcoholism treatment. *Alcohol Research & Health, 23*(2), 86–92.
10. Spooner, C., & Hetherington, K. (2005). *Social determinants of drug use*. Sydney: National Drug and Alcohol Research Centre.
11. Wundersitz, J. (2007). *Criminal justice responses to drug and drug-related offending: are they working?* Canberra: Australian Institute of Criminology.
12. Freeman, K. (2002). *New South Wales Drug Court Evaluation: Health, Well-Being and Participant Satisfaction*. Sydney: NSW Bureau of Crime Statistics and Research.
13. Alberti, S., King, J., Hales, J., & Swan, A. (2004). *Court Diversion Program Evaluation: Overview Report & Final Report*. Victoria BC: Health Outcomes International and Turning Point Alcohol and Drug Centre.
14. Eardley, T., McNab, J., Fisher. K., Kozlina, S., Eccles, J., & Flick, M. (2004). *Evaluation of the New South Wales Youth Drug Court Pilot Program*. Sydney: Social Policy Research Centre, University of New South Wales.
15. Lulham, R. (2009). Magistrates Early Referral Into Treatment Program: Impact of program participation on re-offending by defendants with a drug use problem. *The BOCSAR NSW Crime and Justice Bulletins*, *131,* 20.
16. McSweeney, T., Hughes, C. E., & Ritter, A. (2015). Tackling 'drug-related' crime: Are there merits in diverting drug-misusing defendants to treatment? Findings from an Australian case study. *Australian & New Zealand Journal of Criminology, 49*(2), 198–220.
17. Kornhauser, R. (2018). The effectiveness of Australia's drug courts. *Australian & New Zealand Journal of Criminology. 51*(1), 76–98.
18. Lind, B., Weatherburn, D., Chen, S., Shanahan, M., Lancsar, E., Haas, M., & De Abreu Lourenco, R. (2002). *New South Wales Drug Court Evaluation: Cost-effectiveness*. Sydney: NSW Bureau of Crime Statistics and Research.
19. Weatherburn, D. (2008). NSW Drug Court: A re-evaluation of its effectiveness. *The BOCSAR NSW Crime and Justice Bulletins, 121*, 16.
20. Hughes, C. & Shanahan, M. (2019). Drug courts in Australia. In Collins, J., & Agnew-Pauley, W. (Eds.), *Beyond drug courts - International lessons* (pp. 21–50). London: London School of Economics.
21. Passey, M. (Ed.). (2003). *Evaluation of the Lismore MERIT Pilot Program - Final Report.* Sydney: NSW Attorney General's Department.
22. Crime Research Centre. (2007). *WA diversion program - evaluation framework (POP/STIR/IDP): final report and summary report.* Perth: Western Australia Drug and Alcohol Office.
23. Shanahan, M., Lancsar, E., Haas, M., Lind, B., Weatherburn, D., & Chen, S. (2004). Cost-Effectiveness Analysis of the New South Wales Adult Drug Court Program. *Evaluation Review, 28*(1), 3–27. doi: 10.1177/0193841X03257531
24. PricewaterhouseCoopers Indigenous Consulting Pty Limited. (2017). *Evaluation of the Alcohol Mandatory Treatment Program*. Sydney: Northern Territory Department of Health.

25. Wegman, M. P., Altice, F. L., Kaur, S., Rajandaran, V., Osornprasop, S., Wilson, D., Wilson, D.P., & Kamarulzaman, A. (2017). Relapse to opioid use in opioid-dependent individuals released from compulsory drug detention centres compared with those from voluntary methadone treatment centres in Malaysia: a two-arm, prospective observational study. *The Lancet Global Health, 5*(2), e198–e207.
26. Amon, J., Pearshouse, R., & Cohen, J. (2013). Compulsory drug detention centers in China, Cambodia, Vietnam, and Laos: Health and human rights abuses. *Health and Human Rights, 15*(2), 124-137.
27. Pearshouse, R. (2009). Compulsory drug treatment in Thailand: Observations on the N*arcotic Addict Rehabilitation Act B.E. 2545 (2002)*. Toronto: Canadian HIV/AIDS Legal Network.
28. Health Outcomes International (2002). *Evaluation of Council of Australian Governments' Initiatives on Illicit Drugs*. South Australia: Health Outcomes International.
29. Heale P., & Lang, E. (1999). *Court Referral and Evaluation for Drug Intervention and Treatment (CREDIT): Final Evaluation Report.* Melbourne: Turning Point Alcohol and Drug Centre.
30. Crime Research Centre (2003). *Evaluation of the Perth Drug Court Pilot Project*. Perth: University of Western Australia.
31. Department of the Attorney General (2006). *A Review of the Perth Drug Court*. Perth: Government of Western Australia.
32. Makkai, T. & Veraar, K. (2003). *Final Report on the South East Queensland Drug Court*. Canberra: Australian Institute of Criminology.
33. Payne, J. (2005). *Final report on the North Queensland Drug Court*. Canberra: Australian Institute of Criminology.
34. Payne, J. (2008). *The Queensland Drug Court: a recidivism study of the first 100 graduates*. Canberra: Australian Institute of Criminology.
35. Ziersch, E. & Marshall, J. (2012). *The South Australian Drug Court: A Recidivism Study*. Adelaide: Attorney-General's Department of South Australia.
36. King, J. & Hales, J. (2004). *Cost-effectiveness study: Victorian Drug Court*. Melbourne: Health Outcomes International Pty Ltd.
37. KPMG. (2014). *Evaluation of the Drug Court of Victoria: Final Report*. Victoria: Magistrates' Court of Victoria.
38. Mitchell, O., Wilson, D. B., Eggers, A., & MacKenzie, D. L. (2012). Assessing the effectiveness of drug courts on recidivism: A meta-analytic review of traditional and non-traditional drug courts. *Journal of Criminal Justice, 40*(1), 60–71.
39. NSW Bureau of Crimes Statistics and Research. (2008). *NSW Compulsory Drug Treatment Program*.
40. Corrective Services NSW. (2013). *Review of the Compulsory Drug Treatment Program and the Compulsory Drug Treatment Correctional Centre pursuant to the Crimes (Administration of Sentences) Act 1999*. Sydney: Department of Attorney General and Justice.
41. Bradfield, R. (2017). *Mandatory treatment for alcohol and drug affected offenders: Research Paper No.2*. Tasmania: Sentencing Advisory Council.
42. Monahan, J., Hoge, S. K., Lidz, C., Roth, L. H., Bennett, N., Gardner, W., & Mulvey, E. (1995). Coercion and commitment: understanding involuntary mental hospital admission. *International Journal of Law and Psychiatry, 18*(3), 249–263.
43. Kjellin, L. & Westrin, C. G. (1998). Involuntary admissions and coercive measures in psychiatric care: Registered and reported. *International Journal of Law and Psychiatry, 21*(1), 31–42.
44. Olsen, D.P. (2003). Influence and coercion: relational and rights-based ethical approaches to forced psychiatric treatment. *Journal of Psychiatric and Mental Health Nursing, 10*(6), 705–712.
45. Broadstock, M., Brinson, D., & Weston, A. (2008). The effectiveness of compulsory, residential treatment of chronic alcohol or drug addiction in non-offenders. Christchurch: Health Services Assessment Collaboration (HSAC).
46. Werb, D., Kamarulzaman, A., Meacham, M. C., Rafful, C., Fischer, B., Strathdee, S. A., & Wood, E. (2016). The effectiveness of compulsory drug treatment: A systematic review. *International Journal of Drug Policy, 28*, 1–9.
47. Dore, G., Sinclair, B., & Murray, R. (2016). Treatment Resistant and Resistant to Treatment? Evaluation of 40 Alcohol Dependent Patients Admitted for Involuntary Treatment. *Alcohol and Alcoholism, 51*(3), 291–295.
48. International Drug Policy Consortium. (2014). Compulsory rehabilitation in Latin America: an unethical, inhumane and ineffective practice. London: International Drug Policy Consortium (IDPC).

49. Vuong, T., Shanahan, M., Nguyen, N., Le, G., Ali, R., Pham, K., Vuong, T. T., Dinh, T., & Ritter, A. (2016). Cost-effectiveness of center-based compulsory rehabilitation compared to community-based voluntary methadone maintenance treatment in Hai Phong City, Vietnam. *Drug & Alcohol Dependence, 168*, 147–155.
50. Hall, W., Babor, T., Edwards, G., Laranjeira, R., Marsden, J., Miller, P., Obot, I., Petry, N., Thamarangsi, T., & West, R. (2012). Compulsory detention, forced detoxification and enforced labour are not ethically acceptable or effective ways to treat addiction. *Addiction, 107*(11), 1891–1893.
51. International Harm Reduction Development Program. (2010). *Detention as treatment: detention of methamphetamine users in Cambodia, Laos and Thailand*. New York: Open Society Institute.
52. Human Rights Watch. (2010). *'Skin on the cable': The illegal arrest, arbitrary detention and torture of people who use drugs in Cambodia*. New York: Human Rights Watch.
53. Juergens, R. & Csete, J. (2012). In the name of treatment: Ending abuses in compulsory drug detention centers. *Addiction, 107*(4), 689–691.

Acknowledgements:

We are grateful for the assistance of A/Prof Jason Payne as an independent reviewer of an earlier draft. Any errors, omissions are our own.

Citation:

Vuong, T., Ritter, A., Hughes, C., Shanahan, M. & Barrett, L. (2019) Mandatory alcohol and drug treatment: What is it and does it work? *DPMP Bulletin No. 27*. http://doi.org/10.26190/5cc258e2a385c