The ethics and effectiveness of coerced treatment of drug users.

Paper to be presented at the EU-China Human Rights Dialogue, 6-7 September 2011, Beijing.

Alex Stevens, PhD
Professor in Criminal Justice
University of Kent
September 2011

This paper addresses the issues of ethics and effectiveness in coerced treatment for drug users[1]. It is based on the existing evidence on coerced treatment [2-8], as well as on considerations of the ethics of such treatment [e.g. 1, 9, 10-12] and my own research on quasi-compulsory treatment in Europe [13-19].

The issue of effectiveness is secondary to the issue of ethics. If a treatment is unethical, it cannot be justified even if it is effective in meeting a certain aim. So this paper will focus on ethics before effectiveness. Before addressing these issues, it is necessary to clarify terms and principles. We can classify two forms of coerced treatment. And we can - for the purposes of this paper at least - classify three types of drug user.

Classifications

There are two types of coerced treatment. The first occurs when drug users are ordered into treatment with no opportunity to provide informed consent to such treatment. This will be called compulsory treatment. The second type occurs when drug users are given a choice of going to treatment or facing a penal sanction that is justified on the basis of crimes for which they have (or may be) convicted. This will be called quasi-compulsory treatment (QCT).

The first of the three types of drug user includes people who use drugs but who have not

[1] The paper focuses on the coercion that is used in encouraging drug users to enter treatment, and not on forms of coercion and punishment that are used *within* treatment. The use of coercion and punishment within treatment is fundamentally unethical, as has been highlighted by the United Nations special rapporteur on the right to the highest attainable standard of health [1].

committed other crimes and do not meet diagnostic criteria for drug dependence[2] ('non-problematic drug users'). This group includes the majority of people who use illicit drugs. Most of them will discontinue drug use without any need for treatment. Only a very small minority will go on to need treatment to help them give up drugs, or to reduce the harm that their drug use does. The second type is made up of people who use drugs and who meet diagnostic criteria for dependence ('dependent drug users'). Some - but not all [21-23] - of these people will need treatment to help them recover from dependence. The third group is constituted by dependent drug users who have committed other crimes that would attract penal sanctions ('drug dependent offenders'). These people are probably responsible for a large proportion of the social and economic harms that are associated with drug use [24]. They are considered deserving of punishment for the crimes that they have committed and may also be likely to benefit from treatment for drug dependence.

Principles

The purpose of making these necessarily but usefully simplistic classifications is to enable more precise discussion of ethics and effectiveness, as both issues vary across types of coercion and drug user. Before applying them to the ethics and effectiveness of treatment, we need also to specify what we mean by these terms. For this paper, treatment will mean any intervention by medical staff, a therapist or other practitioner that is intended to improve the health of the person with whom this practitioner is in contact. Ethical treatment will be considered to be treatment which complies with both international human rights law and leading codes of medical ethics (e.g. the UN *Principles of Medical Ethics* [25] and the World Medical Association's *International Code of Medical Ethics* [26]). These principles have been applied to drug treatment in a joint publication of the United Nations Office on Drugs and Crime (UNODC) and the World Health Organization [27][3]. The ethical standards that apply include:

- Avoidance of the infliction of harm on the person being treated (guaranteed in all codes of medical ethics since the Hippocratic oath).
- Informed consent (guaranteed both by codes of medical ethics and by the International Convention of Civil and Political Rights [ICCPR], article 7)

[2] Note to translators: Please use the same word for 'dependence' and its derivatives (e.g. 'dependent') that is included in the official Chinese translation of the *Diagnostic Statistical Manual of Mental Disorders* [20].

[3] This document states "[o]nly in exceptional crisis situations of high risk to self or others, compulsory treatment should be mandated for specific conditions and periods of time as specified by the law."

- The prohibition of inhuman and degrading treatment or punishment (Universal Declaration of Human Rights, article 5).
- The right to freedom from arbitrary detention (ICCPR article 9)
- The right to freedom of movement (ICCPR article 12)
- Proportionality in sentencing. This principle is not yet included in UN instruments, but it is included in the European Charter of Fundamental Rights, which states that "[t]he severity of penalties must not be disproportionate to the criminal offence" (article 49). Classically, proportionality has been taken to mean that the harm caused by the punishment must be no greater than the harm that the offender has caused to other people.

The Siracusa principles that were adopted by the UN Economic and Social Council in 1985 may permit limitations on the rights provided under the ICCPR in certain circumstances. As interpreted by Flacks [28], these principles state that such limitations must:

- "be provided for and carried out in accordance with the law;
- be in the interest of a legitimate objective of general interest;
- be strictly necessary to achieve the objective;
- be based on scientific evidence and not drafted or imposed arbitrarily, i.e. in an unreasonable or otherwise discriminatory manner;
- and that there must also be no less intrusive and restrictive means available to reach the same objective."

Treatment of drug dependence can be effective in several ways. The aims that it can achieve include:

- Reduction or elimination of illicit drug use.
- Reduction of the health damages associated with drug use (e.g. transmission of infectious diseases such as HIV and viral hepatitis, drug-related deaths by overdose and other causes).
- Reduction of the harms to society, principally in the form of crimes that drug users may commit while under the influence of drugs, in order to buy drugs, or in resolving conflicts in illicit drug markets.

While it is generally accepted that many forms of drug treatment provide these benefits for people who volunteer for treatment [29-31], the evidence on the effectiveness of treatment that involves coercion by the state is less well established [2].

Non-problematic drug users

In applying the principles described above, we can first consider non-problematic drug users. Any coercion on them to enter treatment must be unethical. Ordering treatment for people who do not have a treatable condition can only be seen as the use of treatment as a form of punishment. As punishment is a harm on the individual and restricts their liberty, this practice would be forbidden by codes of medical ethics[4] and by the ICCPR.

Dependent drug users

Next we can consider coercion of dependent drug users who may benefit from treatment, but who are not subject to penal sanctions for crimes other than drug possession. When considering compulsory treatment for this group, we see that it breaches the principle of informed consent. It would also be difficult to demonstrate how the exceptions provided for under the Siracusa principles could apply to this group. For example, the principles state that such limitation must be based on scientific evidence. But there is little, if any, evidence to demonstrate that compulsory treatment of this nature is effective in meeting the aims of drug treatment. Indeed, there are studies that have demonstrated the failure of compulsory treatment to meet these aims in various countries, including the USA [6], Sweden [32] and the Netherlands [33][5]. The Siracusa principles also state that compulsory measures must be strictly necessary to achieve the objective. If the objective is the reduction of problematic drug use and crime committed by drug users, then it would be necessary to demonstrate that other, less coercive means (such as the general expansion of non-coercive treatment systems to make treatment available to all who need it) have been exhausted before compulsory systems can be justified under this exception.

When we consider quasi-compulsory treatment for this group of dependent drug users, we see that legal systems may provide for penal coercion of drug possessors. The availability of such sanctions may offer the opportunity to give drug users (who are caught in possession of drugs)

[4] The UN Principles of Medical Ethics state that "[i]t is a contravention of medical ethics for health personnel, particularly physicians, to participate in any procedure for restraining a prisoner or detainee unless such a procedure is determined in accordance with purely medical criteria".

[5] It should be noted that the Dutch system of 'Strafrechtelijke Opvang Verslaafden' is a system of compulsory placement in a treatment institution, rather than compulsory treatment itself. The difference is that the sentenced persons may choose not to participate in treatment while they are in the institution. The results of the evaluation of SOV showed that it produced results that were no better than less coercive forms of treatment, and was ineffective for those who felt compelled and therefore did not participate in treatment.

a quasi-compulsory choice between treatment and a penal sanction. However, limitations also apply in such cases, particularly in relation to the proportionality of sentencing for drug possession.

There are two ethical limits to the severity of penal sanctions. They should be no more severe than is justified by the harm caused by the offence. And they should be no more severe than is necessary to achieve their intended purpose. In the case of the offence of drug possession, any harm that is caused is primarily harm to the individual in possession, so it is disproportionate to impose a harmful penal sanction on the drug possessor. In the case of drug law offences, the purpose of sentencing is laid out by the 1988 *United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, which states that the aim of drug law punishments should be "the eradication of illicit traffic"[6]. There is no evidence to suggest that severe penalties for drug possessors (e.g. imprisonment, which is the most severe form of punishment that is internationally considered to be compatible with human rights [34]) have any more effect on the scale of illicit traffic than do lighter (or even no) sanctions [35-37]. Therefore it is difficult to justify penal sanctions for simple drug possession that are of more than minimal severity. Furthermore, it would be unethical to use the threat of penal sanction to encourage drug users into treatment if the treatment is more restrictive of their liberty than would be the usual punishment for their offence [11-12]. It would therefore be possible to give dependent drug users a choice between a penal sanction for drug possession and a form of treatment, but such treatment would have to be only minimally restrictive of their liberty. The offence of drug possession would not justify, for example, compulsory placement in a residential institution (which is as restrictive of liberty as the severe punishment of imprisonment).

Drug dependent offenders

Turning now to the final type of drug user, the drug dependent offender, we find that compulsory treatment is also unethical in this case, for the same reason (stated above) as it is unethical for any other dependent drug user. The possibility of quasi-compulsory treatment is

[6] It should be noted that this convention does not oblige signatories to establish criminal penalties for possession of illicit drugs, unless such possession is for the purposes of "production, manufacture, extraction, preparation, offering, offering for sale, distribution, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation or exportation". This does not include possession for personal consumption. The convention enables signatories to institute more severe penalties than are provided for in the convention, but only if such penalties are "are desirable or necessary for the prevention or suppression of illicit traffic".

more likely to be ethical for drug dependent offenders who have committed other crimes than drug possession. This is because they may be facing penal sanctions for offences which cause direct harm to others, and so may be justifiably longer (in accordance with the principle of proportionality). For example, in Europe and the USA we find that many people who are dependent on drugs also commit repeated crimes of acquisition (e.g. theft, burglary and fraud) and of drug dealing. These offences carry longer sentences than simple drug possession, and so make it possible to offer a quasi-compulsory choice to enter treatment that is less restrictive of liberty than would be the usual penal sanction. But, as stated by previous reviews in this field [10-12], this would still be subject to certain ethical conditions, including:

- That the person is offered the choice not to enter treatment (without being punished for taking this choice by facing a more severe penalty than he or she would otherwise have received).
- That the person is offered a choice between forms of treatment that are adequate and humane, according to his or her individual needs and wishes.
- That the constraint on the person is subject to due process (e.g. the right to know what he or she is accused of and the right to challenge any such accusations).
- That the person is not punished for failing in treatment. Relapse is frequent among dependent drug users and is, indeed, one of the diagnostic indicators of dependence. It should not be used as a reason for punishment, although it may be the occasion to rescind the opportunity to enter treatment and implement the alternative penalty.
- That the treatment takes place in a setting that is the least restrictive of liberty that is necessary for the objectives of treatment (*not* for the objectives of punishment).
- That the period of any judicial order to remain in treatment is limited, subject to review and of no longer duration than the usual punishment for the offence.

Effectiveness of quasi-compulsory treatment

Given that all these conditions are met and are applied only to drug dependent offenders, then we can judge this form of quasi-compulsory treatment (QCT) to be ethical and can turn to the issue of effectiveness. Two arguments are often put forward on this issue. One is that drug users who face on any form of legal coercion will be unmotivated to change and are therefore unlikely to succeed in treatment. The second is that coercion can supplement initial motivation by keeping drug users in treatment for longer and therefore increase the chances of the treatment succeeding. On balance, the available research supports neither of these arguments. Rather it suggests that QCT can be as effective as treatment that is entered voluntarily, but is not generally more or less effective than such voluntary treatment. This

general finding is suggested by research on drug courts in the USA, on drug treatment and testing orders in the United Kingdom, and by systems of quasi-compulsory treatment in other European countries [7-8, 14, 38-39].

One reason why QCT seems to have similarly positive results to voluntary treatment is because, when ethically carried out, it is not necessarily damaging to the patient's motivation to change. Many drug dependent offenders want the opportunity to change their lives and to stop harming themselves and others. In our study of QCT in Europe, we found similar levels of motivation to change among legally coerced and voluntary patients [16]. These patients entered a variety of treatments, including residential abstinence based treatment, out-patient abstinent and opiate substitution treatment. The level of legal pressure experienced by these patients was not a significant predictor of the length of retention in treatment [15]. QCT and voluntary patients achieved, on average, similar reductions in drug use and offending (when controlling for higher levels at entry among the QCT group) [14].

While the evidence on QCT is encouraging, it is necessary to note some reservations. QCT (and any form of drug treatment) is unlikely to have large effects on population levels of drug use and crime. This is because the group of drug dependent offenders who enter the criminal justice system is likely to remain a very small proportion of the overall group of drug users and offenders [40-41]. QCT is also unlikely to have much effect in reducing the prison population, unless it is specifically targeted at people who would otherwise be sent to prison. In many cases, even when this is the stated aim of introducing QCT, the phenomenon of "net-widening" [42] occurs, and the QCT sentences replace less severe sentences, rather than prison sentences. This has occurred in the UK and the USA in the past decade [35, 43-45]. Finally, it should also be noted that the general level of methodological quality of studies on QCT is still less than is necessary to provide definitive meta-analysis of effects. More randomised experiments and detailed qualitative studies on the mechanisms and outcomes of QCT are needed.

Conclusion

This paper has argued that it is very unlikely that compulsory treatment can be considered ethical for any category of drug user, outside of the "exceptional, crisis" situations allowed for under the UNODC/WHO review [27]. It has argued that quasi-compulsory treatment (QCT) may be considered ethical (under some specific conditions) for drug dependent offenders who have committed criminal offences for whom the usual penal sanction would be more restrictive of liberty than the forms of treatment that they are offered as a constrained,

quasi-compulsory choice. It has briefly reviewed research that suggests that QCT may be as effective as treatment that is entered into voluntarily. This may help individuals to reduce their drug use and offending and to improve their health, but it is unlikely to have large effects on population levels of drug use and crime.

References

1. Grover, A., *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* 2010, New York: United Nations.
2. Stevens, A., et al., *Quasi-Compulsory Treatment Of Drug Dependent Offenders: An International Literature Review.* Substance Use & Misuse, 2005. **40**: p. 269-283.
3. Wilson, D.B., O. Mitchell, and D.L. MacKenzie, *A Systematic Review of Drug Court Effects on Recidivism.* Journal of Experimental Criminology, 2006. **2**(4): p. 459-487.
4. De Wree, E., B.D. Ruyver, and L. Pauwels, *Criminal justice responses to drug offences: Recidivism following the application of alternative sanctions in Belgium.* Drugs: Education, Prevention and Policy, 2009. **16**(6): p. 550-560.
5. Community Justice Services, *Review of the Glasgow and Fife Drug Courts: Report* 2010, Edinburgh: The Scottish Government.
6. Inciardi, J.A., *Compulsory Treatment in New York: A Brief Narrative History of Misjudgement, Mismanagement, and Misrepresentation.* Journal of Drug Issues, 1988. **18**(4): p. 547-560.
7. Belenko, S., *Research on Drug Courts: A Critical Review 2001 Update*, 2001, National Centre on Addiction and Substance Abuse: New York.
8. GAO, *Adult Drug Courts: Evidence Indicates Recidivism Reductions and Mixed Results for Other Outcomes. GAO-05-219*, 2005, General Accountability Office: Washington, DC.
9. Gerra, G. and N. Clark, eds. *From coercion to cohesion: treating drug dependence through health care, not punishment. Discussion paper*. 2009, United Nations Office on Drugs and Crime: Vienna.
10. Hall, W.D., *The role of legal coercion in the treatment of offenders with alcohol and heroin problems.* Australian and New Zealand Journal of Criminology, 1997. **30**(2): p. 103-120.
11. Porter, L., A. Arif, and W.J. Curran, *The Law and Treatment of Drug and Alcohol Dependent Persons - A Comparative Study of Existing Legislation*1986: World Health Organisation.
12. Gostin, L.O., *Compulsory Treatment for Drug-dependent Persons: Justifications for a Public Health Approach to Drug Dependency.* The Milbank Quarterly, 1991. **69**(4): p. 561-593.
13. McSweeney, T., et al., *Twisting arms or a helping hand? Assessing the impact of 'coerced' and comparable 'voluntary' drug treatment options.* British Journal of Criminology, 2007. **47**(3): p. 470-490.
14. Schaub, M., et al., *Comparing Outcomes of 'Voluntary' and 'Quasi-Compulsory' Treatment of Substance Dependence in Europe.* European Addiction Research, 2010. **16**: p. 53-60.
15. Schaub, M., et al., *Predictors of Retention in the 'Voluntary' and 'Quasi-Compulsory' Treatment of Substance Dependence in Europe.* European Addiction Research, 2011. **17**(2): p. 97-105.
16. Stevens, A., Berto, D., Frick, U., Hunt, N., Kerschl, V., McSweeney, T., Oeuvray, K., Puppo, I., Santa Maria, A., Schaaf, S., Trinkl, B., Uchtenhagen, A., Werdenich, W. , *The Relationship between Legal Status, Perceived Pressure and Motivation in*

Treatment for Drug Dependence: Results from a European Study of Quasi-Compulsory Treatment. European Addiction Research, 2006. **12**: p. 197-209.
17. Stevens, A., *Quasi-compulsory treatment in Europe: An evidence-based response to drug-related crime?*, in *Crossing Frontiers: International Developments in the Treatment of Drug Dependence*, A. Stevens, Editor 2008, Pavilion Publishing: Brighton. p. 153-172.
18. Stevens, A., et al., *The relationship between legal status, perceived pressure and motivation in treatment for drug dependence: Results from a European study of quasi-compulsory treatment* European Addiction Research, 2006. **12**: p. 197-209.
19. Stevens, A., et al., *On coercion.* International Journal of Drug Policy, 2005. **16**: p. 207-209.
20. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR*2000, Washington DC: American Psychiatric Publishing.
21. Edwards, G., *Natural recovery is the only recovery.* Addiction, 2000. **95**(5): p. 747.
22. Granfield, R. and W. Cloud, *Social Context and "Natural Recovery": The Role of Social Capital in the Resolution of Drug-Associated Problems.* Substance Misuse and Misuse, 2001. **36**(11): p. 1543-1570.
23. Sobell, L.C., T.P. Ellingstad, and M.B. Sobell, *Natural recovery from alcohol and drug problems: methodological review of the research with suggestions for future directions.* Addiction, 2000. **95**(5): p. 749-764.
24. Godfrey, C., et al., *The economic and social costs of Class A drug use in England and Wales, 2000. Home Office Research Study 249.*, 2002, Home Office: London.
25. UN General Assembly, *Resolution 37/194: Principles of Medical Ethics*1982, New York: United Nations.
26. World Medical Association, *WMA International Code of Medical Ethics*2006, Pilanesburg, South Africa: WMA General Assembly.
27. UNODC and WHO. *Principles of Drug Treatment. Discussion Paper*. 2008 20th March 2008]; Available from: http://www.unodc.org/documents/drug-treatment/UNODC-WHO-Principles-of-Drug-Dependence-Treatment-March08.pdf.
28. Flacks, S., *Drug Control, Human Rights, and the Right to the Highest Attainable Standard of Health: A Reply to Saul Takahashi.* Human Rights Quarterly, 2011. **33**(3): p. 856-877.
29. McLellan, A.T. and J. Marsden, *Contemporary drug abuse treatment: A review of the evidence base* 2003, Vienna: United Nations Office on Drugs and Crime.
30. Stevens, A., M. Trace, and D.R. Bewley-Taylor, *Reducing Drug Related Crime: An Overview of the Global Evidence. Report Five*2005, Oxford: Beckley Foundation.
31. Stevens, A., C. Hallam, and M. Trace, *Treatment for Dependent Drug Use: A Guide For Policymakers*2006, Oxford: Beckley Foundation.
32. Heckmann, W., *Schwedische Gardinen": Zur Tradition der Zwangsbehandlung Suchtkranker und -gefährdeter in Schweden.* Sucht. Zeitschrift für Wissenschaft und Praxis, 1997. **43**(3).
33. van 't Land, H., et al., *Opgevangen onder dwang procesevaluatie strafrechtelijke opvang verslaafden*, 2005, WODC, Ministry of Justice: The Hague.
34. UN General Assembly, *Moratorium on the use of the death penalty. A/C.3/62/L.29*2007, New York: United Nationa.
35. Stevens, A., *Drugs, Crime and Public Health: The Political Economy of Drug Policy*2011, Abingdon: Routledge.
36. Reuter, P., *Illicit drug policy: the least worst options.* The Milken Quarterly, 2010. Second quarter: p. 26-35.
37. Babor, T., et al., *Drug Policy and the Public Good* 2010, Oxford: Oxford University Press.
38. van Ooyen-Houben, M., *Quasi-compulsory treatment in the Netherlands: promising theory, problems in practice*, in *Crossing Frontiers: International Developments in the Treatment of Drug Dependence*, A. Stevens, Editor 2008, Pavilion Publishing: Brighton.

39. Rossman, S.B., et al. *The Multi-Site Adult Drug Court Evaluation: The Impact of Drug Courts*. 2011. Washington DC: Urban Institute
40. Reuter, P. and H. Pollack, *How Much Can Treatment Reduce National Drug Problems?* Addiction, 2006. **101**: p. 341-347.
41. Reuter, P. and A. Stevens, *Assessing UK Drug Policy from a Crime Control Perspective.* Criminology and Criminal Justice, 2008. **8**(4): p. 461-482.
42. Cohen, S., *Visions of Social Control* 1985, Cambridge: Polity Press.
43. Drug Policy Alliance, *Drug Courts Are Not the Answer: Toward a Health-Centered Approach to Drug Use* 2011, New York: Drug Policy Alliance.
44. Stevens, A. *Alternatives to what? Drug treatment alternatives as a response to prison expansion and overcrowding*. Paper presentated to *2nd Annual Conference of the International Society for the Study of Drug Policy*. 2008. Lisbon: ISSDP.
45. Pollack, H., P. Reuter, and E.L. Sevigny, *If Drug Treatment Works So Well, Why Are So Many Drug Users in Prison? NBER Working Paper No. 16731* 2011, Cambridge MA: National Burea of Economic Research.