

Kent Academic Repository

Full text document (pdf)

Citation for published version

Stevens, Alex (2012) The ethics and effectiveness of coerced treatment of people who use drugs. *Human Rights and Drugs*, 2 (1). pp. 7-16. ISSN 2046-4843.

DOI

Link to record in KAR

<http://kar.kent.ac.uk/29903/>

Document Version

Publisher pdf

Copyright & reuse

Content in the Kent Academic Repository is made available for research purposes. Unless otherwise stated all content is protected by copyright and in the absence of an open licence (eg Creative Commons), permissions for further reuse of content should be sought from the publisher, author or other copyright holder.

Versions of research

The version in the Kent Academic Repository may differ from the final published version.

Users are advised to check <http://kar.kent.ac.uk> for the status of the paper. **Users should always cite the published version of record.**

Enquiries

For any further enquiries regarding the licence status of this document, please contact:

researchsupport@kent.ac.uk

If you believe this document infringes copyright then please contact the KAR admin team with the take-down information provided at <http://kar.kent.ac.uk/contact.html>

ORIGINAL ARTICLE

The ethics and effectiveness of coerced treatment of people who use drugs

Alex Stevens, PhD*

ABSTRACT

In the context of international debates about ways to reduce the harms related to the use of illicit drugs and their control, this article explores the specific issue of coerced treatment of people who use drugs. It uses established standards of human rights and medical ethics to judge whether it is ethical to apply either of two types of coerced treatment (compulsory treatment and quasi-compulsory treatment, or QCT) to any of three groups of drug users (non-problematic users, dependent drug users and drug dependent offenders). It argues that compulsory treatment is not ethical for any group, as it breaches the standard of informed consent. Quasi-compulsory treatment (i.e. treatment that is offered as an alternative to a punishment that is itself ethically justified) may be ethical (under specified conditions) for drug dependent offenders who are facing a more restrictive penal sanction, but is not ethical for other people who use drugs. The article also briefly reviews evidence which suggests that QCT may be as effective as voluntary treatment.

* Professor in Criminal Justice, School of Social Policy, Sociology and Social Research, University of Kent (a.w.stevens@kent.ac.uk).

Introduction

This article addresses the issues of ethics and effectiveness in coerced treatment for people who use drugs.¹ It is based on the existing evidence on coerced treatment,² as well as on considerations of the ethics of such treatment³ and my own research on quasi-compulsory treatment in Europe.⁴

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. This article will therefore 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. We can also - for the purposes of this article at least - classify three types of person who uses drugs. It should be noted that, in practice, there are countries that are applying compulsory treatment across all three of the categories that are discussed in this article (e.g. China, Malaysia, Vietnam and Cambodia). There are also countries that are applying quasi-compulsory treatment to all three categories (e.g. the US drug court system).

Classifications

There are two types of coerced treatment. The first occurs when people who use drugs are ordered into treatment with no opportunity to provide informed consent to such treatment.

1 The article focuses on the coercion that is used in encouraging people who use drugs 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, Arnand Grover (see note 3 below).

2 Alex Stevens and others, 'Quasi-Compulsory Treatment Of Drug Dependent Offenders: An International Literature Review', 40 *Substance Use and Misuse* 269.; David B. Wilson, Ojmarrah Mitchell and Doris L. MacKenzie, 'A Systematic Review of Drug Court Effects on Recidivism', 2 *Journal of Experimental Criminology* 459.; Eveline De Wree, Brice De Ruyver and Lieven Pauwels, 'Criminal justice responses to drug offences: Recidivism following the application of alternative sanctions in Belgium', 16 *Drugs: Education, Prevention and Policy* 550.; Community Justice Services, *Review of the Glasgow and Fife Drug Courts: Report*, The Scottish Government 2010.; James A Inciardi, 'Compulsory Treatment in New York: A Brief Narrative History of Misjudgement, Mismanagement, and Misrepresentation', 18 *Journal of Drug Issues* 547.; Steven Belenko, *Research on Drug Courts: A Critical Review 2001 Update*, The National Center on Addiction and Substance Abuse at Columbia University, 2001.; General Audit Office, *Adult Drug Courts: Evidence Indicates Recidivism Reductions and Mixed Results for Other Outcomes*, GAO-05-219, 2005.

3 UN General Assembly, 'Right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (6 August 2010) UN Doc. No. A/65/255.; Gilberto Gerra and Nicolas Clark (eds), *From coercion to cohesion: treating drug dependence through health care, not punishment. Discussion paper*, United Nations Office on Drugs and Crime, 2009; W.D. Hall, 'The role of legal coercion in the treatment of offenders with alcohol and heroin problems', 30 *Australian and New Zealand Journal of Criminology* 103.; L Porter, A Arif and W J Curran, *The Law and Treatment of Drug and Alcohol Dependent Persons - A Comparative Study of Existing Legislation*, World Health Organisation, 1986.; Lawrence O Gostin, 'Compulsory Treatment for Drug-dependent Persons: Justifications for a Public Health Approach to Drug Dependency', 69 *The Milbank Quarterly* 561.

4 Tim McSweeney and others, 'Twisting arms or a helping hand? Assessing the impact of 'coerced' and comparable 'voluntary' drug treatment options', 47 *British Journal of Criminology* 470.; Michael Schaub and others, 'Comparing Outcomes of "Voluntary" and "Quasi-Compulsory" Treatment of Substance Dependence in Europe' 16 *European Addiction Research* 53.; Michael Schaub and others, 'Predictors of Retention in the "Voluntary" and "Quasi-Compulsory" Treatment of Substance Dependence in Europe', 17 *European Addiction Research* 97.; Alex Stevens and others, 'The Relationship between Legal Status, Perceived Pressure and Motivation in Treatment for Drug Dependence: Results from a European Study of Quasi-Compulsory Treatment', 12 *European Addiction Research* 197.; Alex Stevens, 'Quasi-compulsory treatment in Europe: An evidence-based response to drug-related crime?' in Alex Stevens (ed), *Crossing Frontiers: International Developments in the Treatment of Drug Dependence*, Pavilion Publishing, 2008.

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 been (or may be) convicted. This will be called quasi-compulsory treatment (QCT).

The first of the three types of person who uses drugs includes those who use drugs but who have not committed other crimes, and do not meet diagnostic criteria for drug dependence ('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 small minority will go on to need treatment to help them give up drugs, or to reduce the harm that their drug use causes.

The second type is made up of people who use drugs who meet diagnostic criteria for dependence ('dependent drug users'). Some - but not all⁵ - 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 (including non-drug law offences) that would attract penal sanctions ('drug dependent offenders'). These people are usually considered responsible for a large proportion of the social and economic harms that are associated with drug use, although critics would argue that prohibition itself is responsible for a substantial proportion of drug-related harm. 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 type of person who uses drugs. Before applying them to the ethics and effectiveness of treatment, we need also to specify what we mean by these terms.

For this article, 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

5 Griffith Edwards, 'Natural recovery is the only recovery' 95 *Addiction* 747.; Robert Granfield and William Cloud, 'Social context and "natural recovery": the role of social capital in the resolution of drug-associated problems', 36 *Substance Use and Misuse* 1543.; Linda C Sobell, Timothy P Ellingstad and Mark B Sobell, 'Natural recovery from alcohol and drug problems: methodological review of the research with suggestions for future directions', 95 *Addiction* 749.

(e.g. the World Health Organization *Declaration on the Promotion of Patients' Rights*,⁶ the UN *Principles of Medical Ethics*⁷ and the World Medical Association's *International Code of Medical Ethics*).⁸ 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,⁹

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 Covenant on Civil and Political Rights, article 7¹⁰)
- The prohibition of inhuman and degrading treatment or punishment (Universal Declaration of Human Rights, article 5;¹¹ the International Covenant on Civil and Political Rights, article 7;¹² and the Convention Against Torture,¹³ among others.)
- The right to freedom from arbitrary detention (International Covenant on Civil and Political Rights, article 9¹⁴)
- The right to freedom of movement (International Covenant on Civil and Political Rights, article 12¹⁵)
- Proportionality in sentencing. 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. This principle is not yet included in UN instruments, but it is included in the European Charter of Fundamental Rights, article 49 of which states that '[t]he severity of penalties must not be disproportionate to the criminal offence'.¹⁶

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

6 World Health Organization, 'Declaration on the Promotion of Patients' Rights in Europe', World Health Organization Regional Office for Europe, 1994.

7 UN General Assembly, 'Principles of Medical Ethics' (18 December 1982) UN Doc. No. A/RES/37/194.

8 World Medical Association, 'WMA International Code of Medical Ethics', WMA General Assembly, 2006.

9 UN Office on Drugs and Crime/World Health Organization, 'Principles of Drug Treatment. Discussion Paper', United Nations Office on Drugs and Crime, 2008. 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', p. 10.

10 International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171, art. 7.

11 Universal Declaration of Human Rights (10 December 1948) 217 A (III), art. 5.

12 International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3 (ICESCR), art. 7.

13 Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (10 December 1984) UNTS vol. 1465, p. 85.

14 Covenant (n 12) art. 9.

15 *ibid.*, art. 12.

16 Charter of Fundamental Rights of the European Union (18 December 2000) Official Journal of the European Communities C 364/1, art. 49(3).

associated with drug use (e.g. transmission of infectious diseases such as HIV and viral hepatitis, drug-related deaths by overdose and other causes) and 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,¹⁷ the evidence on the effectiveness of treatment that involves coercion by the state is less well established.¹⁸

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 ethics¹⁹ and by the Covenant on Civil and Political Rights.

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. There is also 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,²⁰ Sweden,²¹ and the Netherlands,²² as well as unconfirmed reports from China of relapse rates of 98% after compulsory treatment.²³

17 A Thomas McLellan and John Marsden, *Contemporary drug abuse treatment: A review of the evidence base*, United Nations Office on Drugs and Crime, 2003.; Alex Stevens, Christopher. Hallam and Mike Trace, *Treatment for Dependent Drug Use: A Guide For Policymakers*, Beckley Foundation, 2006.

18 Stevens, *et al* (n2).

19 Principle 5 of 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'. (n 7).

20 Inciardi (n 2).

21 Wolfgang Heckmann, 'Schwedische Gardinen': Zur Tradition der Zwangsbehandlung Suchtkranker und -gefährdeter in Schweden', 43 *Sucht Zeitschrift für Wissenschaft und Praxis*.

22 Hedda van 't Land and others, *Opgevangen onder dwang procesevaluatie strafrechtelijke opvang verslaafden*, Trimbos Institute, 2005.

23 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 .

When we consider quasi-compulsory treatment for this group of dependent drug users, we see that legal systems may provide for penal coercion of people possessing drugs. The availability of such sanctions may offer the opportunity to give people who are caught in possession of drugs 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: (1) they should be no more severe than is justified by the harm caused by the offence, and (2) 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 him or her.

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.’²⁴ There is no convincing 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 rights²⁵) have any more effect on the scale of illicit traffic than do lighter (or even no) sanctions.²⁶ 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 people who use drugs into treatment if the treatment is more restrictive of their liberty than would be the usual punishment for their offence.²⁷ 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 category 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

²⁴ UN Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances (20 December 1988) UNTS vol. 1582 no. 27627, preamble.

²⁵ UN General Assembly, ‘Moratorium on the use of the death penalty’ (1 November 2007) UN Doc. No. A/C.3/62/L.29.

²⁶ Thomas Babor and others, *Drug Policy and the Public Good*, Oxford University Press, 2010.; Robert J. MacCoun and Peter Reuter, ‘Assessing Drug Prohibition and Its Alternatives: A Guide for Agnostics’ 7 *Annual Review of Law and Social Science* 61.; Alex Stevens, *Drugs, Crime and Public Health: The Political Economy of Drug Policy*, Routledge, 2011.

²⁷ Porter, *et al* (n 3).; Gostin (n 3).

unethical for any other dependent drug user.

The possibility of quasi-compulsory treatment is more likely to be ethical for drug dependent offenders who have committed more serious crimes than drug possession. This is because they may be facing penal sanctions for offences that cause direct harm to others, and so may be justifiably longer, in accordance with the principle of proportionality.

For example, in many countries we find that many people who are dependent on drugs also commit repeated crimes of acquisition (e.g. theft, burglary and fraud) as well as 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,²⁸ 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.

²⁸ Hall (n 3); Porter, *et al* (n 3); Gostin (n 3).

One is that people who use drugs who face 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 people in treatment for longer periods, 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.²⁹

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.³⁰ 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.³¹ 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).³²

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.³³ 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'³⁴ occurs, and the QCT sentences replace less severe sentences, rather than

29 Belenko (n 2); GAO (n 2); Schaub, *et al* 2010 (n 2); Marianne van Ooyen-Houben, 'Quasi-compulsory treatment in the Netherlands: promising theory, problems in practice' in Alex Stevens (ed), *Crossing Frontiers: International Developments in the Treatment of Drug Dependence*, Pavilion Publishing, 2008.; Shelli B. Rossman and others, 'The Multi-Site Adult Drug Court Evaluation: The Impact of Drug Courts', Urban Institute, 2011.

30 Stevens, *et al* 2006 (n 4).

31 Schaub, *et al* 2011 (n 4).

32 Schaub, *et al* 2010 (n 3)

33 Peter Reuter and Harold Pollack, 'How Much Can Treatment Reduce National Drug Problems?', 101 *Addiction* 341.; Peter Reuter and Alex Stevens, 'Assessing UK Drug Policy from a Crime Control Perspective', 8 *Criminology and Criminal Justice* 461.

34 Stanley Cohen, *Visions of Social Control*, Polity Press, 1985.

prison sentences. This has occurred in the UK and the USA in the past decade.³⁵

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 article has argued that it is very unlikely that compulsory treatment can be considered ethical for any category of person who uses drugs, outside of the 'exceptional, crisis' situations allowed for under the UN Office on Drugs and Crime/World Health Organization review.³⁶

It has been argued that quasi-compulsory treatment 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.

Acknowledgements

This article was originally prepared for an EU-China Human Rights Seminar in Beijing, September 2011. It draws heavily from work undertaken for the QCT Europe project, and I thank my partners in that project and its funder, the European Commission.

³⁵ Stevens (n 26); Alex Stevens, 'Alternatives to what? Drug treatment alternatives as a response to prison expansion and overcrowding', Annual Conference of the International Society for the Study of Drug Policy, Lisbon, 2008.

³⁶ UNODC/WHO (n 9).

