DRUG & ALCOHOL FINDINGS

Pressure *pays*

As the UK opens up new ways to coerce drug-related offenders into treatment, a distinguished expert asks whether the evidence shows this can work, and what it would take to make it work here.

by **Philip Bean**

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The many varieties of enforced treatment lie within the broader range of activities designed to increase the likelihood that drug abusers will enter and remain in treatment, change their behaviour in socially desirable ways, and sustain that change.[1] Closer definition is problematic because what most people see as 'enforced' treatment – treatment under pressure from the criminal justice system – is just one of a range of degrees and types of pressure, which also include unofficial sanctions.

Within the subset of treatment routes which *do* involve the criminal justice system, two major types can be distinguished.

Civil commitment is justified on public health grounds and the person involved has not necessarily committed an offence. For example, commitment may be imposed on addicted mothers-to-be in an attempt to secure their health and that of the unborn child. Or the justification may be that subsequent health care will be more effective if the addiction is treated or that health care costs will be reduced. Spread of HIV among drug injectors and to their sexual partners and children has given impetus to this type of programme.

Judicial commitment to treatment occurs consequent on arrest or conviction for an offence (not necessarily a drug offence). The main objective is usually to combat criminality. Commitment may be imposed by a court as an explicit condition of the sentence or so strongly recommended as to be tantamount to a court order. Sometimes it takes the form of compulsory follow up or aftercare programmes. While some arrest referral schemes[2] impose pressures which amount to diversion, the focus here is on processes which involve the courts. Imprisonment for the offence in question and treatment undertaken in prison are not included.

Civil commitment

Compulsory civil commitment has been used extensively in many countries. It may or may not involve a separate adjudication process, and may be ordered by the courts, by a specially created government agency, or by a medical agency. Comparison between different programmes is hindered by the fact that the criteria used to assess them vary according to the committing authority. When this is a court, the main criterion may be reducing community disruption; when a medical authority, health gains, especially in terms of AIDS prevention or treatment.

Judicial control is essential if change is to occur among drug users as a whole, not just the minority who seek treatment.

Civil commitment has invariably been justified by appeal to a threat to society's health so great that it warrants quarantine-like social control strategies.[3] A secondary justification has been that substance abuse has jeopardised social order and economic progress. In constructing these justifications, governments typically take a series of steps.[4] First the problem is isolated as an issue separate from others; then it is magnified with media assistance. The authorities may even need to *create* the problem. Resistance is minimised if the programme can be projected as a humane and necessary response decidedly in the public interest. Such claims have to be offset against the infringement of civil liberties inherent in civil commitment, the price paid for the control gained by compulsion.

In the 1980s a survey of 43 countries for the World Health Organisation (WHO) found that 27 had compulsory civil commitment programmes for substance abuse.[5] These varied in terms of the procedures used, treatment methods, and lengths of stay. Effectiveness was difficult to determine. The WHO report recommended standardised procedures and called for the universal implementation of four safeguards for patients:

- patients should be released as soon as possible after detoxification;
- civil commitment should be introduced *only* if adequate treatment facilities are available;
- the status of people committed to the programmes should be subject to periodic review;
- during commitment the addict should receive the benefit of the country's normal legal rights and procedures such as the requirement for a certain level of proof, legal representation, ability to cross-examine witnesses, etc.

In the absence of a follow up study, it is difficult to say whether these recommendations have been internationally accepted.

The American experience

Much of what we know about compulsory civil commitment derives from the extensive US programmes. It was proposed there in 1914 after the passage of the first major drug control statute, the Harrison Act. Soon 'narcotic addicts' found themselves dispatched to 'narcotic farms' and from the 1930s to hospitals such as the one in Lexington Kentucky.[6] Coercion was through the civil law – a departure from the more traditional criminal justice commitment procedures and one whose constitutional propriety is still debated.[7, 8]

One authority sees US programmes as based on the belief that most drug abusers are not motivated to enter treatment, so a mechanism is needed to pressure the reticent majority. Its description as 'rational authority' was a euphemism for providing mandatory control whilst appearing not to be punitive.[9]

Civil commitment was revived in the

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Golden Bullets

Essential practice points from this article

- Treatment under pressure from the criminal justice system is just one of a range of degrees and types of pressure which encourage problem drug users to seek or accept treatment.
- Civil commitment is a public health measure and the person involved has not necessarily committed an offence. Judicial commitment is a crime-reduction measure and occurs after arrest or conviction.
- How an addict is exposed to treatment seems irrelevant. What's important is that they are brought into an environment where intervention occurs; the more routes into this environment the better.
- More treatment time leads to better outcomes; coercion can improve retention.
- Treatment programmes for legally coerced clients should be lengthy, provide a high level of structure, be flexible yet firm, and undergo regular evaluation.
- Widespread implementation of judicial commitment in the UK will require major changes which overcome the view that treatment should be 'voluntary' and that clients should be free from the threat of criminal justice sanctions if they fail.
- Before implementing such a policy drug abusers should first be given greater incentive to enter treatment voluntarily, and much more pilot research is required.

1960s. One of the most comprehensive programmes was introduced in California in 1962, permitting addicts to be committed for up to seven years without first being convicted of a criminal offence. New York and other legislatures followed suit.

The British way

Many European countries have laws enabling civil commitment[10] but several implement these infrequently or inconsistently.[11] Britain has no provisions for civil commitment. In the 1960s the government committee reviewing drug policy rejected compulsory treatment entry,[12] but did call for treatment centres to be able to detain voluntary patients whose resolve wavered in the face of a withdrawal crisis,[13] a recommendation never implemented.

In the 1970s a review of the Mental Health Act noted that current expert opinion was incompatible with classing drug dependence and drinking problems as mental disorders: "These conditions are increasingly seen as social and behavioural problems manifested in varying degrees of habit and dependency".[14] In line with this thinking, the 1983 Mental Health Act expressly excluded drug addiction as a category of mental disorder, though disorders resulting from drug abuse could warrant compulsion.

Foreshadowing today's interest in 'dual diagnosis', the Mental Health Act review recognised that "alcohol or drug dependency can be associated with certain forms of mental disorder". Increasing awareness of this conjunction[15] may have the unintended consequence of blurring the distinction between substance abuse and mental disorder. As a result, many substance abusers could find themselves in (potentially compulsory) psychiatric treatment because their drug problem is misdiagnosed as a mental disorder or because it has led to one.

Retention is the key to effectiveness

Few civil commitment programmes have been evaluated. In this respect it seems not much has changed since the 1980s when the WHO survey found that most countries were unable to report drug use outcomes and, while most could document admissions or periods of retention, often the data was poorly produced and anecdotal.[16] Claims of spectacular successes generally have to be seen as political statements aimed at producing the appropriate image. For example, drug abuse was said to have been virtually eradicated in the Soviet Union after the communist revolution, whilst compulsory civil commitment was said to have been effective in Poland in the 1970s. Little data was presented to support these claims. However, countries such as Singapore have produced data showing that compulsory civil commitment has helped at least to halt if not reverse growth of a heroin epidemic in the 1980s (a more credible claim), though even then a hard core remained impervious to treatment.

Few American civil commitment programmes have been evaluated, whilst assessments of others are based on little more than clinical intuition and hunches.[17] More substantial was the evaluation of California's programme which concluded that civil commitment was an effective way to reduce narcotic addiction and minimise its adverse social consequences,[18] in contrast to the verdict on New York's programme, seen as an abject failure.[19, 20] It wasn't that the programme was misconceived, more that it was underfunded, had poor treatment facilities, appointed untrained staff, had a poorly developed aftercare element, and lost public support leading to a wave of bad publicity.

The evaluator in California was Douglas Anglin, an influential US expert. He argued that *how* an individual is exposed to treatment is irrelevant. The important thing is that the addict is brought into an environment where intervention occurs; the more routes into this environment the better. Similarly, more time in treatment leads to better outcomes – and retention aided by coercion is still retention. Anglin saw civil commitment as a proven strategy for treating people who would not voluntarily enter treatment. Such measures could, he judged, produce significant individual and social benefits.

Yet he cautioned that while this conclusion is amply supported by research, it should not necessarily lead to immediate implementation of civil commitment. First drug abusers should be given greater incentive to enter treatment voluntarily. Unless accompanied by funding to expand treatment capacity, widespread coercion would also exacerbate treatment shortages and divert capacity currently available for voluntary referrals. Commitment is useful for bringing users into treatment, but it is not treatment, and cannot take its place.[21]

Judicial commitment

In principle the distinction between civil and judicial commitment is clear: the former is primarily a public health measure unrelated to offending, the latter a crime-reduction measure. In practice the programmes can merge. For example, US parole officers were authorised to refer relapsed cases into available treatment slots as an alternative to parole violation, while New York purchased facilities for its civil commitment patients from the state's Department of Corrections – "an environment not conducive to therapeutic treatment".[22] In Britain more or less the reverse occurs when schemes such as arrest referral divert offenders from the criminal justice system into a civil treatment programme.

Enforced but not involuntary

Particularly with respect to judicial commitment, voluntary and involuntary treatment are not as sharply distinguished as that simple opposition suggests:

- Civil commitment *does* directly force addicts into treatment, but during judicial commitment offenders often have a *choice* – whether to face penal sanctions or comply with treatment requirements.
- Some offenders ordered into treatment may have agreed to seek help anyway, irrespective of the court's ruling.
- Pressure from sources such as friends or family can be at least as persuasive as threats from the criminal justice system.[23, 24]

'Voluntary' patients have been found to perceive nearly the same power gap between themselves and their clinicians as do criminal justice referrals: in both cases, failure to comply with treatment may result in severe sanctions.[25]

Criminal justice authorities also exercise different degrees of coercion by threatening consequences of varying severity,[26] affecting the extent to which the offender actually experiences *legal pressure* – that is, discomfort over the potential consequences of non-compliance.[27] The treatment programme may itself affect the degree of coercion. For example, in some US probation-led programmes communication between treatment and criminal justice agencies was so poor that it impeded the ability to enact immediate sanctions for non-compliance.[28] Other programmes adjust the level of coercion as treatment progresses.

Seeing voluntary and compulsory referral as opposite ends of a continuum is not only a misunderstanding of what actually happens, but also risks stereotyping the patients by underestimating the voluntary features of some coerced clients, and the coerced features of some voluntary clients. In practice, substance abusers enter treatment at a point on a continuum of coercion, the position of which does not necessarily depend on the referral route.[29]

Referral route is not crucial

Given the overlaps in the degrees and types of coercion experienced by criminal justice and non-criminal justice clients, it is no surprise that this difference in referral route is not a key factor in the treatment process. Treatment needs seem similar in both populations, though motivation to enter treatment is usually lower among criminal justice referrals, a factor which may need to be addressed by treatment providers.[30] However, in relation to outcomes, initial motivation seems less important than retention in treatment.[31]

Anglin's judgement on this issue applies both to civil and judicial commitment: "How an individual is exposed to treatment seems irrelevant. What is important is that the narcotics addict must be brought into an environment where intervention can occur over time."[32] One of the latest assessments of the evidence reaches the same verdict: "Length of exposure to treatment ... powerfully predicts [success] no matter what the treatment setting". This extensive but as yet unpublished review found that beyond a 90-day threshold, treatment outcomes improved in direct relation to time in treatment – and that coerced patients stayed longer.[33] Such findings underpin claims that the post-arrest period provides a valuable opening for interventions aimed at breaking the drugs-crime cycle.[34]

For more information

Leukefeld C.G., Tims F.M., *eds.* *Compulsory treatment of drug abuse: research and clinical practice.* NIDA Research Monograph 86. US Department of Health and Human Sciences, 1988. Still a key source. Consult in ISDD (0171 928 1211) or apply for copies to: National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville MD 20847-2345, USA, fax 00 1 301 468 6433, e-mail info@health.org.

Turnbull P.J., Webster R. *Demand reduction activities in the criminal justice system in the European Union. Final report.* Lisbon: European Monitoring Centre For Drugs and Drug Addiction, 1997. See how the UK compares to its EU partners. For copies apply: EMCDDA, Rua Cruz de Santa Apolónia Nº23/25, 1100 Lisbon, Portugal, fax 00 351 21 813 1711, web site http://www.emcdda. org.

Anglin M.D., Prendergast M., Farabee D. *The effectiveness of coerced treatment for drug-abusing offenders.* Paper presented at the Office of National Drug Control Policy's Conference of Scholars and Policy Makers, Washington, D.C., USA, March 1998. Latest assessment of the evidence from perhaps the leading US researcher in this field. Available at http://www.whitehousedrugpolicy.gov/treat/consensus/consensus.html.

Bean P.T. "America's drug courts; a new development in criminal justice." *Criminal Law Review*: 1997, p. 718-721. A UK perspective on the increasingly popular US drug court model. For copies apply ISDD, 0171 928 1211.

Evidence positive but scant

US research is positive about the impact of coerced treatment, concluding that judicial control is essential if change is to occur in the drug using population as a whole, not just among the minority who seek treatment. Weaknesses occur when clients perceive inconsistency in the legal process, do not experience appropriate pressure to maintain compliance, or if treatment programmes fail to adequately implement their philosophy.[35] This suggests it is not so much coercion *into* treatment that 'works', but positive controls once offenders are *in* treatment.

However, almost all the evidence is of US origin. In Britain we simply do not know what impact judicial decisions have on drug use or treatment outcomes. A study dating back over 25 years did compare treatment outcomes among patients convicted of an offence and those who were not, concluding that "court appearances have no observable therapeutic effect on ... drug taking",[36] but the methodology was unsound and the assessments unsatisfactory.

Even if new research is done, extracting clear-cut practice implications will be difficult – the methodological problems are immense. Finding an appropriate sample of drug users is the first problem; selecting just those charged with a drug offence will miss many drug-related offenders. Where a dominant local agency refuses to accept 'coerced' clients, very few referrals from criminal justice sources will end up in treatment. Establishing a causal link between offence, sentence, treatment and outcomes is extremely complex. By the time a substance abuser appears at court for one offence, they may have court appearances lined up for two or three others; and by the time a probation order is made, often they have committed further offences while on remand. And if treatment *is* successful, how will we know whether coerced entry was a key factor or simply incidental?[37]

How to make it work

Even if we accept US evidence that an effective interface between courts and treatment providers is a valuable route into treatment, there remains the issue of how to construct this interface. In recent years the UK's main attempt to formalise court-ordered treatment was the provision in the Criminal Justice Act 1991 enabling courts to impose treatment as part of a sentence. It was rarely used. Home Office probation inspections[38] suggest this was because:

- The Home Office and probation services adopted a neutral stance on this disposal option, declining to issue guidance to sentencers.
- Believing coerced treatment is unlikely to work, probation officers were reluctant to advocate it in pre-sentence reports.
- Sentencers lacked information on the treatments available and how they fit in with harm reduction strategies.
- Within the criminal justice system, treatment providers were (with some justification) seen as unenthusiastic about operating mandatory programmes.[39]
- There were difficulties in persuading local authorities to meet the cost of treatment.

The latest attempt to link courts and treatment is the Drug Treatment and Testing Order. Subject to results from the pilot areas, from year 2000 these will be made available nationally, strengthening the court's power to require an offender to undergo treatment as part of, or in association with, a community sentence. Courts will regularly review offenders' progress and drug testing will be mandatory, a move

towards heightening coercion and extending judicial controls to more drug-related offenders. But perhaps implementation will not be as smooth as was hoped; over roughly the first nine months, courts in the three pilot areas made just 80 orders.[40] Even taking into account start-up delays, uptake so far seems disappointing.

In America the major development has been the spread of 'drug courts' from an experiment in Florida to nearly all US states. Though in Britain often confused with the Drug Treatment and Testing Order, there are important differences: control of the offender remains with the court rather than being given over to agencies such as the probation service; treatment agencies are employed by the court; and the judge has a central role in the treatment programme, for which they have often received special training or gained experience by specialising in drug using offenders.[41]

Those close to the drug court movement see the results (in terms of drug use and recidivism) as highly encouraging[42] but a more dispassionate assessment rates them merely as "promising", any benefits being mainly due to the provision of a legal incentive stay in drug treatment.[43] A more definitive verdict is hampered by the "limited scientific rigour" of the available evaluations.[44]

The conditions for success

The evidence is that legal pressure can play a positive role in reducing drug problems by enhancing treatment retention and compliance.[45] Addicts who choose to enter treatment without legal pressure rarely complete it, 90% dropping out within the first year when relapse is then the rule.[46] The benefits of legal pressure are, however, not universally observed: coercion into treatment does not guarantee success. Anglin and colleagues[47] recommend that treatment programmes for legally coerced clients should:

- be lengthy, since drug dependence is a chronic, recurring condition;
- provide a high level of structure, particularly in the early stages;
- be flexible yet firm to take account of the inevitable relapses;
- undergo regular evaluation to determine their effectiveness and to detect changes in the target population.

Given these conditions, they argue that coercion is justified by its potential to make a cost-effective impact on the social costs linked to offender drug use, and should find a place in national drug strategies.[48] If this US message is taken on board in Britain, it will mean practice changes even wider than those currently being contemplated.

Such changes would have to overcome the prevailing views that treatment entry should be 'voluntary' and that clients who fail or drop out should be free from the threat of criminal justice sanctions, views difficult to change. As things stand, British courts and treatment services seem to talk past each other. Even when 'treatment' is defined widely enough to embrace attending a needle exchange scheme, a prescription for methadone, or a single contact to make a (rarely kept) further appointment, a recent British study found that only 17% of offenders had sought treatment.[49] Effective implementation requires a strong working relationship between the criminal justice and treatment systems,[50] one currently not evident in Britain.

While civil commitment is not on the UK agenda, judicial commitment certainly is. But before we embark on a wholesale shift towards compulsory treatment, much more research is required. Of course we need to introduce and evaluate pilots for new treatment modalities such as drug courts, but we also need some very basic data, such as on the nature of offender populations and on current treatment programmes. Above all, we must to be able to identify the types of offenders who can effectively be treated and how links between criminal justice and treatment services can be structured so the two systems can work together: "Members of both systems need to move away from adversarial stances and towards collaboration to produce the desired behaviour change in drug users."[51]

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