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From coercion to cohesion

Treating drug dependence
through health care, not punishment

DISCUSSION PAPER

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**From coercion to cohesion:
Treating drug dependence
through health care, not punishment**

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Foreword

The aim of this draft discussion paper, “From coercion to cohesion: Treating drug dependence through health care, not punishment”, is to promote a health-oriented approach to drug dependence. The International Drug Control Conventions give Member States the flexibility to adopt such an approach. Treatment offered as an alternative to criminal justice sanctions has to be evidence-based and in line with ethical standards. This paper outlines a model of referral from the criminal justice system to the treatment system that is more effective than compulsory treatment, which results in less restriction of liberty, is less stigmatizing and offers better prospects for the future of the individual and society. Drug dependence treatment without the consent of the patient should only be considered a short-term option of last resort in some acute emergency situations and needs to follow the same ethical and scientific standards as voluntary-based treatment. Human rights violations carried out in the name of “treatment” are not compliant with this approach.



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Drug treatment as an alternative to criminal justice sanctions—a public health approach as supported by the drug control conventions.

One of the stated aims of the international drug control conventions is to protect the health of individuals and society from the dangerous effects of drug use. The Conventions require Governments to limit the use of narcotic drugs and psychotropic substances to medical and scientific purposes in order to protect people, particularly the most vulnerable, from the health and behavioural consequences of drug use, including drug dependence and drug-related dysfunctions that undermine social cohesion and opportunities for social development.

For this purpose Article 38 of the Single Convention (1961) states that “the Parties shall give special attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved”, underlining the crucial role of health and social interventions.

Article 14 (4) of the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988, further states that “...parties shall adopt appropriate measures aimed at eliminating or reducing illicit demand for narcotic drugs and psychotropic substances, with the view to reducing human suffering and eliminating financial incentives for illicit traffic”. In that provision, the Convention focuses on reducing human suffering arising from the health and social consequences of drug use, as well as on counteracting illicit gains of criminal organizations.

The illicit possession, cultivation and purchase of drugs are criminal offences according to the provisions of the 1988 Convention. However, in line with the health-oriented approach, the Single Convention on Narcotic Drugs, 1961 (Article 36b) stipulates that “abusers shall undergo measures of treatment, education, after-care, rehabilitation and social reintegration”. In accordance with this approach, the report of the International Narcotics Control Board for 2007 (EN/INCB/2007/1), when discussing the principle of proportionality, highlighted that “with offences involving the possession, purchase or cultivation of illicit drugs for the offender’s personal use, the measures can be applied as complete alternatives to conviction and punishment”.

The conventions encourage the adoption of a health-oriented approach to both illicit drug use and drug dependence rather than relying solely upon a sanction-oriented approach. In the case of nondependent drug users, a health-oriented approach may involve: providing education, reliable information, brief motivational and behavioural counselling, and measures to facilitate social reintegration and reduce isolation and social exclusion. In the case of drug dependent individuals it may also involve more comprehensive social support and specific pharmacological and psychosocial treatment, and aftercare.

Following the provisions of the international drug control conventions, treatment, rehabilitation, social reintegration and aftercare should be considered as an alternative to criminal justice sanctions. People suffering from substance use disorders who have committed drug-related offences may be encouraged to enter treatment as an alternative to criminal justice sanctions.

This type of intervention, which uses the coercive power of the criminal justice system, does not necessarily mean that treatment is compulsory or that it involves the deprivation of liberty of an individual: individuals still have a choice between accepting treatment, or facing imprisonment or other administrative sanctions.

Treatment as an alternative to criminal justice sanctions represents an opportunity offered by the community to drug users and drug dependent individuals to accept some form of assistance. It usually allows some choice of education, health care, treatment and rehabilitation and does not force patients into treatment without their consent. This type of pressure is significantly different from compulsory treatment that does not allow the individual to decline treatment or choose the type that they receive.

The alternatives to punishment considered by the conventions are described as educational and clinical interventions. These alternatives to criminal justice sanctions can be offered without violating the rights of drug users and drug dependent individuals to refuse treatment, thus achieving a balance between the desire of the community to reduce drug-related offences and the rights of the individual to receive treatment for drug use disorders.

The scientific case for treatment as an alternative to criminal justice sanctions

Moving from a sanction-oriented approach to a health-oriented one is consistent with the international drug control conventions. It is also in agreement with a large body of scientific evidence. This includes epidemiological and other scientific evidence that harmful and dependent drug use is often related to individual and social disadvantage (Hawkins et al., 1992, Kreek et al., 2005, Sinha, 2008). It also includes clinical and neurobiological research which indicates that drug dependence is a chronic, multifactorial condition that affects brain functioning in ways that makes abstinence difficult to achieve in the short term (Carter et al., 2009, Goldstein et al., 2009, WHO, 2004). There is increasing evidence that a health-oriented approach is also the most effective in reducing illicit drug use, and the social harm that it causes (Chandler et al., 2009, Gerstein and Harwood, 1990).

New scientific findings indicate that many factors contribute to the pathogenesis of drug dependence. These include factors that both increase someone's readiness to experiment with drugs and their susceptibility to develop dependence if they use drugs (Volkow and Li, 2005). Amongst these factors are: a long history of social

and personal disadvantage; temperament and personality traits influenced by genetic variants (Dick et al, 2006, Merikangas et al., 2009); prenatal problems; adverse childhood experiences; poor education; lack of bonding to the family and social isolation; and psychiatric disorders (Fergusson et al., 2008, Zucker et al., 2008). All of these factors may act to create a psycho-biological susceptibility to substance use disorders. Moreover, a large proportion of drug dependent individuals begin and continue to use drugs in a miscarried attempt to cope with adverse conditions in their life, such as violence and abuse, extreme poverty and social exclusion, hunger and excessive workload (Khantzian, 1985).

Drug dependence is a health disorder (a disease) that arises from the exposure to drugs in persons with these pre-existing psycho-biological vulnerabilities. Such an understanding of drug dependence suggests that punishment is not the appropriate response to persons who are dependent on drugs (Chandler et al., 2009, Dackis and O'Brien, 2005, McLellan et al., 2000). Indeed, imprisonment can be counterproductive to recovery in vulnerable individuals who have already been "punished" by the adverse experiences of their childhood and adolescence, and who may already be neurologically and psychologically vulnerable (Neale and Saville, 2004).

"The poor" are more at risk of committing a crime and being imprisoned than people that dispose of sufficient income and live in a more privileged environment. With a criminal record, access to employment is restricted and, because of time served in prison, valuable lifetime is lost which further decreases the chance of leading a sustainable life.

In fact, incarceration in prison and confinement in compulsory drug treatment centres often worsens the already problematic lives of drug users and drug dependent individuals, particularly the youngest and most vulnerable (Jurgens and Betteridge, 2005). Exposure to the prison environment facilitates affiliation with older criminals and criminal gangs and organizations. It also increases stigma and helps to form a criminal identity. It often increases social exclusion, worsens health conditions and reduces social skills. Alternatives to incarceration within the community (outpatient or residential therapeutic setting), such as psychosocially supported pharmacological treatment for opiate dependence, can be more effective than imprisonment in reducing drug-related offences (Chandler et al., 2009).

In many countries, despite the fact that drug users constitute a large part (or the majority) of the prison population, the prison system lacks appropriate treatment and rehabilitation programmes for inmates, including treatment of the concurrent psychiatric disorders that affect a high proportion of drug dependent prisoners (Baillargeon et al., 2009, World Health Organization, 2005a). Moreover, offenders' history of harmful use of alcohol and prescription drugs during the detention period is often ignored. Evidence demonstrates that there is a high rate of relapse to drug use, drug overdose and crime recidivism among drug dependent individuals after they are released from prison (Dolan et al., 2005, Ramsay, 2003).

Furthermore, prisons and other closed settings usually have a high proportion of people with drug use disorders (Oliemeulen et al., 2007), and subsequently also HIV and TB (UNCHR, 1996; WHO, 1993; UNODC, 2006). Since people continue to inject drugs and engage in other high-risk activities for the spread of HIV and hepatitis in prison, the prison environment is highly conducive to HIV spread (Gore et al., 1995, Jurgens and Betteridge, 2005). The overcrowding often present in prisons is associated with high risk of TB transmission, which is particularly problematic for people who already have HIV. The lack of continuity of HIV treatment on entering and leaving prison increases the risk of developing drug resistant strains of the virus.

There is considerable evidence that effective drug dependence treatment offering clinical interventions (inpatient or outpatient) as an alternative to criminal justice sanctions substantially increases recovery, including a reduction in crime and criminal justice costs (Koeter and Bakker, 2007, McSweeney et al., 2007, Uchtenhagen et al., 2008). This improves outcomes both for the person with the drug use disorder and the community when compared to the effects of criminal justice sanctions alone. This option should accordingly be considered in the case of all persons convicted of drug-related offences.

Forms of persuasion used in treatment

Voluntary treatment without the threat of criminal justice sanctions

All voluntary treatment can be said to have some elements of pressure and persuasion. In some instances, informal social pressure or from family and friends may be sufficient to initiate or continue treatment (Wild, 2006). This pressure could be in the form of verbal encouragement to seek treatment or the threat of negative consequences, such as separation, divorce or loss of financial support (Marlowe et al., 1996, Stevens et al., 2006).

Outreach teams and other therapeutic or social work professionals engage drug dependent persons who are not yet in treatment, with the purpose of motivating them to enter treatment. Behavioural interventions may contain a degree of persuasion that helps patients to change their behaviour before sufficient motivation to reduce or cease drug use has been realized (e.g. rewarding positive behaviour).

In treatment facilities, contingency management approaches may include the use of incentives for good treatment responses, which may include cash, vouchers, or more take-home doses for patients receiving methadone or buprenorphine treatment.

In severe forms of drug dependence, more significant social pressure may effectively encourage drug dependent individuals to enter or remain in treatment. This may include the threat of formal negative consequences such as the loss of one's driving licence (for people not able to drive safely), the loss of custody of one's children (for people not able to care for them as a result of their drug use), loss of employment

(for people unable to perform their work as a result of their drug use) or loss of social welfare benefits (where people are not able to comply with expectations for the receipt of benefits).

Criminal justice system treatment referrals: Alternatives to imprisonment for drug users and drug dependent persons

While the non-medical use of narcotic drugs and psychotropic substances is prohibited under the drug control conventions, the severity of the punishment varies considerably between countries (EMCDDA, 2009). All countries have severe punishments for trafficking large quantities of drugs and violent drug-related crime. Countries vary considerably however in how they punish drug use and possession of drugs for personal use. In some countries personal, non-medical use of narcotic drugs and psychotropic substances is punished by imprisonment. In others, personal use is not a criminal offence or does not receive criminal justice sanctions. In some jurisdictions, the legal system views drug dependence as a mitigating factor for other drug-related offences, and may impose a more lenient sentence for someone who is drug dependent than someone who is not, particularly if they are prepared to enter treatment.

Those countries that impose more severe penalties for personal possession and use have a larger number of drug users in prison, at a significant cost to the community. This approach does not appear to have a deterrent effect on drug use in the community, when compared to countries without severe sanctions for personal possession and use (Reuter and Stevens, 2007).

Education, drug dependence treatment, aftercare, rehabilitation and social reintegration can be an effective alternatives to criminal justice sanctions for drug-related crime (for a broader overview of other alternatives to imprisonment, see also UNODC, 2007), as treatment has been shown to reduce drug-related crime more than incarceration (Gerstein and Harwood, 1990, Guydish et al., 2001). Ideally, voluntary treatment would be available to all those who need it and request it. However, not all people who commit drug-related offences are able to access treatment due to the high cost and lack of access to treatment. In some countries, the criminal justice budget includes the purchasing of drug treatment for people accused or convicted of drug use or related crime, because it is a cheaper and more effective means of crime prevention than incarceration. When facing charges or a conviction for drug use or related offences, and given the option of affordable, humane and effective treatment in the community as a proportionate alternative to criminal justice sanctions, many people with drug dependence will often voluntarily choose treatment when offered the choice (van Ooyen, 2008).

The following section outlines the principles of how such an offer of treatment as an alternative to criminal justice sanctions might be most effectively and humanely organized.

Good practice for criminal justice system treatment referrals

Evidence suggests that legally mandated education, treatment and care can be an effective alternative to the imprisonment or compulsory residential detention of drug dependent individuals. This can be offered as an alternative to criminal justice sanctions for offences which are not specified as drug-related crime by the drug control conventions but for which drug use or dependence has been a contributing factor, such as property crime to fund drug use. Such treatment needs to be provided in ways that do not violate the rights of drug users who should be allowed to decide whether they want to be involved in treatment and to choose the form of treatment that they receive (Porter et al., 1986). Legal pressure may encourage engagement in treatment, but the decision whether or not to enter treatment should remain with the individual.

The opportunity to engage with treatment should be progressively restored, facilitating improved interpersonal relationships and community engagement, increasing social cohesion and building a therapeutic alliance. From this perspective, treatment as an alternative to criminal justice sanctions need not be the antithesis of motivation, but an opportunity to change. If done in this manner, motivation for recovery can grow in a mandated treatment paradigm. The quality of treatment is not necessarily compromised by a mandated approach and can be as effective as treatment that is more voluntarily entered into (Burke and Gregoire, 2007).

Ideally, evidence-informed treatment within the community as an alternative to criminal justice sanctions should include clinical and social interventions (both psychosocial and pharmacological) that are provided by a multiprofessional team of practitioners under the auspices of the health-care system.

In this situation:

1. Drug users or drug dependent individuals facing criminal justice sanctions for a drug-related crime consent to treatment and are free to leave treatment at any time (although then subject to criminal justice sanctions for the original drug-related crime if they do so).
2. Treatment is informed by scientific evidence-based clinical guidelines. Where evidence is lacking, new approaches are rigorously evaluated (UK Drug Policy Commission, 2008).
3. Treatment is provided humanely and in accordance with standard principles of health-care ethics, such as, respecting the autonomy and dignity of the individual.
4. Patients are informed about the risks and benefits of a range of treatment options.

5. Programmes create a therapeutic alliance between staff and patients, despite patients being mandated to enter treatment.
6. The legal process of treatment as an alternative to criminal justice sanctions is consistent with the constitution and laws of the country, including those that protect the civil liberties of the patient.
7. The rights of the individuals are protected by “due process” and transparent procedures overseen by the official judicial system in the country.
8. People who have not yet been found guilty of an offence should not be subject to undue legal measures (i.e. no more than for people suspected or charged with any other offence).
9. People facing criminal justice sanctions are fully informed of the treatment options available as an alternative to sanctions. They should also be informed about the likely impact on their criminal proceedings of their choice of treatment, including what would be expected from them in treatment, and how their progress in treatment would affect any criminal justice sanctions.
10. Treatment is available, and if necessary, paid for by the criminal justice system.
11. People facing criminal justice sanctions do not face more severe criminal sanctions as a result of their decision to accept treatment. For those who comply with treatment (even if not fully successful), treatment should be continued while it remains of benefit to the patient.
12. Drug dependent offenders have the right not to choose treatment that is offered as an alternative to criminal justice sanctions. In this case the criminal justice sanctions should not be more severe than they would have been had the person not been offered the choice of treatment, or had the person not been using drugs.
13. The confidentiality of information provided by the patient should be respected as for any other patient. For example, patients may, as part of their agreement with the court, agree for their treatment information to be revealed to the court. The court has to be informed about the compliance of the patient and can revoke the alternative measures in case of lack of compliance.
14. Although involved in treatment as an alternative to criminal justice sanctions, treatment programmes should conform to their role as therapy providers by adopting a compassionate and supportive approach, and avoiding becoming agents of punishment. Treatment should not become a form of extrajudicial punishment.
15. Emergency social support, response to basic needs, such as food, shelter, hygienic measures and clothes, should accompany community-based treatment approaches. Primary social support provides adequate shelter, alleviates poverty and is an essential complimentary intervention to facilitate contact with drug dependent individuals, allowing them to attend treatment programmes and to take care of their overall health. Furthermore sustainable livelihoods interventions might be necessary, such as the provision of vocational skills or alternative education, access to income generation, microcredit and career counselling.

Compulsory treatment: treatment in the absence of the right of refusal

The threat of criminal justice sanctions may encourage some drug dependent people involved in the criminal justice system to seek treatment. For a minority of drug dependent persons, short-term compulsory treatment may be justifiable only in emergency situations for the protection of the person using drugs or the protection of the community. Even in these circumstances, the ethics of treatment without consent is debated and may breach some United Nations conventions, such as the Convention of the Rights of Persons with Disabilities. In any case, this intervention should not exceed a maximum of some days and should be applied under strict legal supervision only.

Emergency short-term involuntary detention or treatment

The acute short-term compulsory treatment for protection of an acutely intoxicated or otherwise seriously drug affected individuals may be justified if they are not able to look after themselves and pose an imminent risk to their own safety. It is a similar situation to the treatment of acute psychiatric emergencies, such as psychosis, and should in fact be governed by the same principles. Most countries also have laws that provide for: arrest by police (and subsequent holding overnight or until intoxication has subsided), or arrest and transport to a treatment facility (such as a hospital) or emergency treatment without consent in a health-care facility.

These patients are at serious risk of harming themselves or others and have either refused treatment or are unable to express their wishes in any coherent way. In these circumstances, a temporary submission to mandatory treatment without patient consent may be justified for a short period of time to protect both the individual and society from severe consequences to health and security. The temporary suspension of autonomy can help to re-establish patient autonomy if effective treatments are used to stop high risk behaviours and aggression towards self or others. The aim in these situations is to treat an acute medical or security emergency, and not a long-term treatment of drug dependence. Compulsory clinical interventions should cease once the acute emergency has been avoided. There should be transparent and careful judicial procedures when applying this kind of compulsion and the effectiveness of providing compulsory clinical interventions should be assessed.

The most common application of this category of treatment would be short-term (i.e. several hours to a maximum of several days) compulsory hospitalization for alcohol or drug intoxication, treatment of opioid overdose or treatment of acute symptoms of concomitant psychiatric disorders (e.g. drug-induced psychosis or suicidal ideation).

Treatment carried out without the informed consent of the patient in clearly defined exceptional circumstances needs to follow similar criteria to those used in mental health emergency situations (World Health Organization, 2005b). It should, for example:

- Require a clinical judgment by at least two qualified health-care professionals that such treatment was necessary.
- Impose a time limit of several days on compulsory treatment (to return the person to a state of autonomy in which decisions regarding their own welfare can be taken, maximum several days).
- Include a judicial review for any continued necessity, including the right to appeal.
- Involve a medically appropriate, individually prescribed plan, subject to regular review, that is consistent with international evidence-based best practice and ethical standards.

Long-term treatment without consent

Many countries provide long-term residential treatment for drug dependence without the consent of the patient that is in reality a type of low security imprisonment.

Evidence of the therapeutic effect of this approach is lacking, either compared to traditional imprisonment or to community-based voluntary drug treatment. It is expensive, not cost-effective, and neither benefits the individual nor the community. It does not constitute an alternative to incarceration because it is a form of incarceration. In some cases, the facilities become labour camps with unpaid, forced labour, humiliating and punitive treatment methods that constitute a form of extrajudicial punishment.

It is argued that the use of any long-term treatment for drug use disorders without the consent of the patient is in breach of international human rights agreements and ethical medical standards (UNODC and WHO, 2008).

With sufficient voluntary treatment resources, appropriate referral for treatment from the criminal justice system, and community mobilization, the residual need to use this form of compulsory/involuntary treatment should decrease until it is not used anymore at all.

Specialist drug courts as compared to the general criminal justice system

In response to the growing number of drug offenders going in and out of the criminal justice system without treatment for underlying drug problems, the judicial systems in a number of countries have adopted drug courts to divert offenders from incarceration to supervised drug treatment (UNODC, 2007). As an alternative to criminal justice sanctions, this form of treatment has been found to be effective (Prendergast et al., 2008). Results of 23 programme evaluations confirmed that drug courts significantly reduced drug use and crime and saved money.

The most rigorous and conservative scientific estimates from five “meta-analyses” have all concluded that drug courts significantly reduce crime by as much as 35 per cent compared to imprisonment. In addition, drug courts produce US\$2.21-US\$3.36 in avoided criminal justice benefits for every \$1 spent on them. Up to US\$12.00 (per US\$1.00 invested) are saved by the community on reduced emergency room visits and other medical care, foster care and victimization costs such as property loss.

Specific drug courts that deal exclusively with drug-related offences are one way of facilitating treatment as an alternative to criminal justice sanctions. The same principles can also be applied in the general legal system without creating specialist drug courts.

In conclusion

In responding to the problem of drug use, many countries have introduced severe penalties for drug use and related crime, which have resulted in large numbers of people in prisons, compulsory treatment centres, or labour camps without significant long-term impact on drug use, drug dependence or drug-related crime in the community and are in contradiction with human rights. At the same time, the long-term incarceration of a large number of people who use drugs is expensive. It also results in high risk for the transmission of HIV, hepatitis, and TB, both in closed settings and beyond, that represents a significant public health risk to the community. Many countries are consequently looking for alternatives to incarceration for drug use and related crime.

The availability of effective, affordable and humane treatment and care that meets the varied medical and social needs of people with drug use disorders in the community will facilitate the voluntary uptake of treatment and prevent drug-related crime. Some degree of pressure is often used to encourage drug dependent individuals to initiate drug dependence treatment and to increase their retention in treatment. This can range from informal pressure exerted by family and friends to formal legal pressure to engage in treatment as an alternative to incarceration or other legal sanctions. Depending on the way in which it is applied, treatment as an alternative to criminal justice sanctions does not violate the patient’s right to accept or refuse treatment.

Where effective treatment is not affordable to all people with drug use disorders, the criminal justice sector can offer treatment, to ensure its availability for those accused or convicted of drug-related crime. Offering basic emergency social support to drug dependent individuals would increase motivation and attract those who are particularly in need. In order to ensure sustainability, treatment and rehabilitation interventions need to be accompanied with sustainable livelihoods interventions that enable the participants to have a perspective for a future self-sustaining and content life, decreasing the risk of relapse.

Treatment as an alternative to criminal justice sanctions is specifically encouraged in the international drug control conventions and it has been found to be more effective than imprisonment in encouraging recovery from drug dependence and reducing drug-related crime. It can be provided in ways that do not violate the rights of the patients, provided that the decision to refuse treatment remains in the hands of the drug user and the patient's autonomy and human rights are respected.

Compulsory or involuntary treatment, without the consent of the patient should only be used in specific cases of severe acute disturbance that pose an immediate or imminent risk to the health of the patient or to the security of society. Short-term involuntary treatment for the protection of the vulnerable individual should be applied for the shortest periods of time necessary, at last resort, and it should always be undertaken by multidisciplinary teams and supervised by transparent legal procedures and be rigorously evaluated.

Making drug dependence treatment facilities more accessible in the community, attractive, qualified and less stigmatized would reduce the legal pressure needed to encourage treatment entry.

Many drug dependent persons are ambivalent about starting treatment and stopping or reducing their drug use. They may not find appropriate treatment services that are responsive to their needs. Offering services with a wide range of humane treatments and support programmes based on scientific evidence of effectiveness, increasing the motivation and empowerment of the patients, engaging them in a strong relationship with their therapist, family and community may be the best way to transform involuntary treatment facilities into opportunities for cohesion and true recovery based in community settings.

According to research, quality, performance and outcomes are the main factors influencing the attractiveness of drug dependence treatment programmes for people who are dependent on drugs. Quality drug dependence treatment is the result of a combination of factors that include among others, good infrastructure, adequate numbers of competent personnel, a team orientation, enough time devoted to each patient, clear clinical rules and related drug legislation, a variety of treatment methods offered, available resources, and case management. Quality treatment programmes provide a service that is attractive and friendly to potential patients.

Personal engagement and emotional involvement are essential in creating a therapeutic alliance. This should be a part of a system of comprehensive services that contribute to the health and well-being of persons affected by drug use, including drug prevention services, drug dependence treatment and care services, but also general health services, courts, probation services, municipalities and social services (Ratna and Rifkin, 2007, Hughey et al., 2008). The entire community should be mobilized in the rehabilitation and reintegration process, adopting cohesive strategies to assist the recovery of vulnerable individuals who use drugs.

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