# Legally Coerced Treatment for Heroin Addicted Offenders

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# Outline

- What is legally coerced addiction treatment?
  - Case for such treatment
  - Ethical issues
- Evidence on  the effectiveness of:
  - Community based addiction treatment
  - Diversion programs and Drug Courts
- Addiction treatment  in prisons
  - Compulsory or voluntary
  - Drug free only or OST as well?

# Legally Coerced Treatment for Addicted Offenders

- Coerced treatment as an alternative to imprisonment
  - before trial and after conviction
  - in prison and after release
- Compulsory addiction treatment:
  - Sentenced to treatment: no element of choice
  - NSW Compulsory Treatment Program

# Case for Coerced Treatment

- Drug dependence among offenders is:
  - Common & causally related to their offences
- High rates of relapse after release
  - Effective treatment can reduce recidivism
- High costs of imprisonment
- Risks of BBV infection among IDU
  - while in prison and post-release

# Ethics of Coerced Treatment 1

- Unethical according to libertarians (e.g. Szasz)
- Addiction is a fiction: drug use is always a choice

HENCE

- Adults should be legally free to use any drug
    - drug use per se should not be a crime
- Drug users who commit crimes should be punished

# Ethics of Coerced Treatment 2

- Ethical to treat drug dependent person
  - convicted of an offence (other than violence)
  - to which their drug dependence contributed
  - on threat of imprisonment if fail to comply
- If (according to WHO (1986)):
  - Judicial oversight of process
  - Offenders given constrained choices
    - treatment or imprisonment
    - type of treatment (if treatment is accepted)
  - Humane and effective treatment is provided

# Community-based Options for Addiction Treatment

- Drug Free treatment
  - Self-help groups
  - Therapeutic communities
- Opioid antagonist treatment
  - Oral or implantable naltrexone
- Opioid agonist maintenance treatment
  - Oral: methadone; buprenorphine; codeine; SROM
  - Injectable: methadone; heroin

# Effectiveness of Community-based Addiction Treatment

- Therapeutic Communities
  - Lower treatment retention than MMT
  - Intensive residential programs 3 months or more
  - Better social outcomes for those who remain
  - More cost effective than imprisonment
- Naltrexone
  - Oral naltrexone no better than placebo
  - Implants encouraging results at 6 months in 2 trials
    - Selected patients; small numbers

# Opioid Substitution Treatment 1

- MMT oldest form of OST
  - Effective in RCTs & observational studies
  - Reduces but does not eliminate heroin use
  - Often ambivalently implemented: low doses
  - Community intolerance of imperfection
- BMT newest form of OST
  - Marginally less effective than MMT
  - Less frequent dosing required
  - Probably a lower overdose risk
  - Lower diversion risk of suboxone?

# Opioid Substitution Treatment 2

- Heroin maintenance treatment
  - More effective in RCTs than MMT
  - Reduces but does not eliminate heroin use
  - Larger impacts on crime than MMT
- Some caveats
  - Model programs in highly selected heroin users
    - those who have failed at MMT
    - more criminally involved
  - Expensive to deliver because of supervised dosing
  - Cost effective because of its effects on crime
    - makes it hard to sell politically

# Evidence for Legally Coerced Addiction Treatment

- Limited “gold standard” evidence: RCTs
  - Cultural challenges in doing RCTs in CJS
- Observational evidence from USA
  - coerced treatment has better retention
  - no worse outcome than voluntary treatment
  - most studies on TCs & outpatient counselling
- Supported by some evidence
  - In Europe and Australia
  - Effects not always as good as reported in the USA

# Coerced Community Treatment: Observational Evidence 1970s

- DARP study
  - TC and OPC equally effective
  - with or without "legal pressure"
- DeLeon's TC studies
  - Comparable outcomes for coerced vs noncoerced
- TOPS
  - MMT outcomes comparable with or without coercion

# Implementation Issues

- Limited menu of treatment options
  - Preference for abstinence-oriented treatment
  - Against agonist maintenance treatment
- Funding and resourcing
  - Good to start with but often erodes with time
  - So does staff training, support and morale
  - Adverse impacts on voluntary treatment access?
- Cultural interface problems
  - Punitive vs therapeutic orientation
  - Duties to client vs Criminal Justice System

# Drug Courts in USA

- Began in late 1980s in response to
  - increase in imprisonment of drug offenders
  - prison overcrowding and revolving door
- Quickly grew into a “movement”
  - » Rapidly proliferated across US with local variations
  - » in absence of rigorous evaluation
- Quasi-experimental evaluations came later:
  - poorly constructed comparison groups
  - short term follow ups

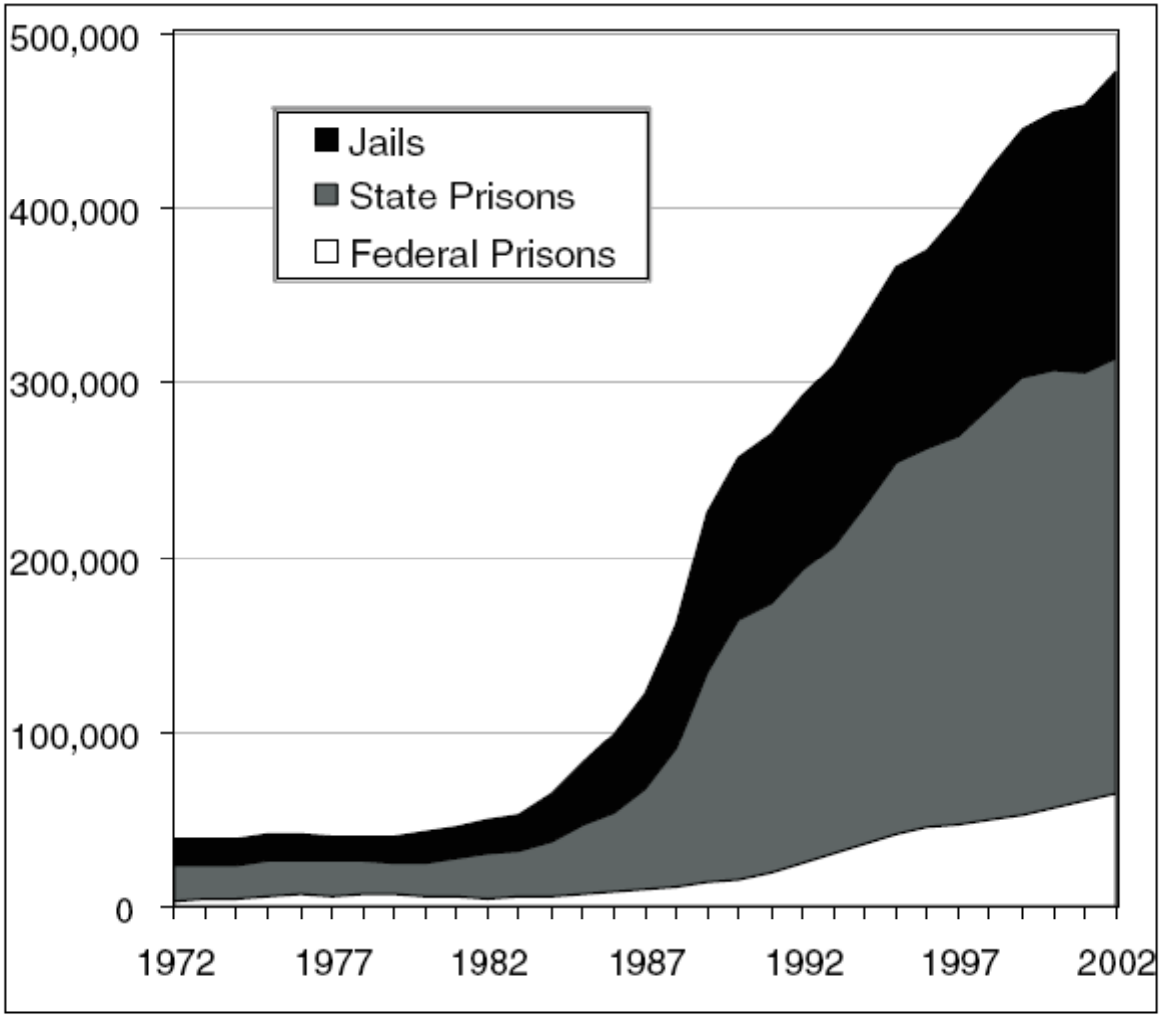


**Figure 1: The Number of Adults Incarcerated for Drug Law Violations in the United States Has Grown Sharply Over Time**

# Drug Courts Evaluations

- Some RCTs showing modestly positive effects
  - Retention rates 40-60%
  - Less drug use during program
  - Reduced recidivism
- Meta-analyses of quasi-experimental studies
  - Generally supportive
  - Retention rates 40-60%
  - Reduced recidivism: 8% below 50% base rate
  - Variations in effectiveness between courts

# Coerced Community Treatment: Recent Observational Evidence

- NSW Drug Court BOCSAR evaluations
  - RCT modest reductions in recidivism
  - Later observational study more positive results
- European studies of coerced treatment
  - Quasi-experimental studies with weak designs
  - Echo US results:
    - Reasonable retention
    - Reduced drug use and recidivism  while in treatment

# Prison-based addiction treatment

- Strong case for treatment in prisons
  - Public health and safety needs
  - Ideal opportunity with captive population
  - Human rights case
- Prima Facie:
  - Voluntary addiction treatment should be available
    - often only 12 step or counselling
  - Incentives to entry:
    - remission of sentence or prison privileges

# Voluntary Prison-based Addiction Treatment

- Most often TC programs in US prisons
  - Often observational studies
  - Reduced drug use while in prison
  - Some RCTs evidence of reduced recidivism
- Evidence best for programs
  - that provide support post release
  - recidivism high in absence of such support

# Voluntary Prison-based Addiction Treatment

- Less support for MMT programs
  - Prejudice against OST in prisons
  - Hostility to NSW MMT program
- Nonetheless some evidence
  - RCT showing reduced drug use in prison
  - Some evidence of reduced recidivism post release
    - US RCT and  follow up of NSW RCT cohort

# Compulsory Prison-based Treatment: US Evidence

- US PH Narcotic Hospitals 1935-1971
  - Detoxification + group therapy + no supervision
  - 90% recidivism after release
- California Civil Addict Program 1960s
  - 12 year follow up of 1962-1964 program
  - Compulsory treatment + community supervision
  - Substantial reductions in crime and drug use
- New York Civil Addict program late 1960s
  - Failed because poorly implemented

# Compulsory Addiction Treatment Recent Experiences

- Other countries
  - Netherlands Prison Program: no evaluation
  - China and Vietnam: no evaluations
- UN Office on Drugs and Crime 2010:
  - Supports coerced treatment instead of imprisonment
  - But not compulsory “treatment” e.g. boot camps
    - No evidence for effectiveness
    - Violates human rights of drug users

# Summary

- Good evidence for community-based treatment
  - Better for OST than TCs
- Coerced treatment in community positive
  - Mostly observational; with no comparison group
  - Selection biases likely; studies primarily in USA
  - Weaker support from Europe and Australia
- Compulsory treatment weakest evidence

# Compulsory treatment in the NSW Prison Program

- Rationale for NSW Program:
  - Target recidivist drug dependent offenders
  - Reduce their recidivism and hence crime
  - More cost effective than simple imprisonment
- Little recent evidence for such treatment
  - No controlled studies of their effectiveness
  - No evidence on cost-effectiveness
  - Little guidance on how to provide it and to whom
  - Past experience not inspiring

# Implementation issues 1

- Criteria for selecting offenders:
  - If too tight, too few customers to be worthwhile
  - A small expensive program hard to justify
    - Minimal impact on recidivism or crime
- Where and how in the prison system?
  - A Special Unit: equity of access
  - A mainstream program: quality control
- These choices will affect impact

# Implementation issues 2

- Drug free treatment only?
  - Often a political imperative
  - Prisoner preference
- How likely is abstinence
  - given clientele's history?
  - unless good post-release support
- Political expectations?
  - Settling for less than perfection often difficult
  - But the most likely outcome

# Should prison addiction treatment include OST?

The case for providing MMT or BMT:

- Evidence of effectiveness in community
- RCT evidence of effectiveness in NSW prison
- Human rights access to most effective treatment
- Prisoner choice of treatment options

# Should prison addiction treatment include OST?

Special challenges for OST in prison:

- Diversion and security of supply in prison
- Ideological opposition from correctional staff
  - often impairs quality of provision
- Fit between OST and CDTCC approach
  - Difficult to provide DF and OST in same place

# Should treatment in the CDTCC be compulsory?

How meaningful is compulsion?

- Recidivist group inured to prison life
- Failure to comply means return to main prison

Is Judicial oversight necessary?

- Court oversight adds to the expense & difficulty

Why not offer places to current candidates?

- Drug free prison setting probably attractive
- If demand exceeds supply conduct an RCT

# Evaluation is Essential

- But rigorous evaluations rarely done
  - Instead “pilot programs”
  - Small numbers and well resourced programs
  - In the absence of any comparison group
- Impossible to evaluate program so it either:
  - Becomes institutionally embedded
  - Often rolled out and poorly implemented
  - Abandoned with a change of government or fashion
  - Left none the wiser for the experience

# Conclusions 1

- Strong case for treating addicted offenders
  - High rates of problem drug use in prisoners
  - Drug dependent prisoners offend at high rates
  - At high risk of recidivism if  untreated
  - Treatment can reduce recidivism
- Case for treatment a confluence of
  - Human rights: access to addiction treatment
  - Community safety: reducing drug related crime
  - Public health: reducing deaths and BBV infections

# Conclusions 2

- Best evidence voluntary community based
  - OST and TCs
- Coerced community treatment:
  - OST & TCs best supported
- Voluntary treatment in prison
  - Good support for TC style programs
  - Reasonable evidence for OMT

# Conclusions 3

- Compulsory treatment in prison
  - A weak evidence base and poor rationale
- Better evidence needed if it continues
  - To learn from experience
  - An end to small scale trials that cannot be evaluated
- Invest in better supported approaches
  - Diversion to community-based programs
  - Voluntary prison-based addiction treatment