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 Communitybased 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

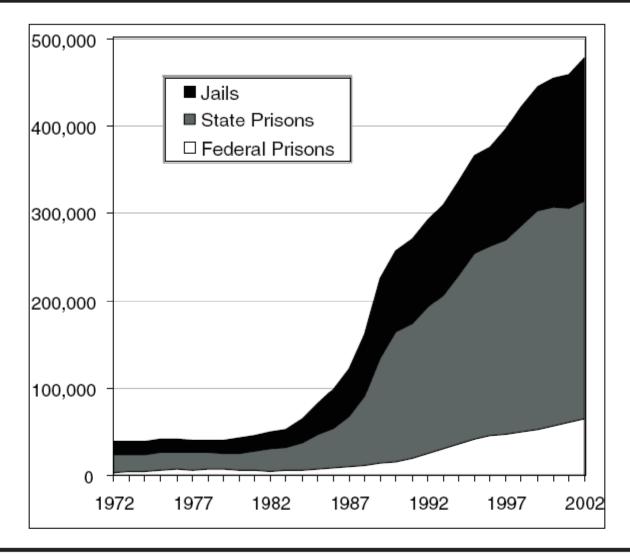


Figure 1: The Number of Adults Incarcerated for Drug Law Violations in the United States Has Grown Sharply Over Time

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