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Toby Seddon
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Coerced drug treatment in the criminal justice system:
Conceptual, ethical and criminological issues

TOBY SEDDON
University of Manchester, UK

Abstract

A striking phenomenon in many western countries is the increasing use of the criminal justice system as a means of channelling and coercing drug users into treatment. Despite somewhat equivocal research evidence about its effectiveness, this approach has continued to expand, including in Britain. This article takes a step back and explores some of the critical background issues that have been largely overlooked to date. Some conceptual, ethical and criminological aspects of coerced treatment in the criminal justice system are considered. It is argued that coerced treatment is a central issue for both contemporary criminology and criminal justice policy.

Key Words

coerced treatment • criminal justice • drugs • drug treatment
• ethics

Introduction

One of the articles of faith of many drug workers in this country is that problem users cannot be coerced into treatment.

(Hough, 1996: 36)

In Britain, this was no doubt true in 1996 but there has been a sea change in attitudes over the last decade. Starting with the introduction of the Drug
Treatment and Testing Order (DTTO) pilots in 1998 (Turnbull et al., 2000) and most recently with the ‘Tough Choices’ initiative, coerced treatment has become a key part of British drug policy and practice (Hunt and Stevens, 2004). This development has occurred in the context of a broader policy shift which since 1998 has focused on ‘a major expansion of services within the criminal justice system using every opportunity from arrest, to court, to sentence, to get drug-misusing offenders into treatment’ (Home Office, 2002: 4). Coercive approaches that utilize the leverage of the criminal justice system are thus part of a wider programme of ‘voluntary’ referral from all stages of the system.

Although coerced treatment is a relatively new departure in Britain,1 some countries have a much longer experience of using criminal justice leverage in this way. The most obvious example is the United States, where the idea can be traced back to the ‘narcotic farms’ of the 1920s right through to the California Civil Addict Program in the 1960s (Anglin, 1988), but other countries have been following this route for several decades, notably Australia and several European countries (Webster, 1986; Stevens, 2004).

The rationale for the policy of coerced treatment, certainly in its contemporary British form, is based on three foundational principles:

1. that there is a strong causal connection between drug ‘addiction’ and acquisitive crime;
2. that treatment is effective in reducing this ‘drug-related’ crime;
3. that coerced treatment is effective.

The strength of the evidence base for these three principles varies. Principle One has been the subject of a long-running and unresolved debate. While the association between certain types of drug use and involvement in property crime is indisputable, the causal nature of this relationship is far from clear (see Seddon, 2000) and the concept of addiction on which it rests is problematic and contested (e.g. Grapendaal et al., 1995). Evidence for Principle Two is much stronger. In the British context, the National Treatment Outcome Research Study has indicated that treatment can contribute towards substantial reductions in offending for some individuals (Gossop et al., 2001, 2005, 2006). On the other hand, there is limited British evidence in support of Principle Three, the main substantive contribution currently being the recent report by McSweeney and colleagues (2006). Reviews of the international research reveal a wide range of outcomes for coerced treatment, with some studies suggesting coerced clients do no worse than those entering treatment voluntarily and that legal pressure can aid treatment retention but with others showing negative effects (Klag et al., 2005; Stevens et al., 2005b).

The aim of this article, however, is not to revisit the evidence base for these three principles. Rather, it seeks to consider some of the critical conceptual and theoretical issues underpinning coerced treatment. The first section examines some of the basic conceptual building blocks in this area, looking specifically at the idea of coercion itself and the related concept of motivation, as well as the notion of treatment as it is used in this context. In the second section, some of the ethical issues posed by coerced treatment
are considered. The third section discusses some important criminological aspects of the issue. Although the article has a particular focus on the British context, it has a wider relevance. It not only draws on international research but also concentrates on the analysis of general issues and principles relating to coerced treatment that have a transnational applicability.

Conceptual issues

The idea of coerced treatment obviously involves two central concepts, coercion and treatment, and these will both be examined here. Looking first at coercion, a basic definition provides a useful starting point: ‘Coerce (verb) Persuade (an unwilling person) to do something by using force or threats’ (source: Compact Oxford English Dictionary). Following this definition, the idea of coercion breaks down into three component parts:

1. persuading someone to do something
2. which they are unwilling to do
3. by using force or threats.

The first component, persuasion, implies a process of convincing or encouraging someone to undertake a particular course of action by making what might be termed a ‘sales pitch’, setting out the benefits of following that course and/or the dangers of not doing so. Central to this, therefore, is the communication of information to targeted individuals about the options on offer and their relative merits. In other words, we can say that coercion must include an informative or communicative element. Reference to options is a reminder that coerced individuals still retain a choice, however constrained. This marks the distinction between coerced and compulsory treatment, as the latter does not involve or require consent. The discussion in this article focuses on coerced treatment, although it is worth noting that arrangements for compulsory placement in drug treatment do exist in some countries (Stevens et al., 2005a: 207). The idea of (constrained) choice, which underpins coercion, has some further significant implications and will be returned to later in this article.

The second component, that the person is unwilling, raises some important points. Research has found that not all those who are legally mandated into treatment are unwilling entrants (Farabee et al., 2002; Longshore et al., 2004: 112–13). Nor do they all lack interest in treatment or feel that they do not need it (Hiller et al., 2002). The mere fact that legal pressure is applied to direct a person into treatment does not in itself necessarily mean that they were actually coerced into it in the sense of being forced against their will. As Longshore et al. (2004: 113) observe, a blanket assumption that individuals referred through criminal justice routes are under greater coercion than those who are not would be mistaken and unfounded. Willingness or desire to participate in treatment cannot be simply or directly inferred from the referral route (Stevens et al., 2006) and equating coercion with criminal justice referral is misleading (Wild, 1999, 2006). This is a major conceptual weakness in much of the research literature to date (Wild et al., 2002; Wild, 2006: 43).
The third component, that of using force or threats, again raises a significant issue. The alternative to entering treatment needs to be perceived, in relative terms, to be less beneficial or less pleasant for there to be a threat. To give a British example, the Drug Treatment and Testing Order (DTTO)\textsuperscript{2} was intended as a community-based alternative to imprisonment, with the expectation that those offenders who refused or failed to comply with the order would end up in custody. This has been described by some critics of coerced treatment as illustrating how the apparent requirement for offenders to consent to this type of intervention is in fact a sham. What kind of ‘informed consent’ can offenders realistically give if the alternative is prison? Yet the fact that within these kinds of initiatives, drug treatment typically represents for many offenders an ‘offer they cannot refuse’, to use Mike Hough’s (1996: 36) phrase, is of course intrinsic to the whole concept of coercion. It is not a regrettable indicator that coercion has gone too far, rather it is its hallmark. The whole point is to try and shift the cost–benefit ratios of the different options so that treatment is clearly and obviously the preferential choice for as many individuals as possible.

These three elements then are the core components of the idea of coercion in this context. Typically ‘coerced’ treatment is defined in contrast with ‘voluntary’ treatment, implying that there is a binary distinction between the two—either an individual freely enters into drug treatment or else they are coerced into it. As already indicated, conceptually this is a rather crude and simplistic way of describing the decision-making processes of drug users about treatment entry. A number of studies have found that coercion is most usefully conceptualized as a continuum rather than as a dichotomous variable (Anglin et al., 1989; Anglin and Hser, 1990; Farabee et al., 1998; Hiller et al., 1998; Longshore et al., 2004: 111–12).

A key article by Marlowe and colleagues (1996) established two central points. First, they demonstrated that coercive pressures at drug treatment entry were ‘operative in multiple life spheres’ (1996: 82). In other words, coercion is a multi-dimensional concept, with coercive pressures emanating from diverse sources, including family and financial concerns as well as the criminal justice system (Polcin and Weisner, 1999; Marlowe et al., 2001; Polcin, 2001: 594–5; Longshore et al., 2004: 112). As Bean puts it:

In a different form [coercion] occurs also outside the criminal justice system, for rarely do offenders enter treatment free of all forms of coercion, whether from friends, relatives or others. To talk, therefore, of ‘coercion’ and compare this unfavourably with ‘voluntary’ decisions to enter treatment is to be too optimistic about the nature of many drug users’ lives.

(2004: 229)

Second, and most interestingly, Marlowe and colleagues went on to show that ‘legal pressures may exert substantially less influence over drug treatment entry than do informal, extra-legal influences’ (1996: 81). Research subjects ‘perceived treatment-entry pressures as stemming predominantly from psychological, financial, social, familial, and medical domains respectively’
(1996: 81). Again, for many people it may be false to assume that the application of criminal justice leverage dramatically increases the level of coercion they feel to enter treatment. This leads on to another important point. Coercion is an inherently subjective concept because it is the perception of persuasion by threat that influences behaviour and not the level of threat that objectively exists (Wild et al., 1998; Polcin, 2001: 594–5; Young, 2002; Longshore et al., 2004: 112–13). This has obvious research implications for the measurement of coercion.

This subjective dimension to coercion (external pressure) suggests importantly a close link with the concept of motivation (internal pressure). In the drugs field, there are a number of models of motivation for change, perhaps the best known of which is Prochaska and DiClemente’s (1986) ‘cycle of change’, which suggests that individuals progress through a series of stages as they change their addictive behaviour. Despite its strong research and clinical influence, the ‘cycle of change’ has been heavily criticized in recent years (Sutton, 2001; Davidson, 2002) and increasingly distinctions are drawn between motivation to enter treatment and motivation to engage in treatment (Drieschner et al., 2004; see also Longshore and Teruya, 2006). Nevertheless, however it is conceptualized, motivation is widely viewed as a critical factor in treatment participation, retention and success (Hiller et al., 2002).

It has been argued that coerced treatment is doomed to failure precisely because individuals do not have this internal motivation. As we have already seen though, the assumption that all individuals referred through criminal justice routes lack any interest in or desire for treatment is a false one (Farabee et al., 2002; Hiller et al., 2002) and, as Hough (2002: 991) suggests, in reality many ‘voluntary’ treatment entrants begin their treatment engagement with a degree of ambivalence (Klag et al., 2005: 1781). The critical question then is how we can conceptualize and understand the relationship between external pressure (coercion) and internal pressure (motivation). It has been suggested that legal coercion may increase readiness for treatment (Gregoire and Burke, 2004; cf. Stevens et al., 2006), while others have argued the contrary. Both viewpoints imply that internal and external pressures are not entirely separate or independent domains. Rather, there is an interactive relationship between them. There is some evidence that this interaction may have a significant impact in some circumstances. Several studies have found that the combination of strong external pressures and strong internal motivation can lead to better treatment outcomes than those produced by either factor on their own (Simpson and Joe, 1993; de Leon et al., 1994; Longshore et al., 2004: 115–16). Longshore and colleagues hypothesize that: ‘External and internal motives may jointly affect treatment success when external pressure is internalised or “transformed” by the person into an internal motive’ (2004: 115–16). Some recent contributions to the literature (Longshore and Teruya, 2006; Stevens et al., 2006; Wild, 2006) argue that unravelling these complex interactions between legal pressure, other external pressures, perceptions of coercion and internal motivation is vital for more conceptually robust research on ‘coerced treatment’.
Turning from coercion to the second central concept, treatment, this is on the face of it easier to define. In the British context, the National Treatment Agency (NTA) has produced the following definition:

[Drug treatment] describes a range of interventions which are intended to remedy an identified drug-related problem or condition relating to a person’s physical, psychological or social (including legal) well-being. Structured drug treatment follows assessment and is delivered according to a care plan, with clear goals, which is regularly reviewed with the client. It may comprise a number of concurrent or sequential treatment interventions. (NTA, 2002: 2)

Other definitions broadly speaking offer variations on this theme. The critical issue here concerns the objectives of treatment interventions. This is important as there is a significant debate about whether viewing drug treatment through a criminal justice lens has distorted service provision. It is clear from the NTA’s definition, and other similar ones, that the social domain is only one of three drug-related problem areas that treatment may seek to address. Within that domain, criminal activity and coming into contact with the criminal justice system represent only one set of problems. In this sense, the level of priority given to crime reduction as an objective of coerced treatment in its own right (as opposed to a useful by-product) may actually shift in a fundamental way what is meant by the term ‘treatment’. This is not simply a semantic point. The prioritization of crime reduction might result in a preference for particular treatment modalities that might differ from those that would be suggested were physical or psychological well-being the primary treatment goals. It could be hypothesized, for example, that within coerced treatment there might be a greater emphasis on methadone prescribing, given its perceived effectiveness as a tool for reducing offending by heroin users (Gossop et al., 2001). Certainly, the recent British experience has been that in some local areas ‘rapid prescribing’ has been seen as a way of making coerced treatment more attractive to users, a strategy which may be in some tension with a more careful and clinically driven approach to prescribing.

Clearly, the concept of ‘coerced treatment’ is more complex than it might first appear. A failure to grasp this has ‘significantly impeded the accurate measurement of the effects of coercion into treatment on treatment process and outcome variables’ (Klag et al., 2005: 1783). As a consequence the evidence base is actually much weaker than might be suggested by the number of studies in this area. A more conceptually sophisticated approach is essential both for future research and future policy development.

Ethical issues

The ethics of coerced drug treatment is a matter of much debate and raises some fundamental questions. There are several inter-linked issues concerning justice and human rights that will be explored here.
In the previous section, it was suggested that the significance of legal coercion tends to be over-stated, given that drug users generally make decisions about treatment under the influence of pressures from a range of sources. However, Stevens and colleagues make the point that the coercive pressure exerted by the State on individuals has a distinctive character, as the State has ‘agencies to deal with those who try to avoid it’ (2005a: 207). The question then is on what moral basis this pressure is placed on drug-using offenders. Two answers are often given: first, on the grounds of benevolence (‘it’s good for them’); second, on the basis of the crime prevention benefits to communities that may result from effective treatment (‘it’s good for us’).

Neither answer is persuasive. The first is difficult to sustain as people in liberal societies are not usually under any obligation to do what is good for them. Individuals generally have a right to pursue unhealthy lifestyles if they so wish and are not obliged to seek help to alleviate any afflictions from which they may suffer. Indeed, the right to refuse treatment has been held to come within the ambit of Article 8 of the European Convention on Human Rights (Havers and Neenan, 2002; cf. Caplan, 2006). The second answer raises arguments that have some echoes of older debates about the ethics of rehabilitation in the penal system. Norval Morris (1974) argued over 30 years ago that the use of imprisonment for the sole or primary purpose of rehabilitation was incompatible with justice. The core of the ethical difficulty identified by Morris is the problem of treating individuals only as means and not as ends, an argument that draws on Kantian moral philosophy. If every individual is seen to have an intrinsic value, then his or her rights should not be sacrificed solely in order to protect others. From this perspective, the justification of coerced treatment on crime prevention grounds is highly problematic in ethical terms.

A different moral basis for the use of coercion has been suggested by Gostin (1991) who argues that it can be ethical provided that it, first, restricts the liberty of the recipient no more than the alternative disposal already justified by the offence, second, is consistent with due legal process (see also Porter et al., 1986) and, third, is targeted at those most in need of and susceptible to treatment. Against this yardstick, current practice in Britain raises some difficulties. Individuals who refuse or fail to comply with treatment may indeed end up with a harsher punishment than they would have received on the basis of their original offence. For example, under recent provisions in the Drugs Act 2005, a person who is arrested and subsequently released without charge but who tested positive for opiates or cocaine at the police station might receive up to three months in prison should they fail to attend their required drug assessment. In other words, an individual could be wrongly arrested and later released but still end up facing charges and possible imprisonment simply for not turning up for an assessment at a drugs service.

Concerns of this kind recall aspects of the critique of rehabilitation in the 1970s which argued that in practice it had often turned out to be harsh and excessive, prolonging interventions beyond what a purely punitive system
would have required (von Hirsch, 1976; Allen, 1981; Cohen, 1985). They relate too, albeit less directly, to the more polemical arguments of Thomas Szasz (1963) and others about the rise of the ‘Therapeutic State’ in which the medical role or label is used to cloak what is in fact a moral and political enterprise of social control. In this vein, Fischer argues that Drug Treatment Courts in North America, with their symbolism of ‘health’ and ‘treatment’, ‘obscure the fact that “punishment” is the persistent and predominant mode of addiction control’ (2003: 244).

However, some of these criticisms may be seen as misplaced or overblown. Coerced drug treatment involves a constrained choice rather than actual compulsion. The rights of individuals are therefore not subordinated to those of others as they are able to choose whether or not to enter treatment. Indeed, British policy-makers have been at pains to emphasize the idea of choice rather than coercion. The latest initiative is called ‘Tough Choices’ and the language of ‘coercion’ appears to have entirely disappeared from the most recent guidance documents that have been issued.

The validity of this argument hinges on whether individuals targeted for legal coercion are genuinely able to give proper informed consent to treatment. Is the appearance of choice in fact an illusion? Is consent in effect given under duress? These questions are ultimately only answerable empirically. There is little research evidence directly on this point but Stevens and colleagues (2005a: 208) suggest that in their experience ‘coerced’ drug users tend to view the offer made to them as a genuine choice and opportunity rather than as an imposition. Nevertheless, attempting to get informed consent from potentially vulnerable individuals in a highly stressful environment (typically in the police station or at court) risks being ethically problematic.5

The requirement for genuine and informed patient consent is firmly established in medical law and ethics (Herring, 2006). The question of consent thus raises issues of professional ethics for health workers. As Bateman (2001) argues, nurses and other health professionals are bound by codes of ethics which enshrine their duty to act in the interests of individual patients at all times. If a drug user is coerced into treatment and their consent is not genuine, should the health professional decline to treat them? A further related issue is the question of patient confidentiality and the sharing of information between drug agencies and the criminal justice system. In order to monitor compliance with coerced treatment, criminal justice agencies require information about whether offenders are attending and engaging with treatment. Barton has explored this area in a series of articles (Barton, 1999a, 1999b; Barton and Quinn, 2002). He notes that the practice of confidentiality within mainstream health care is complex and ambiguous. In the criminal justice context, he suggests that for information sharing there is a fundamental tension between practice driven by the needs of individuals and practice guided by the demands of the risk management of groups considered to be ‘high-risk’ offenders (Barton and Quinn, 2002). In other words, for drug treatment provision, the crime reduction agenda may distort the exercise of professional discretion concerning patient confidentiality.
A final set of ethical issues concerns the equity of access to treatment services. The core concern is whether coerced treatment involves offenders jumping the treatment queue ahead of non-offenders and, if it does, how can this be justified? Finch and colleagues (2003) describe how the provision of DTTOs in one area created what they considered to be unacceptable inequalities in access to treatment. This of course can only happen where there is a local shortfall of capacity in the treatment system relative to demand. Yet, in the British context at least, it is arguable that the criminal justice agenda has actually levered in additional funding which has improved access to treatment both for offenders and non-offenders. A slightly more nuanced argument is that coerced treatment distorts how priorities for treatment access are determined. Barton (1999a), for example, reports how in one area women came to be ‘squeezed out’ of treatment because they were not high priorities from a criminal justice perspective. Rush and Wild (2003), reporting on Canadian research, suggest that the operation of a coerced treatment programme in Ontario was disproportionately drawing young males into the treatment system and that this raised the issue of equity of access. Again, it is possible to see the potential distorting impact of drug treatment being viewed through the criminal justice lens.

In summary, there are a number of ethical concerns about coerced drug treatment. It is clear that there are some significant and serious issues of justice and human rights at stake which merit further debate. A theme running through the discussion here has been that many of the ethical questions relate to the ways in which the use of coercion and the criminal justice agenda can distort the principles and practice of drug treatment.

Criminological issues

Coerced treatment for drug users in contact with the criminal justice system raises a number of significant criminological issues, which will be explored in this section. The concept obviously resonates strongly with rational choice theory (Cornish and Clarke, 1986), one of the new ‘criminologies of everyday life’ that have become so influential over the last 25 years in providing a new ‘way of thinking’ about crime and social order in late modernity (Garland, 2001). It is an underpinning assumption that drug-using offenders will weigh up the costs and benefits of accepting treatment and make a rational decision. The coercion or leverage provided by the criminal justice system is intended to alter the cost–benefit ratio in favour of treatment. The individual offender is thus conceived as a rational calculator making choices in order to maximize benefits and minimize costs (Frisher and Beckett, 2006).

However, there is a real paradox in the reliance on rational choice theory in relation to coerced drug treatment. The interventions are predicated on the targeted individuals acting as rational calculators, yet at the same time those individuals are viewed as ‘addicted consumers’ who are considered to lack the capacity to exercise properly their freedom to choose...
In empirical terms, this notion of ‘addictive consumption’, which is a key part of the rationale for coerced treatment, has been challenged by several studies (e.g. Grapendaal et al., 1995). At a more theoretical level, recent work by Pat O’Malley and others (O’Malley, 1999, 2002, 2004: 155–71; Gomart, 2002; O’Malley and Valverde, 2004; Reith, 2004) has shown how these paradoxical ‘problems of freedom’ are actually quite central to understanding contemporary modes of governing the conduct of drug users. It is this dialectic between ‘addiction’ and freedom which underpins changing representations of drug users and changing responses to their behaviour.

The idea of freedom has become a central theme more broadly within studies of contemporary politics and government (Rose, 1999; O’Malley, 2004). Nikolas Rose (1999), for example, has argued that within neo-liberal governmental strategies, we are increasingly governed through freedom. He observes that: ‘The programmatic and strategic deployment of coercion … has been reshaped upon the ground of freedom, so that particular kinds of justification have to be provided for such practices’ (1999: 10). He goes on to argue that these justifications include:

The argument that the constraint of the few is a condition for the freedom of the many, that limited coercion is necessary to shape or reform pathological individuals so that they are willing and able to accept the rights and responsibilities of freedom, or that coercion is required to eliminate dependency and enforce the autonomy of the will that is the necessary counterpart of freedom. (1999: 10)

From this perspective, coerced drug treatment can clearly be seen as a strategy that is constructed on the ‘ground of freedom’. This should not be mistaken as meaning that we have ‘entered the sunny uplands of liberty and human rights’, as Rose (1999: 10) nicely puts it, but rather that certain values and ideas given the name ‘freedom’ have come to provide the grounds on which governmental power is exercised. This leads to an important point. Coerced treatment is based on a very particular formulation of ‘freedom’ in which the drug user is imagined as a ‘choice-maker’ (O’Malley, 2004: 161–3) and furthermore one who is obliged to choose. It is here that the apparent ‘paradox of freedom’ described above—‘addicts’ with attenuated free will are at the same time expected to act as rational calculators—is resolved. Within coerced treatment initiatives drug users are not required to exercise their full and sovereign free will, they are simply obliged to make a choice from a highly constrained set of options (typically, prison or treatment). Hence, O’Malley (2004: 169) argues that ‘choice’ displaces ‘free will’ in this formulation of ‘freedom’. The idea of ‘Tough Choices’, the name for the latest British drug-crime initiative, is particularly apt in this respect.

Another, and related, feature of neo-liberal government is its distinctive focus on risk and risk management. Indeed, the concept of risk has become a central motif across the social sciences over the last 15 years (Beck, 1992; Douglas, 1992; Hope and Sparks, 2000; Garland, 2003; O’Malley, 2004).
and understanding the nature of risk management practices has been described as one of the ‘central theoretical problems for contemporary criminological enquiry’ (Sparks, 1997: 432). Sparks notes that there is an ‘intrinsic connection between the notions of rational choice and of risk’ (1997: 424), or, as O’Malley puts it, they are ‘compatible and complementary terms’ (2004: 169). The cost–benefit calculations undertaken by rational actors are about maximizing benefits and minimizing risks. However, in respect of drug-using offenders, the animating idea of coerced treatment is that they themselves are particular sources of risk to others, a form of risk that has been termed actuarial (Feeley and Simon, 1994; O’Malley, 2004: 22). In this sense, coerced treatment can be viewed as a technology for the identification and management of the actuarial risk of ‘drug-driven’ crime. Its rise to prominence in recent years can therefore be understood as part of the wider ‘rise of risk’ (Garland, 2003) within neo-liberalism.

Within the risk management technology of coerced treatment, drug testing serves a critical function and has been described as a ‘necessary prerequisite’ for criminal justice treatment (Carver, 2004). It is frequently used in the initial identification of ‘high-risk’ offenders, the tests providing ‘data in a flow of information for assessing risk’ (Feeley and Simon, 1994: 179). For example, in the British context, testing of arrestees takes place in police custody suites (Deaton, 2004), identifying individuals who may subsequently be targeted for drug treatment as they progress through the criminal justice process. Once individuals have been channelled into treatment, testing can also provide a means of monitoring and enforcing compliance, providing the ‘material basis for surveillance’ (Simon, 1993: 187) which, as Ericson notes, is a key component of the administration of risk:

> Surveillance is the production of knowledge about (monitoring), and supervision of (compliance), subject populations. Knowledge production and supervision are mutually reinforcing, and together they create surveillance as a system of rule ... Surveillance is THE vehicle of risk management.

(1994: 161, capitals in original)

In contrast to Beck’s (1992) influential thesis, David Garland (2003) has suggested that the core issue in today’s ‘risk society’ is not about modern technology and its unwanted side-effects but rather concerns choices about life-style and consumption. He argues that these kinds of choices and some of their associated risk technologies have a particular resonance within contemporary consumer capitalism: ‘[Criminological] accounts that highlight rational choice and the responsiveness of offenders to rewards and disincentives chime with ... the individualistic culture of our consumer culture’ (Garland, 2001: 198). In these terms, the management of the risks associated with the consumption of illegal drugs and involvement in drug subcultures obviously goes to the heart of the matter. Coerced treatment, in particular, is archetypal of contemporary risk management practices in three senses. First, it involves managing the risks posed by a particular form of ‘disordered consumption’ (Reith, 2004) and its related life-style. Second, it utilizes the notion
of choice and the responsiveness of drug-using offenders to ‘rewards and disincentives’ in order to manage risks. Third, it deploys surveillance, typically via the use of drug testing, as a key tool for this risk management.

The attempted coercion or channelling of drug-using offenders into drug treatment is a form of what Nikolas Rose describes as the government of conduct within ‘circuits of inclusion’ (2000: 187). These circuits are associated with a ‘criminology of the self’, that characterizes offenders as normal, rational consumers, just like us’ (Garland, 2001: 137, emphasis in original). For those individuals who cannot be accommodated in this way, they are governed within ‘circuits of exclusion’ (Rose, 2000: 187) linked to a ‘criminology of the other, of the threatening outcast, the fearsome stranger, the excluded and the embittered’ (Garland, 2001: 137, emphasis in original). For coerced drug treatment in the criminal justice system, these exclusionary circuits predominantly involve the use of imprisonment. Those individuals who reject the ‘offer’ of treatment will often face prison. Similarly, and in practice much more commonly, those who accept treatment but subsequently find themselves unwilling or unable to comply with its requirements may be incarcerated. Coerced treatment thus fits with the more general pattern of control practices within neo-liberal government.

Summarizing, the area of coerced treatment intersects with some major themes in criminology today. In particular, it feeds into important debates about the distinctive place of risk in late modern society. It is also closely linked with the new styles of criminological thinking that have emerged over the last couple of decades and which are associated with contemporary strategies for crime control. It thus represents an important site for the engagement with these highly significant areas of criminological debate.

Conclusions

This article has suggested that to frame the debate about coerced drug treatment simply in terms of whether it ‘works’ is premature and misleading. The conceptual confusions that have characterized much of the research to date rule out any possibility of definitive declarations about effectiveness. One contribution of the article is to indicate some of the conceptual building blocks that might underpin the future development of a much more coherent and useful evidence base.

Entering into the effectiveness debate is arguably premature in another sense too. There are profound ethical issues raised by coerced treatment that do not appear to have been fully examined yet. Some commentators have directly linked the question of ethics with that of effectiveness, arguing that coerced treatment is only ethically justifiable if it achieves positive outcomes (Gostin, 1991). However, this begs some questions. The whole moral basis for the approach is far from clear and there are concerns about potential conflicts with principles of justice in its practical application. Perhaps even
more significant are the issues of consent and confidentiality. It is the case, in the British context at least, that much of the drug treatment provision into which individuals are coerced is part of the National Health Service. It should be a matter of disquiet at the very least that the principles of patient consent and confidentiality may operate to a different standard when patients are coerced into health services by the criminal justice system.

Finally, it has been argued that the issue of coerced treatment throws some interesting light on some of the ‘big’ questions of criminological thought and should therefore be seen as a central issue for contemporary criminology. Notably, it goes to the heart of debates about the distinctive place of notions of risk and freedom within crime control practices at the beginning of the 21st century, debates which are at the forefront of criminological enquiry today (Loader and Sparks, 2002). Coerced drug treatment in the criminal justice system should be of interest to a much broader set of constituencies than the drug specialists who have occupied the area up to now.

Notes

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1 As Berridge (1996: 303) notes, there had in fact been discussions in Britain at the turn of the 20th century about the possibility of compulsory treatment for drug addicts under the inebriates legislation. While this did not materialize, it illustrates that in the British context the idea of coerced treatment is not completely new, even if the practice is relatively novel.

2 The DTTO was replaced in April 2005 by the Drug Rehabilitation Requirement (DRR) which involves a similar programme of drug testing and treatment.

3 There is a parallel here with the wider community safety literature in which it has been argued that the pre-eminence of the ‘law and order’ agenda may be distorting the provision of mainstream public services (Crawford, 2002: 233).

4 Thanks to Alex Stevens for suggesting this way of summarizing the two positions.

5 In a recent research project in which the author was involved, a court-based drugs worker gave an example of the type of situation sometimes presented in practice: ‘You’re assessing somebody who’s literally holding the wastepaper basket in front of them, heaving into it […] And then you say I’d just like you to sign these forms […] and they will sign anything.’

6 Empirical studies cast doubt on the idea that the risks of offending associated with drug use constitute an objective or fixed risk that can be measured and managed by drug testing and treatment (e.g. Grapendaal et al., 1995; on testing, see Seddon, 2005: 16).
References


Stevens, A., D. Berto, U. Frick, N. Hunt, V. Kerschl, T. McSweeney et al. (2006) ‘The Relationship between Legal Status, Perceived Pressure and Motivation...

TOBY SEDDON is Senior Research Fellow in the Centre for Criminology & Socio-Legal Studies in the School of Law at the University of Manchester. Previously he held a research position in the Centre for Criminal Justice Studies at the University of Leeds. He is author of Punishment and Madness (2007, Routledge-Cavendish).