A compulsory drug treatment program for offenders in Australia: Therapeutic jurisprudence implications

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INTRODUCTION

In August 2006, the Compulsory Drug Treatment Correctional Centre Bill 2004 (the Model Bill) established a new drug treatment prison. With the current law being dispersed between the three newly-amended Acts, this article will refer to the Compulsory Drug Treatment Correctional Centre Bill 2004 as the source of these amendments and the status of the current law for ease. In Australia, the legislation is unique and the prison is the first of its kind; under Australian law, prisoners cannot generally be ordered to submit to treatment as part of a prison sentence. The Compulsory Drug Treatment Program (the Program) allows the New South Wales Drug Court to order sentenced, repeat drug-related offenders to a prison that provides comprehensive drug treatment and rehabilitation (see s106B(a)). The Program resembles similar legislation in the Netherlands and the abstinence approach to drug use in the United States. The SOV-Regulation in the Netherlands was created in 2001 and was incorporated into the legislation governing the Legal Detention of Addicts where compulsory drug detention could be imposed for a maximum of two years on drug addicts who had become a serious “nuisance element” (Oei, 2005). In presenting the second reading speech, the Honourable John Della Bosca (Special Minister of State) stated that the then senior Drug Court Judge (Judge Neil Milson) had visited similar programs in the United States but did not detail which programs (Parliament Readings, 2004). The Program is an interagency effort of the New South Wales Drug Court, Justice Health, and the Department of Corrective Services, and reports to the Attorney-General, the Justice Minister, and the Health Minister. The government expects that one hundred adult male offenders will be treated and rehabilitated; if after two years, the Parliament deems the Program successful, the government will extend its reaches to female offenders (Parliament Readings, 2004). Currently, the Program is a pilot project. As such, the New South Wales Bureau of Crimes Statistics and Research is evaluating participant health and social functioning, along with program outcomes, and will provide a final report to the Parliament in 2010 (s 106Z).

In the second reading of the Model Bill, the Honourable John Della Bosca (Special Minister of State) stated to the New South Wales Parliament that the legislation provides:

[A] comprehensive legal basis for Australia’s first compulsory drug treatment correctional centre. . . . The Compulsory Drug Treatment Correctional Centre will target a hard-core group of offenders with long-term drug addiction and an associated life of crime and constant imprisonment. It is for offenders who have failed to enter or complete other voluntary or court-based treatment programs.

The program sits at the end of the continuum of drug diversion programs in New South Wales aimed at breaking the drug-crime cycle. Eligible offenders to the program will be sent to a special correctional facility dedicated to abstinence-based treatment, rehabilitation and education. There will be intensive judicial case management of these offenders, in close partnership with the correctional authorities as well as health and other service providers.

The compulsory drug treatment program will build on the productive justice and health system linkages already established for programs such as the Drug Court program. Offenders will be gradually reintegrated back into the community and targeted with support after completion of their program and even beyond parole. The aim is to achieve better outcomes for the State’s most desperately entrenched criminal addicts by assisting them to become drug free and crime free, to take personal responsibility, and to achieve a more productive lifestyle. (Parliament Readings, 2004).

The Model Bill required amendments to the Drug Court Act 1988, the Crimes (Sentencing Procedure) Act 1999, and the Crimes (Administration of Sentences) Act 1999 (Schedules 1-3). In June 2006, amendments to the Model Bill included the participant being convicted of at least two other offences (rather than three other offences), and that a history of committing violent offences would be considered in the suitability assessment rather than
offences involving serious violence automatically deeming the participant ineligible (Courts Legislation Further Amendment Bill, 2006).

The objectives of the legislation are (s106B (a-d)):

(a) to provide a comprehensive program of compulsory treatment and rehabilitation under judicial supervision for drug dependent persons who repeatedly resort to criminal activity to support that dependency, and
(b) to effectively treat those persons for drug dependency, eliminating their illicit drug use while in the program and reducing the likelihood of relapse on release, and
(c) to promote the re-integration of those persons into the community, and
(d) to prevent and reduce crime by reducing those persons’ need to resort to criminal activity to support their dependency.

I. THE COMPULSORY DRUG TREATMENT PROGRAM

The government has based the Program in a small, stand-alone prison that accommodates up to seventy participants (New South Wales Government, Department of Corrective Services, Compulsory Drug Treatment Correctional Centre, 2006). The Program entails three Stages: Stage 1 is closed detention where the participant is in full-time custody; Stage 2 is semi-open detention where the participant can access the community for employment, education, or social programs; and Stage 3 is community custody where the participant resides under intensive supervision at accommodations approved by the Drug Court (s106D).

The process of gaining access to the Program is a complex process explained by the Senior Judge of the Drug Court of New South Wales (Dive, 2006). First, a sentencing court refers the offender to the Drug Court if it ascertains that he may be an “eligible convicted offender” (s18B). To be eligible, the offender needs to meet five criteria. The offender must be: (1) sentenced to imprisonment with an unexpired non-parole period of eighteen months to three years; (2) convicted of at least two offences in the previous five years; (3) not convicted of specified offences such as drug trafficking, sexual assault, and murder; (4) reside in the broader Sydney region; and (5) be over the age of eighteen (s5A). Second, the Drug Court determines whether the offender is both eligible and suitable for a Compulsory Drug Treatment Order (s18E).

Once the Compulsory Drug Treatment Order is made, a multidisciplinary team develops the Compulsory Drug Treatment Personal Plan (the Personal Plan) with the participant for the Drug Court to approve (s106F). The Personal Plan is both a treatment plan and a case management plan. The Personal Plan: (1) identifies the areas regarding dynamic risk factors for re-offending and well-being needs, (2) identifies the conditions for drug treatment and rehabilitation, and (3) specifies the rewards for meeting the specified conditions and the sanctions for not meeting the specified conditions. Success in meeting the conditions of the Personal Plan is rewarded with progression toward reintegration into the community. Failure to meet the conditions of the Personal Plan can result in sanctions of increased management, regression to the prior Stage, or revocation (s106M, 106Q).

The Drug Court Judge approves the Personal Plan and monitors the participant’s progress throughout Stages 1, 2, and 3 and determines release upon parole (as the parole authority). The Drug Court in this instance functions as a re-entry court. Re-entry courts manage the offender’s transition back to the community through positive reinforcement, graduated sanctions, and interagency cooperation (Maruna & LeBel, 2003). Further, the Program provides for the assessment, treatment, and management of participants as summarized below.

A. Assessment

The assessment process first determines a potential participant’s eligibility and suitability for the Program, and second, determines the risk of re-offending and treatment needs for the Personal Plan to address. A multidisciplinary team is in place to first assess the participant’s eligibility, and thereafter his or her suitability, before approval by the Drug Court (s8E). The multidisciplinary team consists of staff employed by the Department of Corrective Services and Justice Health (New South Wales Government, Department of Corrective Services, Compulsory Drug Treatment Correctional Centre, 2006). The eligibility assessment determines whether the offender is drug dependent, whether the offence was related to his drug dependence and an associated lifestyle, and whether the offender is
not so mentally ill that he may be violent or unable to participate in the Program (s15A). At this stage, there may be a contested hearing about eligibility (Dive, 2006). Thereafter, if the Drug Court endorses eligibility, the multidisciplinary team conducts a suitability assessment (Dive, 2006). The suitability assessment considers the offender’s drug treatment history, previous violent offending history and institutional behaviour, the likelihood of domestic violence upon release, and the level of treatment readiness (although this is not an exclusionary criterion) (s18E(2)).

The multidisciplinary team then determines the participant’s risk of re-offending and what treatment the Personal Plan should address. The team determines treatment needs through a battery of psychometric tests and a detailed clinical interview of the participant. It also considers dynamic risk factors, which are treatable problems that are obstacles to meeting physical, social, and psychological human needs (Ward, 2002) and must be treated to reduce re-offending (Andrews & Bonta, 2003). Assessment of risk and need are combined into a case formulation. A case formulation is a detailed functional analysis that considers individual differences among participants hypothesizing the dynamic risk factors, their relationship, and the problem areas that need to be addressed (Ward, Vertue, & Haig, 1999).

Based on the assessment, the Personal Plan identifies the following areas to be addressed in participants’ treatment: physical and mental health, emotional and psychological needs, accommodation, finances, employment and education requirements, positive and negative social supports, thinking and feeling patterns, criminal thinking and behaviour, impulsivity and problem solving skills, and treatment readiness.

B. Treatment

Treatment determines interventions that will result in behaviour change. Coerced treatment rests on the assumption that it will reduce drug-related offending, and the data supports this assumption (see Seddon, 2007). The Program is a treatment community with cognitive-behavioural intervention and community reintegration. Researchers conducted a meta-analysis of 291 rigorous evaluations conducted throughout the United States and other English-speaking countries over the last 35 years to determine what reduces re-offending rates (see Aos, Miller, & Drake, 2006). Meta-analysis examines the relationship between findings across various primary studies based on intervention experiments or evaluations (see Leschied, 2001). The following percentages show statistically significant reductions in re-offending in comparison to treatment-as-usual groups; even a 5% reduction in re-offending in high risk offenders can be cost-effective (Aos et al., 2006). Aos et al found in a meta-analysis of 92 studies of drug-related offenders that re-offending rates were reduced by drug treatment in the community (12.4%), therapeutic communities (or separate units) in prison with community reintegration (6.9%) and without community reintegration (5.3%), and cognitive-behavioural treatment in prison (6.8%).

The Program also relies upon employment and education strategies. A meta-analysis of thirty studies of general offenders by Aos et al. (2006) found that there was a modest reduction in re-offending through employment training in the community (4.8%), basic adult education in prison (5.1%), correctional industries in prison (7.8%), and vocational education in prison (12.6%). Note that the last finding about vocational education in prison was based on only three studies and requires more research. Furthermore, a meta-analysis of seventeen studies by Aos et al. found that the following types of programs required further research before researchers could make any conclusions: case management for drug-related offenders in the community (0%), regular parole supervision versus no parole supervision (0%), and work release programs (5.6%). Aos et al. noted that fifty-six studies found that re-offending rates were reduced by 10.7% in drug courts. Therefore, treatment appears most effective in drug courts followed by treatment in the community and lastly by treatment in prison alone.

Treatment in the Program includes drug abstinence and intensive cognitive-behavioural programs. In Stage 1, the focus is on physical and psychological needs. Physical treatment includes dental care, medical treatment and a gradual reduction from opiate substitution to abstinence, although the psychiatrist may prescribe other psychotropics. Psychological rehabilitation includes a manualized intensive program that addresses drug use and
offending behaviour, individual counselling, and work and education readiness (see generally Wanberg & Milkman, 2006). In Stage 2, the focus is on social needs. Social rehabilitation includes community reintegration through supported access to education and employment, increased family contact, and appropriate leisure options. In Stage 3, the focus is on maintaining lifestyle changes.

C. Management

Management determines the levels of supervision and monitoring needed to maintain behaviour changes. The meta-analysis discussed above considered seventy-four studies of intermediate sanctions including surveillance with and without treatment. There was no reduction in re-offending through electronic monitoring or intensive supervision without treatment, but there was a 21.9% reduction through intensive supervision with treatment (Aos et al. 2006). The Program relies upon risk management strategies through intensive supervision combined with treatment in Stage 3. Risk management strategies include regular and random drug testing, electronic monitoring in the community, screening family members and employers as suitable "sponsors," and regular cell, property, and body searches.

The theoretical underpinnings of assessment and treatment in offender rehabilitation in terms of the risk-need model, the good lives model, and therapeutic jurisprudence are beyond the scope of this Article (see Birgden, 2002b describing the combined theoretical underpinnings of assessment and treatment in offender rehabilitation). In summary, the Program provides for the assessment, treatment, and management of participants in order to meet the objectives of the Model Bill.

II. THERAPEUTIC JURISPRUDENCE IMPLICATIONS

Therapeutic jurisprudence is a framework developed by David Wexler and Bruce Winick that focuses on the impact of the law on a participant's well-being (Slobogin, 1995). Wexler and Winick define therapeutic jurisprudence as:

the study of the role of the law as a therapeutic agent. It is an interdisciplinary enterprise designed to produce scholarship that is particularly useful for law reform . . . . Legal rules, legal procedures, and the roles of legal actors (such as lawyers and judges) constitute social forces that, whether intended or not, often produce therapeutic or antitherapeutic consequences. Therapeutic jurisprudence calls for the study of these consequences with the tools of the social sciences to identify them and ascertain whether the law's antitherapeutic effects can be reduced, and its therapeutic effects enhanced . . . .(Winick, 1997, p. 185)

Most importantly, therapeutic jurisprudence utilizes social science knowledge to determine ways in which the law can enhance well-being. As a legal inquiry, therapeutic jurisprudence considers:

(1) substantive law- whether the law actively promotes therapeutic objectives by balancing community rights against individual rights; (2) legal procedures- whether the legal system maximizes therapeutic effects and minimizes anti-therapeutic consequences; and (3) legal roles- whether the behaviours of legal actors are therapeutic or anti-therapeutic (see Wexler, 1990). This section focuses on the use of social science evidence to determine whether the Program's substantive law, legal procedures, and legal roles are likely to be therapeutic. A therapeutic outcome in this context is positive behaviour changes in participants and the balancing of participant rights and community rights.

A. Substantive Law

Substantive law has therapeutic aspects. The law seeks to actively promote therapeutic objectives by weighing community rights and participant rights. When the law purports to promote therapeutic objectives, it is important to determine whether it actually does so (Wexler, 1990). The Model Bill aims to decrease the likelihood of drug use and re-offending, and reintegrate the participant into the community (s106B). There are two assumptions that underpin this law: that drug dependence leads to offending and that compulsory treatment is effective.

1. Case Formulation

The Program is based on a case formulation for each participant. The relevant literature assumes there is a causal link between drug dependence and offending behaviour, although the direction and nature of the relationship has been subject to a long-running and unresolved debate (see Seddon, 2007; Stevens, Berto, Eckmann, Kerschl, Oeuvray, & Van Ooyen, 2005). Some authors argue that drug
dependence motivates continued and escalating acquisitive offending, and other authors argue that drug users may develop such narratives to justify offending behaviour rather than take responsibility for it (see McSweeney, Stevens, Hunt, & Turnbull, 2007). While there is a relationship between drug use and offending, pathways to a particular offence may differ. Drug use may predict offending, offending may predict drug use, and a third factor, such as a personality trait or delinquency, may lead to drug use and offending (see Klag, O’Callaghan, & Creed, 2005). The Model Bill, in its initial design, assumed that drug dependence leads to offending behaviour and that if the drug dependence is addressed, the offending behaviour will be reduced (i.e., a medical model of addiction approach). However, in practice, the case formulation has been broadened to take into account the various causes of offending behaviour particular to individuals.

2. Compulsory Treatment

The Program uses compulsory treatment, which is controversial, but can be therapeutic if properly implemented. Through the influence of therapeutic jurisprudence, drug courts have used the law to impose compulsory treatment (See Hora, Schma, & Rosenthal, 1999). Quasi-compulsory treatment provides a “constrained choice” between consenting to enter treatment outside the correctional system or facing a legal consequence such as imprisonment (see Klag et al., 2005; Seddon, 2007; Stevens, McSweeney, Van Ooyen, & Uchtenhagen, 2005).

In contrast, compulsory treatment directs the offender, without his or her consent, to enter treatment as the result of a criminal order, usually within the correctional system or a community-based service Klag et al., 2005). The Program is compulsory because the participant does not consent to, and cannot appeal, the Compulsory Drug Treatment Order (s18D (4)). Both compulsory and quasi-compulsory treatment entails rehabilitation rather than medication, with the recognition that it is impossible to force individuals to fully engage in psychotherapeutic treatment (Stevens et al., 2005). In addition, if the participant does not engage in rehabilitation and drug treatment, he may fail to progress, or regress, or be removed from the Program (ss106M. 106Q). Compulsory treatment is the most controversial and divisive issue in the drug dependence field, particularly in relation to ethical concerns, tension between the legal system and treatment providers, and claims of effectiveness (see Klag et al., 2005; McSweeney et al., 2007). Compulsory treatment is viewed as either using the judicial role appropriately with sanctions and rewards to retain participants and increase treatment efficacy or as forcing treatment upon involuntary participants, overriding due process, and providing unsolicited and ineffective treatment (Monahan, Steadman, Silver, Appelbaum, Robbins, Mulvey et al, 2001).

Is compulsory treatment for offenders therapeutic? The social science evidence regarding this is unclear. In particular, there are serious methodological flaws in the research. Determining the efficacy of compulsory treatment for drug use is difficult because of inconsistency in basic concepts, definitions, measures, styles of empirical research, definitions of success, assumptions regarding referral source, and interpretations of existing studies. For more details regarding methodological problems see Klag et al. (2005), Stevens et al. (2005), and Wild (2006). Most studies fail to meet the Campbell/Cochrane criteria regarding social science evidence (McSweeney et al., 2007) and the evidence base is weak and conceptually unsophisticated (Seddon, 2007). Methodological flaws will not be dealt with here.

Compulsory treatment is assumed by some to be effective in reducing drug-related offending (see Seddon, 2007). A review of studies found that legal coercion was previously assumed to assist in treatment entry, retention, and outcomes. But more recent studies have found that coerced and voluntary clients do not differ in treatment outcomes, or voluntary clients have better treatment outcomes, or coerced clients are more likely to successfully complete programs, or legal coercion is unrelated to treatment outcomes (Klag et al., 2005). Compulsory treatment does not necessarily result in worse outcomes than voluntary treatment, and motivation is important in terms of problem recognition, treatment readiness, and help-seeking behaviour (Stevens et al., 2005). Most recently, a quasi-compulsory drug treatment program in England was evaluated where drug-dependent offenders were ordered into treatment in the community (McSweeney et al., 2007). The authors concluded that the offenders showed reduced substance use, injecting risk and offending behaviour, and improved mental health, but that similar findings occurred for those in voluntary treatment.
Nevertheless, critics have described compulsory treatment of drug use as “a world-wide social experiment being implemented without a compelling evidence base on its utility” (Wild, 2006, p. 46). On the present evidence, some have concluded that compulsory treatment can sometimes be effective in reducing drug use and offending for some individuals, but, generally, the evidence is not strong (see Pritchard, Mugavin, & Swan, 2007). However, the majority of studies contrast civil treatment and criminal non-treatment as if these are mutually exclusive categories. They also focus on the treatment of drug use within a prison setting where other offending behaviours are not necessarily addressed.

In reviewing compulsory treatment in Europe, researchers found that: access to treatment in the criminal justice system was low, it had increased dropout rates, it resulted in non-significant reduction in offending (although there was reduction in drug use), and it required initial internal motivation; an involuntary motivated individual may be preferable to a voluntary unmotivated individual (see Stevens et al., 2005). The authors concluded that the criminal justice and treatment systems in Europe are divided with differences in selection criteria for treatment between sentencers and treatment providers. This causes involuntary participants to have a negative impact on treatment processes, drop out more readily, and hinder the progress of other participants. However, motivational strategies early in treatment may counteract these problems.

The Program, in its design, avoids such pitfalls. It provides integrated drug treatment and rehabilitation, within a prison-based treatment community, with motivational strategies to counteract the compulsory nature of the Order. The benefits of participation outweigh the costs of non-participation. If the participant meets the conditions of his Personal Plan, he may be accessing the community within six months (Stage 2) and he may be living in the community full-time within twelve months (Stage 3). This is an alternative to serving an eighteen month to three year sentence in an ordinary prison before being eligible for release on parole. Notably, the majority of participants (and their families) to date have actively sought referral to the Program, so treatment engagement is high to begin with, although treatment retention may be more difficult to maintain, particularly if participants fail to progress or regress.

In terms of applying substantive law, the Drug Court Judge oversees strategies to manage individual participants. To date, the Director has increased management and the Drug Court Judge has imposed regression or revocation orders. Increased management of participants has resulted in additional treatment to combat anti-social behaviour in Stage 1 and admitted drug use in Stage 2, which subsequently delays progression to the next Stage. Regression from Stage 2 to Stage 1 has occurred in response to non-admitted drug or alcohol use or a second instance of drug use. Revocation has been imposed for physical assault, lacking the capacity to progress, and actively interfering with the participation of others. In special circumstances, the Commissioner of Corrective Services may immediately regress or revoke a participant and within twenty-one days the Drug Court Judge must review the decision(s106P(5)). While the participant cannot appeal such decisions (s106P (7)), the Judge gives weight to the opinion of the Commissioner (delegated to the Director, s106P (7)). To assist in the deliberations, prison staff must justify recommendations to the Drug Court and the judge considers the views of the prosecution and defence. Consequently, judicial reviews assist in defining, on a case-by-case basis, behaviour of a “serious nature” that indicates a likely lack of progress, an unacceptable risk of re-offending, or a risk to self and others, which will then result in revocation.

3. Abstinence Approach

The Program is based on an abstinence approach to drug treatment, meaning there is no pharmacotherapy administered amongst any participants (see Parliament Readings, 2004 and s16H (a)). Australia’s National Drug Strategy, and State and Territory drug strategies, are based on a harm minimisation approach in an effort to prevent future harm and decrease actual harm, and, as such, may not include abstinence (Pritchard et al., 2007). Methadone maintenance for opioid dependence has the highest retention rate of all treatment modalities, results in significant changes in drug use, offending, and community reintegration, and lowers HIV risk behaviour (Gostin, 1991). Abstinence, however, may be useful for individuals who have long-standing problems with opioid dependence, a history of multiple drug use related to relapse, and who have had little success with programs that do not promote abstinence (Piotrowski & Hall, 1999). For
example, an evaluation of a quasi-compulsory drug treatment program of eighty-nine drug-dependent offenders in the community in England found that reporting abstinence at the first follow-up and having independently achieved abstinence without treatment support was correlated with reduced re-offending (McSweeney et al., 2007).

B. Legal Procedures

Legal procedures reflect the therapeutic aspects of the legal system and may need to be reformed to maximize their therapeutic effect (Wexler, 1990). Since the Program is compulsory, procedures are set in place to harness the law as a way to engage the participant to commence a pro-social life. The procedures include a focus on treatment readiness and contingency contracting to counteract the compulsory nature of the Program.

1. Treatment Readiness

Treatment readiness requires empirically-based techniques that increase the likelihood of behaviour change. The Program implements a particular treatment readiness model (see Ward, Day, Howells & Birgden, 2004 describing this treatment readiness model). To be “treatment ready,” a participant must be motivated, respond appropriately, find the program relevant and meaningful, and have the capacity to engage. Treatment readiness is considered to be a function of the relationship between the individual participant and the environment where changes are enacted and supported, such as court, prison, or the community. Evaluation of treatment engagement commences even prior to the Compulsory Drug Treatment Order. The suitability assessment asks the offender to describe “the kind of life you would like to lead” rather than “what drugs did you take, how often, and when”. Upon entry to the prison, the staff administers a treatment readiness tool to assist in the development of the Personal Plan (see Day, Howells, Casey, Ward, Birgden, 2007). As a dynamic construct, the staff then re-assesses treatment readiness at the end of each Stage.

2. Contingency Contracting

Contingency contracting is an empirically-based approach for increasing motivation to change, which emphasizes rewards rather than sanctions (see Petry, 2000 discussing contingency management, which is synonymous with contingency contracting). Some authors consider procedures that motivate compliance with legal decisions, rather than fear of sanctions, to be more effective (see Darley, Fulero, Haney, & Tyler, 2002). Drug courts incorporate this view, using contingency contracting by providing rewards and sanctions quickly, consistently, and publicly to provide external motivation to attend and complete programs (Freiberg, 2002). In using contingency contracting, rewards should be individualized and naturally occurring and thus act as stronger alternatives to drug use. The reinforcement schedule should have escalating rewards for meeting conditions, rewards should be a four-to-one ratio to sanctions, the schedule should have a “reset” to zero for not meeting conditions, and only serious violations of rules should be sanctioned (Gendreau, Cullen, & Bonta., 1994; Longshore, Turner, Wenzel, Moral, Harrell, McBride et al 2001; Marlowe & Kirby, 1999; Petry, 2000). Contingency contracting is a positive approach to behaviour change and the agreement should be developed together with the participant.

Contingency contracting within the Program entails developing the Personal Plan with the participant. Staff record all instances of pro-social or anti-social behaviour through the electronic offender management system, which also becomes data incorporated into regular assessment reports to the Drug Court. The participant meets weekly with the therapist and a custodial officer to review the behaviour. Rewards for pro-social behaviour differ in each Stage and are increasingly naturally occurring. In order to meet a four-to-one ratio for rewards and sanctions, the standard for pro-social behaviour in Stage 1 is low. In Stage 1, each week the participant receives a reward chosen from an individualized menu he has developed. The rewards are minor, such as a milkshake or cappuccino, a photo sent to the family, or a DVD for the evening. In Stage 2, the reward is access to social programs in the community, for example, shopping, the local gym, and family visits. In Stage 3, the reward is verbal reinforcement.

In contrast, sanctions for anti-social behaviour respond to three levels of behaviour. Level 1 behaviours are general non-compliance, such as being late for muster, refusal to clean, or being rude to staff. The sanction is a return to the beginning of the reward list, which is a non-reward rather than a punishment. Level 2 behaviours compromise the security of the prison and may
include interfering with locks, breaking chairs, graffiti about staff, diverting prescribed medication, or bullying other participants. The sanction for Level 2 behaviours is a formal prison charge with increased management and logical consequences. The logical consequences are based on the behaviour. For example, if a participant releases a fire extinguisher then he would pay for it to be replaced. Violence towards another participant results in repeating the therapy program, causing a longer stay in that Stage. Level 3 behaviours are of a “serious nature” to be determined on a case-by-case basis. To date this has included physical assault and illicit drug use. The sanction is a report to the Drug Court with a recommendation for regression or revocation from the Program. A contingency management approach regarding all behaviours, twenty-four hours per day, is unusual in a prison where the emphasis is traditionally on managing institutional misbehaviour, rather than managing pro-social and anti-social behaviour likely to occur in the community.

C. Legal Roles

The roles and behaviours of legal actors can be therapeutic or anti-therapeutic (Wexler, 1990). This section will consider judges, as well as staff within the prison, as legal actors. Prison staff includes: custodial officers, who extend into the community; therapy staff, including psychologists, drug and alcohol workers, probation and parole officers, and teachers; and health professionals, such as nurses, general practitioners, psychiatrists, and dentists.

1. Judicial Supervision

One of the objectives of the Model Bill is to provide judicial supervision (106B (a)). Under the Model Bill, the Drug Court Judge has regular contact with both participants and staff thereby assuring judicial supervision (ss106F, 106I). There has been an increasing emphasis in therapeutic jurisprudence on the importance of psychological techniques to increase compliance and address behaviour change (Winick, 2003). Therapeutic jurisprudence has a particular interest in due process and its impact upon well-being (Winick, 2002). Social science evidence indicates that due process is made up of participation, dignity, and trust (Tyler, 1996). Participation is ensured if the individual is able to present his or her own views and share in decision-making because he perceives the procedure as fair, even if it may not influence the outcome. Dignity, respect, and politeness ensure that the individual responds better because his rights and values as a competent, equal citizen are acknowledged. Trust is ensured when the authority allows the individual to present evidence, displays dignity and respect, and clearly explains decisions. In turn, being treated with respect translates into greater compliance with the law. Individuals are more willing to accept legal decisions if they perceive the authority’s motives as benevolent, trustworthy, and in good faith, creating a therapeutic alliance in offender rehabilitation terms. Due process is largely influenced by the role of the judge. A therapeutic judge, rather than being a neutral fact finder, actively directs the proceedings and tracks the progress of the participant (Miller, 2004). In drug courts, the same judge monitors behaviour to resolve the legal problem and underlying causes (Winick, 2003).

In practice, the judge first meets the offender when he imposes the Compulsory Drug Treatment Order in the Drug Court. At this hearing, the judge impresses upon the offender the opportunities for drug treatment and rehabilitation the Order has provided him and what conditions he must meet to progress towards community reintegration. Once the Drug Court approves progression to Stage 2, the judge, registrar, public prosecutor, and defence lawyer may go to the prison to issue the Community Supervision Order (see s106O describing the Community Supervision Orders under the Act), which imposes conditions on the participant while he accesses the community. At these ceremonies, the judge reiterates to all participants in Stage 1 the message that each of them received in the Drug Court. Once progression to Stage 3 occurs, the Judge regularly reviews the participant at the Drug Court (as of May 2008, five participants are in Stage 3 and four have obtained parole).

2. Corrections Staff Support

In recognition of the social science evidence regarding the issues outlined above, the Program has strategies to counteract likely problems with treatment attendance, participation, and retention. As with due process in drug courts, the Program aims to enhance participation, dignity, and trust within the prison. As previously described, treatment readiness is sustained through participant-staff interactions utilizing a therapeutic alliance and contingency contracting (see Part II.B.). An active case management system includes regular staff meetings and formal meetings with the participant.
A therapeutic alliance between staff and participants is required to enhance treatment readiness. A therapeutic alliance requires that staff have supportive attitudes, knowledge, and skills. Therapy staff can use motivational interviewing, which is a directive, client-centered, therapeutic approach (see generally Miller & Rollnick, 2002). Motivational interviewing strategies can be matched to treatment readiness. However, drug treatment and rehabilitation will not be effective unless custodial officers are harnessed as "legal actors and potential therapeutic agents" (Birgden, 2004, p. 283). A review of substance abuse programs used since 1989 in the California Department of Corrections and Rehabilitation found that programs had failed to reduce re-offending primarily because of the absence of a "therapeutic community" environment separate from the mainstream prison system. Likewise, in offending behaviour programs in prisons in the United Kingdom, no consideration had "really been given to getting prison staff ‘on side’, and thus the productive work in the group room is often undermined as soon as the offender steps back out onto the wing" (Farrall, 2004, p. 5).

To provide a therapeutic environment, custodial staff are also being trained in motivational interactions (Farrall, 2004). This training package is designed for frontline staff to apply motivational interactions in opportunistic, informal, and brief interactions with offenders during casual conversation to increase treatment readiness. Defence lawyers can also apply these motivational techniques as well as police, judges and magistrates, and parole board members (Birgden, 2002b).

CONCLUSION

This Article has considered social science evidence to determine the likely therapeutic and anti-therapeutic effects of the Compulsory Drug Treatment Program in practice. In operationalising the objectives of the legislation, the Program aims to manage risk and meet needs, which is consistent with therapeutic jurisprudence principles in the context of offender rehabilitation, as previously proposed (Birgden, 2002b). First, the law can increase, decrease, or have a neutral effect on well-being, and social scientists should identify rules, procedures, and roles that enhance well-being. Although drug treatment and rehabilitation in the Program are compulsory, procedures and legal roles have been designed to engage participants in behaviour change and enhance well-being. The independent evaluation will determine whether this has occurred.

Second, the law should capitalise on the “teachable moment” that occurs when the offender is brought before the courts, and treat that moment as a way to start a pro-social life. Anecdotal information indicates that almost all of the participants prefer the Compulsory Drug Treatment Order to mainstream imprisonment, and so the law can be used to this effect. However, at times the participants will display reduced treatment readiness as a reaction to consequences for drug use or other serious behaviours.

Third, development of the law should be a multidisciplinary endeavour, with the relationship between law and social science being cooperative rather than antagonistic. In the Program, the law and legal procedures direct a cooperative approach where information sharing is expected between identified agencies.

Fourth, the law balances therapeutic principles against justice principles. Legal considerations such as offender rights and community rights should not be trumped by therapeutic considerations; societal values may override therapeutic values. The law and procedures in the Program provide the opportunity to use rehabilitation to manage risk and to meet needs.

Last, therapeutic jurisprudence does not support paternalism, coercion, carrot-and-stick approaches, or a therapeutic state. In terms of normative values, although the Program is coercive, it also provides for release of the offender into the community before the original sentence ceases, which provides an incentive to change (a "carrots and consequences" approach). In addition, the law ensures that the participant is not imprisoned beyond the original sentence and so avoids the risk of a therapeutic state.

In conclusion, with appropriate procedures and legal actors in place, the Compulsory Drug Treatment Program is potentially therapeutic for the community in managing risk and therapeutic for the participant in meeting needs.
References


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Contact: astrid99@hotmail.com This Article represents the effort of staff in the New South Wales Drug Court, Justice Health, and Department of Corrective Services in developing and delivering the Compulsory Drug Treatment Program.