

LETTER TO THE EDITOR

Cannabis, Coerced Care, and a Rights-Based Approach to Community Support

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Introduction

Recently, a special section in this journal reviewed the widespread misuse of compulsory drug detention and rehabilitation centers.¹ Although the issue was a welcome addition to the literature, most contributors focused on formal responses to injected drugs. A detailed discussion of the rise of coerced treatment as part of cannabis decriminalization was notable by its absence.² Cannabis remains the most used psychoactive substance under international control. In 2020, the United Nations Office on Drugs and Crime reported that cannabis enforcement is undertaken in almost all countries worldwide.³ Any focus on the harms of compulsory treatment must consider the worrying trend by which cannabis decriminalization is being married with police-led diversion to mandated treatment programs.

Mandated cannabis treatment programs are consistent with the definition of “compulsory” that informs the special section.⁴ We argue that blending public safety and public health in this way represents a Faustian bargain.⁵ This has been explored in terms of law, society, and medicine.⁶ Masquerading as progressive drug reform, coercive treatment undermines autonomy, agency, and respect, which are the values that form the basis of therapeutic relationships.⁷ Efforts to confront compulsory treatment must not ignore mandated programming as part of cannabis diversion programs. We agree with calls in the special section that more voluntary programs be piloted.⁸ Likewise, this expansion must be combined with meaningful and informed program evaluation.⁹ Such an approach could allow for the extension of voluntary community-based programming.¹⁰ However, unless programs are rooted in theories that support communities to reduce harm, they may not withstand the tendency to replace a focus on care with approaches emphasizing abstinence, control, and punishment.¹¹

Cannabis, public health, and coercive care

Cannabis’s status as the most widely used and extensively sanctioned illegal drug globally is based on policies driven by ethnic animus.¹² Historically, these approaches served colonial and neocolonial goals.¹³ Internationally, the War on Drugs, focused mainly on cannabis, has undermined human rights wherever it has been waged.¹⁴ As cannabis reforms take root around the world, adaptations by governments where cannabis is not yet legal often de-emphasize public safety by investing in public health.¹⁵ For example, public health was identified as a focus of the first decriminalized cannabis policy in the Netherlands.¹⁶

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Today, more than 30 countries implement models of drug decriminalization based on public health interventions and drug treatment.¹⁷

These approaches often expand rather than constrict compulsory treatment.¹⁸ In practice, treatment is organized through police-led diversion programs nominally designed to “direct people away from criminal sanctions and towards educative, therapeutic, or social services.”¹⁹ Too often, coercive cannabis treatment backed by the threat of criminal prosecution imposes public safety policies using public health mantras.²⁰ Coercive cannabis programs cannot be divorced from other forms of compulsory treatment. For example, Claudia Stoicescu and colleagues note that treatment is compulsory if individuals are denied the unconditional right to refuse it, cannot rely on due process protections, or cannot access evidence-based programming.²¹

Although those arrested for possession of cannabis can refuse treatment, this choice comes with conditions. While described as “voluntary,” many programs threaten criminal prosecution if participants fail to comply with guidelines. Further, such programs do not result in improved outcomes.²² In fact, they can result in harm.²³ This is of particular concern given racial disparities in cannabis arrests.²⁴ The inequalities that result have recently been framed as the consequence of “predatory” arrangements that dominate the criminal justice system in the United States.²⁵ For example, in 2016, it was reported that US\$1.6 million was collected through diversion fees in the state of Arizona, and most of those referred were arrested for cannabis possession.²⁶ A year later, in the same state, an individual stopped by police with a small amount of cannabis was offered two options: up to two years in prison and a maximum fine of US\$150,000, or seek treatment through the Marijuana Diversion Program, at a cost of US\$950.²⁷

Attending a program is certainly better than prison. However, a review of cannabis diversion programs suggests numerous coercive features. Most are based on the 12-step model of Alcoholics Anonymous, a culturally prominent but psycho-

logically problematic means to address drug use.²⁸ This approach requires people with addiction to accept that they have a disease and engage in recovery based on surrendering to a “higher power.”²⁹ Not all programs are religious. However, a cannabis diversion program in Pennsylvania requires that those referred not just attend but “successfully” complete the program.³⁰ Although a program in the state of Texas explicitly notes the problems of stigma for “employment, education, and housing opportunities,” completing a “four-hour education class” is required to avoid arrest and prosecution.³¹

Examples exist around the world. In the United Kingdom, the Johnson government has announced a new policy to ensure that those arrested for drug possession face jail sentences if they refuse treatment.³² Even in Portugal, where all drugs are decriminalized, people who use drugs report that policy reforms have led to increased surveillance and invasions of their privacy. This includes drug testing, routinely implemented without informed consent by untrained law enforcement personnel to “pressure, impose, or coerce people who use drugs into decisions or actions,” including treatment.³³ Research in Scotland suggests that problems emerge when diversion embeds health-focused support “*within* criminal sanctions, rather than acting as *alternatives*.”³⁴ The problematic criminalized consequences of noncompliance within cannabis diversion programs are expressly noted in Australia.³⁵ Even well-intentioned programs may unconsciously adopt abstinence frames by relying on risk-based messaging.³⁶

Illusions of reform and a community model of support

The problems with compulsory drug detention and rehabilitation centers have recently been itemized.³⁷ Despite the potential for community-based treatment and care, coercive programming endures.³⁸ This is true for cannabis, despite its relative safety.³⁹ As has been noted, 90% of people who use drugs do not develop problematic or dependent drug use, and this number is even smaller for people who

use cannabis.⁴⁰ Nonetheless, coercive public health models, including cannabis diversion programs, are growing, and ideological obstacles remain impediments to reform.⁴¹ Furthermore, cannabis's changing legal status has resulted in the state's regulatory expansion.⁴² As noted by Stan Cohen, new regulatory arrangements often reproduce within the community the same coercive features of the older carceral system.⁴³

The United Nations' recommendation that states adopt policies that provide for "decriminalizing drug possession for personal use" is important.⁴⁴ However, in the United States, there is a reasonable fear that public health may be expanded in ways that constrain human rights.⁴⁵ Replacing the idea that people who use drugs are moral failures requires rethinking the theories by which we organize community-based responses.

Restorative justice, harm reduction, and voluntary community-based treatment

Important lessons can be gleaned from Kathy Fox's work on how community justice centers (CJCs) in the US state of Vermont support those in conflict with the law. Some of these lessons are theoretical.⁴⁶ Others are practical.⁴⁷ Community-based alternatives that are credible, consistent, and effective engage trained volunteers, are rooted in relationship building, and are based on mutual respect.⁴⁸ The value of CJCs includes mitigating exclusion and isolation, embracing destigmatization, and creating relationships based on shared obligation.⁴⁹ CJCs are a novel application of restorative justice principles.

Restorative justice is often linked to re-integrative shaming.⁵⁰ As Liz Elliott argues, this nomenclature is unfortunate. Instead, she posits that restorative justice should provide a means for communities to respond to harm.⁵¹ This includes the harm done to people who use drugs under prohibition.⁵² Replacing coerced treatment models with a "non-judgmental" approach focused on care, treatment, and harm reduction requires a paradigm shift and the explicit inclusion of communities.⁵³

Programs based on support and connections

to existing resources serve as an authentic alternative to the expansion of the punitive character of the criminal justice system. Such an approach affirms rather than demeans and offers access to voluntary treatment based on consent and respect. While most cannabis users do not and never will need such support, harnessing the vital role of the community when substance use becomes problematic can be protective against the traditional system. For example, drug use deemed of sufficient concern can trigger meetings where community members signal their concern, offer support, and inform people of existing services.

Conclusion

The unethical blending of public safety goals through public health policies is pernicious.⁵⁴ It can escalate moral injury by increasing the influence of private treatment professionals and mercurial addiction counselors.⁵⁵ Critics reasonably worry about the role of cannabis diversion schemes in providing a constant supply of clients.⁵⁶ These worries may increase given the tendency for justice systems to "financially exploit subjugated communities."⁵⁷ Using the language of care and treatment to emphasize control and abstinence undermines trust and may limit those who might otherwise seek treatment in the future.⁵⁸ As is increasingly apparent, such concerns have international dimensions.⁵⁹

Interest in models of voluntary community-based treatment for people who use drugs is growing.⁶⁰ As we have observed, cannabis policy serves as a case study in moral-legal-cultural renegotiation.⁶¹ It provides a window into the opportunities and challenges of a rights-based approach to community care for people who use drugs. Staffed by trained and caring community members, voluntary programs can recast treatment as social support. The international liberalization of cannabis should be seen as an opportunity to understand how states adapt to the legalization of once illicit substances. Learning from cannabis may offer a means to understand how tolerance, harm reduction, and community support can be expanded.

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