



## Commentary

## The contractual governance of drug users in treatment

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## ABSTRACT

One of the challenges for drug treatment services is how to engage drug users effectively. This commentary examines one particular strategy for enhancing engagement that appears to have spread quite rapidly in recent years: the use of contract-like written agreements between treatment service providers and users. The development of the contractual governance of drug users in treatment is located in the wider context of emerging social control strategies and practices. In particular, insights are drawn from the socio-legal literature which has begun to examine these new control practices in diverse domains. The commentary also reports on the findings of a national survey of all 149 local authority areas in England that was designed to provide a preliminary mapping of the extent of contractual governance in treatment settings (response rate = 62%). In spite of the fact that the use of contracts between drug services and service users does not feature in the national drug policy framework, our survey strongly indicates that it is a widespread practice. Although these agreements can take on many different forms, typically they set out the responsibilities and requirements placed on users and, somewhat less frequently, what the service commits to providing for them. This novel practice of contractual governance may be viewed as having considerable potential but it also raises important issues concerning justice and rights. We conclude by arguing that this is an important area of emerging practice which raises significant theoretical and policy questions and the need for further research.

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## Introduction

One of the abiding challenges for drug treatment services is how to engage drug users effectively: to identify and attract them, to keep them coming and to ensure they comply with what is required of them. Services which are unable to do this will obviously struggle to contribute to important drug policy objectives, such as reducing mortality rates, curbing the spread of blood-borne viruses and supporting recovery. Effective engagement is the *sine qua non* of effective treatment.

Over the years, many innovations have been introduced to deal with engagement and retention problems, including reducing access thresholds (Finch, Groves, Feinmann, & Farmer, 1995), establishing rapid prescribing services (Keene, Stenner, Connor, & Fenley, 2007), rewarding attendance and compliance (Prendergast, Podus, Finney, Greenwell, & Roll, 2006; Petry, 2012), developing outreach services (Needle et al., 2005), making case management more 'assertive' (Vanderplasschen, Wolf, Rapp, & Broekaert, 2007), and using criminal justice leverage (Seddon, 2007a). Inevitably, there is a mixed picture of success from this diverse range of efforts

and the challenge has far from disappeared. Indeed, to the contrary, in an 'age of austerity' with public spending budgets across Europe (and beyond) being squeezed tighter than for many years, the problem has arguably become even more acute. The need for drug treatment to demonstrate that it can engage effectively with its target group is greater than ever.

This commentary examines one strategy for enhancing engagement that appears to have spread quite rapidly in recent years: the use of contract-like written agreements between treatment service providers and users. Although these agreements can take on many different forms, typically they set out the responsibilities and requirements placed on users and, somewhat less frequently, what the service commits to providing for them. This novel practice of contractual governance of drug users in treatment may be viewed as having considerable potential, not only to address the engagement challenge but also to underpin efforts to provide more personalised social and health care through individualised, tailored agreements. On the other hand, it may also be seen to raise serious ethical issues and concerns about human rights, as it appears to be based on a model of autonomy and responsibility that is at odds with conventional notions of addiction (West, 2006; cf. Foddy & Savulescu, 2006).

It is significant that if we look beyond the drug policy field, the emergence of contractual governance is clearly part of a wider set

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of developments in the realm of politics and government at the turn of the twenty-first century (see [Crawford, 2003](#)). A key part of our purpose in this commentary will be to locate the contractual governance of drug users in treatment in this wider context of emerging new social control strategies. In particular, we will draw theoretical, conceptual and empirical insights from the largely socio-legal literature which has begun to examine these novel control practices.

In the first section of the commentary, we introduce some of the key conceptual building blocks for our enquiry, specifically, the ideas of 'contract' and 'contractual governance'. We then turn, in the second part, to a consideration of some of the particular issues that may arise in relation to the contractual governance of drug users in treatment settings and include a review of the small body of literature in this area. In the third section, we present some preliminary findings from the first stage of an empirical study we are currently conducting. Finally, in conclusion, we map out a future research agenda to advance understanding of what we believe to be a significant development in the field.

### Contracts and contractual governance

The idea of legally binding promises can be traced as far back as Roman law ([Nicholas, 1975](#)). The concept of contract emerged in a form that we would recognise today in the late eighteenth century, at around the same time as the birth of modern industrial capitalism. In this sense, contracts, as a mechanism for ordering economic exchange, are foundational to modernity. As [Atiyah's \(1979\)](#) magisterial legal history demonstrated, the fortunes of the contract rose and fell during the 19th and 20th centuries, but in recent decades it has once again taken on a renewed centrality in social and economic life ([Vincent-Jones, 2000, 2006](#)). We will return in due course to consideration of this 'renewal' but we must first address a more basic question: what is a contract?

A standard definition in common law is that a contract is an agreement giving rise to obligations that are recognised by law ([Furmston, 2006](#)). From this perspective, contracts form social bonds, structure relationships and act as instruments through which the separate and potentially conflicting interests of the parties are brought to a shared and mutually beneficial purpose. There is usually an assumption that parties to a contract have what is known as 'contractual capacity'. By providing legal remedies if a contracting party fails to perform their duties or comply with the requirements of the contract, they also act as a mechanism for social regulation.

In certain important respects, however, this classic, legalistic concept of contract is unduly narrow and fails to capture the everyday realities of contractual arrangements. [Teubner \(2007, pp. 52–3\)](#) argues that the legal institution of the contract has 'fragmented into a multiplicity of different operations, each occurring in a different mutually-closed discourse'. These operations include not only legal obligations but also economic transactions and 'productive acts' (see also [Black, 2004, 2007; Gilbert, 1996](#)). [Macneil \(1980\)](#) makes the simple yet significant observation that the 'bindingness' of contractual obligations can be attributed to social norms as well as legal rules and institutions. The idea that contracts create both legal and social obligations is developed further by [Collins \(1999\)](#), who uses a regulation perspective to demonstrate that a contract does not have to be legally enforceable to create contractual relations. Indeed, his work highlights the ways in which contracts provide normative guides to behaviour that influence the conduct of the parties even if they do not actually constitute legally binding agreements. In fact, he argues that the law actually plays only a minor role in practice, compared to the extra-legal dimensions of contractual relations. [Collins \(1999, p. 15\)](#) suggests that a contract is best understood as 'a

form of communication system' which "'thinks" about the relation between people in a particular way'.

[Andersen \(2008, p. 84\)](#) argues similarly that contracts establish a specific medium through which people can observe and communicate with each other. Both [Collins](#) and [Andersen](#) draw attention to the fact that the construction of contractual identities, roles and responsibilities is significantly shaped by the social context from which the relations arise. Likewise, they stress the need to acknowledge that the performance of contractual duties is affected by the setting and circumstances within which they are embedded and performed. It is evident, then, that in order to study the use of contracts in any setting, we must go beyond the texts of agreements and investigate the environment in which they function.

In recent decades, the contract has risen to a new social and economic prominence. Most notably, since the 1980s, there have been concerted efforts to introduce a range of contractual terminologies, principles and mechanisms into the running and regulation of the state, with 'new public management' reforms designed to introduce markets to the public sector in order to promote greater economy, efficiency and effectiveness ([Hood, 1991; Osborne and Gaebler, 1992](#)). Enabling this development is what [Vincent-Jones \(2006\)](#) has termed the 'new public contracting', the emergence of which has fundamentally restructured the functions and activities of the state and the organisation of public service. Not only have relationships between state institutions and their policy-making procedures become increasingly structured by contracts, but central and local governments are increasingly outsourcing and entering into contracts with public, private and voluntary sector agencies in order to pursue public policy goals. This has been very evident in the drug treatment sector. In the UK, for example, local multi-agency Drug and Alcohol Action Teams (DAATs) enter into service level agreements with a range of providers.

At the same time as this internal reconfiguring of the 'state', social relationships between state agencies and citizens are also being regulated more and more through a variety of mechanisms that resemble contracts. These have emerged across a very diverse set of domains, from home-school agreements in education to behavioural contracts in public housing. In both appearance and effect, these mechanisms constitute distinctive new forms of contract, as their purpose is neither to facilitate economic exchange nor to regulate the provision of services but rather to modify and control specific behaviours – hence [Mackenzie \(2008\)](#) refers to them as 'control contracts'. More specifically, they are aimed at governing the conduct of individuals who are viewed as socially 'problematic' because certain elements of their behaviour breach social norms. [Crawford \(2003\)](#) has described this phenomenon as the 'contractual governance of deviant behaviour'.

We can locate this new practice in the wider context of neoliberal responses to the perceived shortcomings of the welfare state in late modern society. According to [Vincent-Jones \(2000, pp. 344–5\)](#), the use of contracting regimes reflects 'the loss of faith in state interventions directed at rehabilitation and the view that clients and offenders are free agents who should accept greater responsibility for their predicaments' (see also [Jayasuriya, 2002](#)).

In probation and social work, contracts have been used as a technique of behavioural control since the 1980s. A pioneering series of papers by [Nelken \(1987\)](#), [Nelken \(1988\)](#), [Nelken \(1989\)](#) examined the use of 'contracts' and 'working agreements' as social work techniques, whilst [Cohen \(1985, pp. 72–4\)](#) observed their early deployment in the criminal justice context in his seminal *Visions of Social Control*. In the 1990s, the UK government, as happened elsewhere, made the notion of contract the basis for radical social security reforms as benefit entitlement became conditional on entering a 'jobseeker's agreement' with an employment officer. Home-school agreements were introduced under the School Standards and Framework Act 1998, whilst the Youth Justice and

Criminal Evidence Act 1999 gave rise to 'youth offender contracts' as part of a court sentence. The use of contracts to regulate 'deviant behaviour' has even entered the virtual world, where millions of people are required to agree to be governed by specific terms and conditions before becoming members of online communities (Fairfield, 2008).

As a mode of behavioural control, what is common to these examples of contractual governance is that they operate under a strategy of 'responsibilization' (O'Malley, 1992) and are informed by the principles of what has been termed 'regulated self-regulation' or 'meta regulation' (Grabosky, 1995). In other words, they are designed to activate what Foucault (1993) described as 'self-technologies', in that their aim is to establish, restore or retune the internal normative frameworks that citizens use to shape their perspectives and routine activities. As Andersen (2007, p. 120) explains in relation to the citizens' contract in Denmark, they 'are employed not only to commit clients to a specific behaviour, but first and foremost to commit them to a particular inner dialogue about obligation and freedom'. This indicates that a central function of contractual governance is to communicate social values, norms and expectations. In this way, contracts act as directive codes of practice that set out how citizens should behave in any given context and how they should contribute to the maintenance of social order. Nelken (1987) found that social workers were able to use contracts to help clients identify and understand which of their potential actions should be acted upon and prioritised. This suggests that a useful way of investigating contractual governance is by trying to understand how the particular 'configuration of normative forces' (Vincent-Jones, 2000, p. 335) in operation in each context shapes contractual behaviour towards specific regulatory objectives.

We can see then that underpinning control contracts is the expectation from the 'controlling party' that contracting individuals will learn to govern themselves through their own autonomous choices. There is a clear resonance here with the work of behavioural economists who talk of redesigning the 'choice architecture' to 'nudge' people to make 'better' choices (Vuchinich & Heather, 2003; Thaler & Sunstein, 2008). A related expectation is that contracts may create a sense of empowerment and that this may make self-regulated compliance more likely. These expectations rest, in turn, on the assumption that the individuals are rational and competent actors, or at least that they are capable of acting rationally. In this sense, contractual governance or control contracts are rooted in a classic, legal understanding of contractual capacity.

Commentators have also highlighted a number of concerns about control contracts. Fundamentally, it has been questioned whether the appearance of consent and choice is genuine or simply an illusion created by the use of contractual terminology (Sulkunen, 2010). Freedland and King (2003) provide a useful normative critique, focusing on the power imbalances and consequent lack of mutuality inherent in the contractual governance of marginalised groups, arguing that it amounts to an illiberal practice. For Mackenzie (2008, p. 236), the contractual governance of incivility and undesired behaviour 'represents a top-down Hobbesian exercise of state authority rather than anything more voluntary, consensual, communitarian or dialogical'. Commenting on the contractual governance of young people, Crawford (2009, p. 177) notes that 'the reality is often one of limited choice, a lack of real options, and a weak bargaining position on the part of the young person'. Indeed, when the state is a party to a contract with a citizen, it is arguably self-evident that there is a significant inequality in bargaining power. As a result, the contracting process may take on a coercive rather than consensual aspect. This coercive potential might seem even more likely to be realised in relation to the contractual governance of vulnerable populations.

## Contractual governance in drug treatment settings

It is notable that despite the apparent novelty of the examples Crawford and others describe, in the drug treatment sector we can find examples of the use of contracts going back to the early 1970s. A number of North American studies in the 1970s and 1980s examined the use of what was termed 'contingency contracting' with drug users. This was a technique of controlling behaviour that originated in behavioural psychiatry and was based on the principles of operant conditioning. Stuart (1971, p. 3) described it in the following way, which makes very clear the lineage to contemporary contractual governance:

Contracts structure reciprocal exchanges by specifying who is to do what, for whom, under what circumstances. They therefore make explicit the expectations of every party to an interaction and permit each to determine the relative benefits and cost to him of remaining within that relationship.

Boudin et al. (1977) considered the application of contingency contracting to help heroin addicts gain control of their routine activities in their natural environment. The contingent consequences for the fulfilment and nonfulfilment of contracted behaviours included the provision of financial resources and the increasing responsibility for self-management. Similarly, Beatty (1978) investigated the effect of contingency contracting with heroin addicts living in a 'halfway house' environment. The findings of his study showed that the implementation of contracts did significantly increase their performance of certain contracted behaviours (e.g. reporting drug urges and use and attending scheduled therapy meetings), although simply signing a written contract stating that these behaviours were to be performed did little to alter the actual level of performance. Beatty (1978, p. 525) concludes by suggesting that contracting can be an effective technique for regulating behaviour, 'but only if reinforcers offered to the clients are meaningful to them'. Anker and Crowley (1982) carried out a similar study of cocaine users in specialised clinics which produced comparable findings, whereas Dolan, Black, Penk, Robinowitz, and DeFord (1985) and Magura, Casriel, Goldsmith, Strug, and Lipton (1988) evaluated the effectiveness of contingency contracting interventions on reducing illicit drug use by methadone maintenance outpatients. Magura et al. (1988, p. 117) discovered that patients perceived the reinforcement of desired behaviours by controlling consequences through contracts as 'reasonable' and as 'making it easier to stay clean'. Drug workers in the study also indicated that contracting helped them develop treatment relationships and made patients more aware of their problems and the options available to them.

Moving into the 1990s, the idea of contracting seemed to disappear from the drug treatment literature, whilst the use of contingencies or rewards as a tool for behaviour management began to flourish. Rebranded as 'contingency management', reward-based interventions share with the earlier 'contingency contracting' technique an assumption that the behaviour of drug users can be controlled or shaped by manipulating its consequences through positive reinforcement. For example, it is assumed that drug users will use street drugs less if they are offered 'vouchers' for providing negative drug-test samples. Similarly, although more controversially, access to affordable housing and work opportunities have been made contingent on negative drug tests (Milby et al., 2003). Therapists have also used vouchers to reinforce the development of social skills and activities (Iguchi, Belding, Morral, Lamb, & Husband, 1997). A meta-analysis of the research evidence carried out by Prendergast et al. (2006) found strong support for the effectiveness of contingency management as an approach for reducing drug use and improving attendance and retention in drug treatment

programs. Indeed, the literature indicates that treatments which incorporate adjunctive contingency management are more effective than the same treatments without such techniques (Petty, 2012). Despite this relatively strong evidence base, there has been a variable take-up around the world of contingency management in drug treatment settings. In the UK, for example, it has been quite limited so far, although there is currently a programme of research underway which includes two randomised trials and its use has also been recommended for some years in clinical guidance.

From our own contacts with treatment services in the UK in recent years, we have observed that, rather than a rise of contingency management, what has actually unfolded has been the (re-)emergence and subsequent proliferation of contracting in such settings. As far as we are aware, this development has occurred largely under the radar, going almost entirely unnoticed, undocumented and certainly unresearched. Yet, in our view, there are some significant issues at stake here.

There is, first of all, the question of contractual capacity that we have already referred to. Put simply, are drug users mentally capable of deciding to enter into binding agreements with drug treatment services? And is it appropriate to consider them to be bound by such contracts? These are not easy questions to answer, not least because the concept of mental capacity is difficult to define, let alone measure, but they highlight significant ethical concerns. Notwithstanding the fact that control contracts will rarely be legally enforceable, we can nevertheless usefully draw insights from how the law has approached this question. English common law recognises certain classes of persons who are generally not considered to be capable of contracting because of the existence of a range of cognitive or other impairments, the most relevant for our purposes being mentally impaired persons or persons of unsound mind (Hart v O'Connor [1985]; *Irvani v Irvani* [2000]). If such persons enter into a contract it is generally considered to be voidable rather than void – that is, it is presumed to be enforceable but for the capacity of one of the parties which permits them to avoid their otherwise valid contractual obligations. The Mental Capacity Act 2005 provides a more general legal framework for regulating issues relating to persons who lack capacity. According to section 2(1), 'a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain'. It goes on to explain in section 3(1) that a person is unable to make a decision for himself if he is unable: (a) to understand the information relevant to the decision; (b) to retain that information; (c) to use or weigh that information as part of the process of making the decision; or (d) to communicate his decision. This illustrates the complexity of the notion of mental capacity but, at the same time, also points to how it might start to be operationalised by researchers and practitioners in appraising the situation for individual cases.

A second, related, issue concerns the potential for 'undue influence'. Again, legal approaches to this question are instructive (Madoff, 1997; Smith, 1997; Lucy, 1989). In basic terms, the law recognises that undue influence occurs when one party to a contract has exercised such a strong influence over the other that his or her autonomy of decision-making is substantially undermined. It does not question the person's ability to understand the choice that they made, but rather looks at the issue of whether the decision was made freely. The nature and operation of undue influence in the modern law was considered by the House of Lords in eight appeals heard together and reported as *Royal Bank of Scotland Plc v Etridge* [2001]. According to the principles set out in the speech of Lord Nicholls unacceptable conduct 'arises out of a relationship between two persons where one has acquired over another a measure of influence, or ascendancy, of which the ascendant person then takes unfair advantage'. The courts have ruled that drug addiction

is not a basis for a presumption of influence (*Irvani v Irvani* [2000]). In the *Etridge* case, their Lordships considered that it was only where the duties of care and confidence arose as a matter of law by virtue of the relationship between the parties that there is a true presumption of influence. While it has been stated that the relations which fall into this category cannot be listed exhaustively, they include the relationship between doctor and patient. This raises the question of whether we might view the relationship between drug worker and service user in a similar light, such that there might be a (rebuttable) presumption of influence.

A third matter relates to the theoretical significance of this development. As we have seen, conflicting understandings of the autonomy and capacities of drug users bring out important ethical–legal concerns (see also: Husak, 1999; Morse, 2006; Foddy & Savulescu, 2006). But they also pose an intellectual puzzle: what kind of citizen–subject is understood simultaneously as endowed with contractual capacity (rational, autonomous, 'in control') and, at the same time, as requiring treatment to repair a damaged 'will' (characterised by irrationality and 'loss of control')? Engaging with this paradox of freedom has been identified as central to cutting-edge inquiry into the contemporary governance of drug users (O'Malley, 2004; Reith, 2004; Seddon, 2007b). The operation of contractual governance in treatment settings provides an important site in which we can explore the parameters and significance of this paradox. What does it tell us about the nature and functioning within treatment of the inter-locking constructs of 'responsibility', 'will', 'motivation' and 'addiction'? Or, to put it more simply, what kind of person is a drug user in treatment who is made subject to one of these control contracts (Seddon, 2011)?

#### **A study of contractual governance in the English treatment system**

In this section of the commentary, we move on to introduce an empirical study we are conducting on contractual governance in drug treatment. This is a multi-site, multi-methods study designed to map out and critically examine this emerging practice. The first phase, on which we report here, has involved a national survey to map the extent and spread of the use of contractual governance techniques within treatment services in England.

There is no single, complete or up-to-date treatment service database for England in existence. We therefore sent the survey initially via email to the commissioning and coordinating managers of Drug and Alcohol Action Teams (DAATs). At the time of the study there were a total of 149 DAATs in England, each partnership area being coterminous with the geographical boundaries of either their county or unitary local authority. Aside from being easily identifiable and relatively accessible, the logic behind surveying DAAT managers was that they are responsible for the local commissioning of drug treatment and could therefore act as valuable informants and gatekeepers to the services in their areas. Non-response to the initial contact was followed up by two reminder emails and then a telephone call. The overall achieved response rate for the survey was 62 per cent.

Survey respondents were asked a short series of questions about whether any of the services they commissioned currently made use of any agreements that resembled contracts with their service users, how widespread the practice was and which particular services used them. Follow-up questions were asked in response to answers with the aim of filling any gaps in the information, clarifying ambiguities and eliciting general views on contractual agreements as tools in the drug treatment process. As a result of this approach to conducting the survey, as well as a quantitative map of the extent of the phenomenon, we also generated some useful qualitative insights from email exchanges and telephone conversations.

**Table 1**  
The use of contracts in drug treatment settings in England.

Region	Response rate	Contracts in use
East Midlands	4/9	2/4
East of England	8/10	6/8
London	16/33	15/16
North East England	6/12	5/6
North West England	14/22	12/14
South East England	13/19	12/13
South West England	10/15	9/10
West Midlands	10/14	7/10
Yorkshire & Humber	11/15	10/11
Total	92/149 (62%)	78/92 (85%)

Although the use of contracts between drug services and service users does not feature in the national drug policy framework, our survey indicated that it was a widespread, indeed near-ubiquitous, practice. Excluding non-responders, 85 per cent of the local areas in England confirmed the use of contracts by some or all of the providers in their locality. This strongly indicates that the contractual governance of drug users is a common practice within the English treatment system. By clustering DAAT partnership areas within regions, the data presented in [Table 1](#) shows how widespread the practice is across the whole country.

Of the 14 areas where contracts were not currently being used, five commissioners reported that they had been used by previous providers or by existing providers previously. These services were contacted by telephone for informal interview, as it was felt they might have particular insights on the appropriateness and effectiveness of contractual devices in drug treatment. One service manager explained why he decided to discontinue the practice:

The [contracts] in place at the time appeared punitive and unenforceable. Collaborative, individualised care planning with regular review was felt to be more effective.

Drug Service Manager, East of England

Another manager made a similar observation, also highlighting the issue that we have discussed of the potential for undue influence:

[T]here were problems in that some service users didn't want to sign it but worried that treatment would be withdrawn or not given if they didn't. The feeling was it was too draconian – and the content should be reinforced through good key working anyway.

Drug Service Manager, North East England

In conducting the survey, it also became very evident that in some treatment services, an individual could be governed by multiple contracts. For example, a service manager described the following in an email response:

In speaking with my colleagues and a few practitioners we believe that there are at least four identifiable “contracts” between the service/key worker and client. (1) The Care Plan (this is thought to be the central or main contract and there will be various agreed actions between client and key worker as the plan develops); (2) The Patients Charter; (3) Prescription Collection Contract; and (4) The Prescribing Contract (a three way signed agreement between the client, the pharmacist and the key worker). There is also the ‘permission to share’ form but I have not included this as even though the client signs it, they

then have a passive role and it is the service that is contracted to stay within the clients chosen agencies that we can share information with.

Drug Service Manager, South East England

To summarise, then, the survey revealed that there are many types of contract-like agreements in operation through which services structure their relationships with service users and attempt to modify and control specific behaviours. Examples that we came across included: Agreement on Urine Testing; Behaviour Contract; Client Code of Conduct Agreement; Confidentiality Statement; Consent to Share Information Form; Contract for Clients Being Prescribed; House Rules; Pharmacy Contract; Re-engaging Agreement; Service User Contract; Service User's Rights and Responsibilities; The Service User's Charter; Treatment Agreement. Indeed, arguably, even ‘care plans’ (sometimes know as treatment or recovery plans) – which are a required element of treatment in the English system – effectively act as contractual agreements, in the sense that they constitute an agreed joint plan between the service and the user. From this perspective, it could be argued that *all* drug treatment services in England essentially engage in at least one form of contractual governance through care planning.

Although they go by various names, take various forms and relate to various aspects of the treatment process, these documents typically spell out what is expected of the service user and what the service will provide in return. Viewed collectively, they provide evidence of how the behaviour of drug users in contact with treatment is increasingly governed through a ‘maze of contracts’ ([Crawford, 2003](#), p. 480).

## Conclusion

Our aim in this article has been to set out a platform for enquiry into what we believe to be a highly significant development in the ways that drug treatment services relate to and engage with drug users. The proliferation of techniques of contractual governance has attracted little attention to date but arguably has led to an important reshaping of contemporary treatment practices.

The first phase of our empirical study, on which we have reported here, has generated three principal findings. First, contractual governance techniques are now widespread across the treatment system in England. Our national survey found that 85% of responding Local Authority areas reported some use of contracts. Second, contracts used in treatment settings take on a variety of forms and are deployed for a range of purposes at different stages in the treatment process. They are not solely used at treatment entry. Third, individual service users are often subject to several agreements or contracts at the same time, indicating that a complex web of controls is in play rather than a single form or channel of governance.

A future research agenda will need to focus on examining *how* contractual governance operates in this domain. This will require an in-depth understanding of the contexts in which agreements are deployed. As [Teubner \(2007, p. 55\)](#) notes, the ‘nature of the contract finds its basis in the inescapable hermeneutic differences of the different social contexts in which the individual contract is situated’. In other words, contractual relations emerge from specific social contexts and so can only be properly understood as situated relationships and practices. We therefore need to ask a series of contextualised questions about the different instances of contractual governance in treatment settings. What do the parties understand the particular agreement to be? Do they consider themselves ‘bound’ by it? What is the source of this ‘bindingness’? How does the agreement affect their expectations of what the other

party will do? How does it shape their own behaviour? What do they think 'breach' of the agreement might consist of? How should it be responded to? These types of questions will need to be pursued through detailed qualitative research studies in different settings.

This research agenda will contribute to the development of important new knowledge and understanding about the value of contractual governance techniques for the crucial processes of drug treatment engagement, retention and effectiveness. These are vital aspects of drug policy debates around the world. We also believe that these enquiries will speak to wider debates amongst 'law and society' scholars about the nature of contemporary strategies and practices for the regulation of the behaviour of 'minority' or 'deviant' groups and the profound questions of justice and rights that they raise.

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The authors confirm that they have no conflicts of interest.

### References

- Andersen, N. (2007). Creating the client who can create himself and his own fate – the tragedy of the citizens' contract. *Qualitative Sociology Review*, 3(2), 5–29.
- Andersen, N. (2008). The world as will and adaptation: The interdiscursive coupling of citizens' contracts. *Critical Discourse Studies*, 5(1), 75–89.
- Anker, A., & Crowley, T. (1982). Use of contingency contracts in speciality clinics for cocaine abuse. *NIDA Research Monograph*, 41, 452–459.
- Atiyah, P. (1979). *The rise and fall of freedom of contract*. Oxford: Oxford University Press.
- Beatty, D. (1978). Contingency contracting with heroin addicts. *The International Journal of the Addictions*, 13(4), 509–527.
- Black, O. (2004). Agreements, undertakings and practical reason. *Legal Theory*, 10, 77–95.
- Black, O. (2007). Two theories of agreement. *Legal Theory*, 13, 1–22.
- Boudin, H., Valentine, V., Ingram, R., Brantley, J., Ruiz, M., Smith, G., Catlin, R., & Regan, E. (1977). Contingency contracting with drug addicts in the natural environment. *The International Journal of the Addictions*, 12, 1–16.
- Cohen, S. (1985). *Visions of social control*. Cambridge: Polity Press.
- Collins, H. (1999). *Regulating contracts*. Oxford: Oxford University Press.
- Crawford, A. (2003). "Contractual governance" of deviant behaviour. *Journal of Law and Society*, 30(4), 479–505.
- Crawford, A. (2009). Restorative justice and antisocial behaviour interventions as contractual governance. In P. Knepper, J. Doak, & J. Shapland (Eds.), *Urban crime prevention, surveillance, and restorative justice: Effects of social technologies*. London: CRC Press.
- Dolan, M., Black, J., Penk, W., Robinowitz, R., & DeFord, H. (1985). Contracting for treatment termination to reduce illicit drug use among methadone maintenance treatment failures. *Journal of Consulting and Clinical Psychology*, 53(4), 549–551.
- Fairfield, J. (2008). Anti-social contracts: The contractual governance of virtual worlds. *McGill Law Journal*, 53, 429–476.
- Finch, E., Groves, I., Feinmann, C., & Farmer, R. (1995). A low threshold methadone stabilization programme – description and first stage evaluation. *Addiction Research & Theory*, 3(1), 63–71.
- Foddy, B., & Savulescu, J. (2006). Addiction and autonomy: Can addicted people consent to the prescription of their drug of addiction? *Bioethics*, 20(1), 1–15.
- Foucault, M. (1993). About the beginning of the hermeneutics of the self: Two lectures at Dartmouth. *Political Theory*, 21(2), 198–227.
- Freedland, M., & King, D. (2003). Contractual governance and illiberal contracts: Some problems of contractualism as an instrument of behaviour management by agencies of government. *Cambridge Journal of Economics*, 27(3), 465–477.
- Furmston, M. (2006). *Cheshire, Fifoot & Furmston's Law of Contract* (5th ed.). Oxford: Oxford University Press.
- Grabosky, P. (1995). Using non-governmental resources to foster regulatory compliance. *Governance*, 8(4), 527–550.
- Gilbert, M. (1996). *Living together: Rationality, sociality and obligation*. Lanham, MD: Rowman & Littlefield.
- Hood, C. (1991). A public management for all seasons? *Public Administration*, 69, 3–19.
- Husak, D. (1999). Addiction and criminal liability. *Law and Philosophy*, 18(6), 655–684.
- Iguchi, M., Belding, M., Morral, A., Lamb, R., & Husband, S. (1997). Reinforcing operants other than abstinence in drug abuse treatment: An effective alternative for reducing drug use. *Journal of Consulting and Clinical Psychology*, 65, 421–428.
- Jayasuriya, K. (2002). The new contractualism: Neo-liberal or democratic? *Political Quarterly*, 73(3), 309–320.
- Keene, J., Stenner, K., Connor, M., & Fenley, S. (2007). A case study of substitute prescribing for drug-using offenders. *Drugs: Education, Prevention & Policy*, 14(5), 443–456.
- Lucy, W. (1989). Contract as a mechanism of distributive justice. *Oxford Journal of Legal Studies*, 9(1), 132–147.
- Mackenzie, S. (2008). Second-chance punitivism and the contractual governance of crime and incivility: New Labour, old Hobbes. *Journal of Law and Society*, 35(2), 214–239.
- Macneil, I. (1980). *The new social contract: An inquiry into modern contractual relations*. New Haven: Yale University Press.
- Madoff, R. (1997). Unmasking undue influence. *Minnesota Law Review*, 81, 571–629.
- Magura, S., Casriel, C., Goldsmith, D., Strug, D., & Lipton, D. (1988). Contingency contracting with polydrug-abusing methadone patients. *Addictive Behaviors*, 13(1), 113–118.
- Milby, J., Schumacher, J., Wallace, D., Frison, S., McNamara, C., Usdan, S., et al. (2003). Day treatment with contingency management for cocaine abuse in homeless persons: 12-month follow-up. *Journal of Consulting and Clinical Psychology*, 71, 619–621.
- Morse, S. (2006). Addiction, genetics and criminal responsibility. *Law and Contemporary Problems*, 69(1/2), 165–207.
- Needle, R., Burrows, D., Friedman, S., Dorabjee, J., Touzè, G., Badrieva, L., et al. (2005). Effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users. *International Journal of Drug Policy*, 16(1), 45–57.
- Nelken, D. (1987). The use of "contracts" as a social work technique. *Current Legal Problems*, 40, 207–232.
- Nelken, D. (1988). Social work contracts and social control. In R. Matthews (Ed.), *Informal justice?* London: Sage.
- Nelken, D. (1989). Discipline and punish: Some notes on the margin. *Howard Journal of Criminal Justice*, 28(4), 245–254.
- Nicholas, B. (1975). *An introduction to Roman law*. Oxford: Clarendon Press.
- O'Malley, P. (1992). Risk, power and crime prevention. *Economy and Society*, 21, 252–275.
- O'Malley, P. (2004). *Risk, uncertainty and government*. Cavendish: Routledge.
- Osborne, D., & Gaebler, T. (1992). *Reinventing government: How the entrepreneurial spirit is transforming the public sector*. Reading, MA: Addison-Wesley.
- Petry, N. (2012). *Contingency management for substance abuse treatment: A guide to implementing this evidence-based practice*. Hove: Routledge.
- Prendergast, M., Podus, D., Finney, J., Greenwell, L., & Roll, J. (2006). Contingency management for treatment of substance use disorders: A meta-analysis. *Addiction*, 101, 1546–1560.
- Reith, G. (2004). Consumption and its discontents: Addiction, identity and the problems of freedom. *British Journal of Sociology*, 55(2), 283–300.
- Seddon, T. (2007a). Coerced drug treatment in the criminal justice system: Conceptual, ethical and criminological issues. *Criminology & Criminal Justice*, 7(3), 269–286.
- Seddon, T. (2007b). Drugs and freedom. *Addiction Research & Theory*, 15(4), 333–342.
- Seddon, T. (2011). What is a problem drug user? *Addiction Research & Theory*, 19(4), 323–333.
- Smith, S. (1997). Contracting under pressure: A theory of duress. *Cambridge Law Journal*, 56(2), 343–373.
- Stuart, R. (1971). Behavioral contracting within the families of delinquents. *Journal of Behavior Therapy and Experimental Psychiatry*, 2, 1–11.
- Sulkunen, P. (2010). Agency and power: The contractual illusion. *European Journal of Cultural Studies*, 13(4), 495–510.
- Teubner, G. (2007). In the blind spot: The hybridization of contracting. *Theoretical Inquiries in Law*, 8, 51–71.
- Thaler, R., & Sunstein, C. (2008). *Nudge: Improving decisions about health, wealth and happiness*. New Haven, CT: Yale University Press.
- Vanderplasschen, W., Wolf, J., Rapp, R., & Broekaert, E. (2007). Effectiveness of different models of case management for substance-abusing populations. *Journal of Psychoactive Drugs*, 39(1), 81–95.
- Vincent-Jones, P. (2000). Contractual governance: Institutional and organizational analysis. *Oxford Journal of Legal Studies*, 20(3), 317–351.
- Vincent-Jones, P. (2006). *The new public contracting: Regulation, responsiveness, relationality*. Oxford: Oxford University Press.
- Vuchinich, R., & Heather, N. (Eds.). (2003). *Choice, behavioural economics and addiction*. Oxford: Pergamon Press.
- West, R. (2006). *Theory of addiction*. Oxford: Blackwell.

### List of cases

- Hart v O'Connor [1985] AC 1000.
- Irvani v Irvani [2000] 1 Lloyd's Rep 412, CA.
- Royal Bank of Scotland plc v Etridge (No. 2) [2001] UKHL 44.