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There has been renewed advocacy in Australia and the USA for the revival of compulsory treatment of severely addicted persons for their own good. The reasons for this revival are unclear but probably include a convergence of factors that includes the frustration of health providers in dealing with repeated hospital presentations for alcohol-related problems and pressure from family members for the health system to intervene in the self-destructive or harmful alcohol and drug use of their members.

This paternalistically motivated form of compulsory addiction treatment differs from the more common practice of coercing addicted offenders into treatment as an alternative to imprisonment. Legally coerced treatment through the criminal justice system has been criticised for a lack of evidence of its effectiveness and its infringement of the rights of offenders (e.g. Fischer [1] and Wild et al. [2]). We do not have the space to discuss this form of coerced treatment; our focus is on paternalistically motivated compulsory treatment, namely, that which occurs when addicted individuals who have not committed any offence (apart from being repeatedly intoxicated in public) are compelled to enter treatment, usually by order of a court or a quasi-judicial body, for their own good or the good of family members.

For over a century, a number of jurisdictions have permitted persons with severe addiction to be compulsorily treated in this way. Involuntary treatment of inebriety was introduced in Australia and the USA in the mid to late 19th century [3,4]. It largely fell out of favour in the 20th century because of its high cost and low success rates [5]. Switzerland still allows civil commitment of addicted persons, but these admissions comprised less than 2% of admissions in the late 1990s [6]. Sweden has had a compulsory treatment system for alcohol and drug dependence for over a century, but the number of persons coming under these provisions has declined in the past decade [7]. Legislation in many US states allows the civil commitment of addicted persons but these provisions are rarely used [8].

Paternalistic compulsory addiction treatment is again being trialled in two Australian states, New South Wales (NSW) [9] and Victoria [5]. The rationale for its revival is similar to that used to justify the involuntary treatment of adults with serious mental illnesses. We first briefly review the arguments for the latter practice before assessing whether a similar case can be made for involuntary addiction treatment.

The case for involuntary psychiatric treatment

It is generally accepted in many developed countries that adults with serious mental illnesses, such as schizophrenia, bipolar disorder and severe depression, are not autonomous when they are acutely ill [10]. Opinions differ on whether this justifies their involuntary treatment [11], and if so, under what conditions [12]. The law in many countries provides the state with the legal powers (under some forms of safeguards) to compulsorily treat persons with serious mental illnesses for their own good and/or to protect others [10]. This policy assumes that the persons' condition is treatable and that they will benefit from being treated.

Legislation that permits involuntary treatment usually requires a medical practitioner to certify that the person has a mental illness that requires treatment either to protect the person or others. This recommendation has to be supported by a psychiatrist and is usually subject to a judicial or quasi-judicial review at which the patient may have legal or other representation. Involuntarily treated patients are expected to receive effective and humane treatment, using the least restrictive means, such as supervised treatment in the community.

These practices have come under renewed criticism (see Sheehan [13] for a recent review) because of a lack of evidence that they improve the health of patients who are so treated [14]. Critics point out that there are no randomised controlled trials showing that compulsory treatment is effective and at best, only weak evidence of efficacy from poorly controlled observational studies [13,14].

Reservations have also been expressed about proposals to extend compulsory medication into the community by using Community Treatment Orders [15].

The case for involuntary treatment of addiction

Some severely addicted persons will not stop using alcohol and other drugs even when they are at risk of serious harm to themselves or others. When intoxicated, they seem incapable of making informed decisions about their own health or safety. Some addiction physicians and ethicists have argued that the most humane policy is for the state to compel these individuals to be treated in their own best interests [16]. This view has also been advocated by family members who want medical professionals to intervene in the self-destructive or harmful behaviour of their family members (NSW Parliament Legislative Council Standing Committee on Social Issues [9], pp. 96–106). The persons who are most likely to be compulsorily treated are indigent and homeless and have long lost all contact with family members [16].

The argument for involuntary addiction treatment in these cases parallels that for involuntary psychiatric treatment. The analogy is strongest in the case of severely alcohol- and drug-dependent people who endanger their personal safety and the safety of others because they are chronically and severely intoxicated. In these cases, short-term, involuntary treatment to safely withdraw from alcohol and drugs and treat serious medical problems may save their lives. Many such persons would also arguably satisfy the criteria for involuntary psychiatric hospitalisation in that they suffer from drug-induced mental disorders (e.g. delirium, psychosis or mania) that make them incapable of acting autonomously. However, mental health legislation in many jurisdictions specifically excludes alcohol- and drug-dependent persons from being treated as involuntary psychiatric patients. Even when the law allows it, psychiatric services are often reluctant to accept addicted persons because of practical challenges in treating them in the same settings as persons with psychiatric disorders. This is despite the fact that many patients with major psychiatric disorders also have serious addiction problems.

Proponents argue that the loss of liberty is justified by the immediate reductions in the risk of serious harm that compulsory treatment provides for severely addicted individuals. They also argue that in the longer term, their health may be substantially improved and their autonomy restored, if they can be successfully engaged in rehabilitation [16].

The costs of providing compulsory addiction treatment can be substantial for a relatively small number of cases. These costs are often met by the state because indigent addicted individuals are unable to pay for such care. Public funding of compulsory treatment is, in turn, justified by an appeal to the economic savings from early treatment of health problems that, if left untreated, may require much more expensive emergency and inpatient medical care [16]. Despite this claim, there has been no research in either addiction (or psychiatry) to assess whether assertive community-based voluntary treatment is any less effective or cost-effective than involuntary treatment [15].

Practical challenges in compulsory addiction treatment

How adequate are procedural safeguards?

Procedural safeguards are usually proposed to ensure that compulsorily treated persons receive effective medical treatment in a way that respects their civil and human rights. The adequacy of these safeguards has rarely been evaluated. Historical experience with the Inebriates Act in NSW suggests that over time, these safeguards were eroded and the system became routinised and operated more as a form of social control that incarcerated addicted persons for long periods without providing effective treatment [3].

What type of treatment should be provided?

Intoxication and drug withdrawal can be safely and effectively managed over a period of one to two weeks [17]. However, longer term treatment is required to maintain abstinence in the longer term and for severely addicted persons, this may require residential rehabilitation. In NSW under the Inebriates Act, compulsory addiction treatment often lasted for six months. Should compulsory treatment allow such prolonged periods of treatment under compulsion?

Should patients be compelled to use drugs to maintain their abstinence? Some drug treatments benefit a substantial proportion of persons who receive them voluntarily, namely, methadone and buprenorphine maintenance for opioid dependence, and acamprosate, disulfiram and naltrexone for alcohol dependence [18]. Compelling patients to accept such treatment is often regarded as ethically problematic [12], and there was little support for compelling addicted patients to receive these treatments in evidence to the NSW parliamentary inquiry (see NSW Parliament Legislative Council Standing Committee on Social Issues [9], chapter 6). Caplan [19] is one ethicist who has advocated the compulsory use of an implantable form of the opioid antagonist naltrexone to treat heroin-dependent persons, arguing that it will restore patient autonomy [19]. We have pointed out problems with Caplan's view elsewhere [20].

How effective is compulsory addiction treatment?

A major problem shared by all forms of paternalistic coerced addiction treatment is the lack of evidence on its safety and efficacy. There are no randomised controlled trials or observational studies showing that persons who have been compulsorily treated have lower rates of re-hospitalisation, premature death and morbidity than similarly addicted persons who have not been compulsorily treated [9,21].

The only evidence offered for the effectiveness of compulsory addiction treatment are case series of small numbers of patients who have been treated in this way (see reviews in NSW Parliament Legislative Council Standing Committee on Social Issues [9] and Broadstock et al. [21]). The assertion that these patients have benefitted from compulsory treatment is accordingly made in ignorance of what may have happened if they had not been so treated, or if they had been encouraged to enter treatment in other ways.

Advocates claim that compulsory treatment can be justified by the economic savings that would be made by averting a small number of highly expensive episodes of inpatient care (e.g. in intensive care units for liver failure). As noted above, there is no evidence that these benefits have been realised. This type of argument is also ethically problematic. The use of an economic rationale for compulsory treatment of addiction does not sit well with the claim that such treatment is primarily provided in the best interests of the addicted person. It implicitly gives a higher priority to reducing the economic and social costs of treating severely addicted persons.

What should be done?

Governments that have reintroduced compulsory addiction treatment should rigorously evaluate how it operates. Specifically, they should:

Assess how these schemes operate over substantial periods of time. We need more than uncontrolled case reports of persons who have been treated when programs are well-resourced and treatment is provided by well-trained and highly motivated staff.

Conduct more rigorous trials of compulsory addiction treatment. This could involve randomly assigning candidates for compulsory treatment to either compulsory treatment or an alternative, such as active outreach to engage them in addiction treatment (as has been done recently in psychiatry). These trials should also evaluate the cost and cost-effectiveness of providing compulsory treatment. Examine the effects that providing compulsory treatment may have on voluntary addiction treatment. How does the power to compel treatment affect demand for voluntary treatment? How does it affect

the morale of staff who provides the treatment? How does it affect outcomes in persons who receive voluntary addiction treatment?

Examine how well procedural protections of civil rights perform in compulsory treatment systems, especially after treatment becomes more routine?

How does compulsory addiction treatment interact with legally coerced addiction treatment such as that provided for addicted offenders in the criminal justice system?

A failure to properly evaluate the current trials of compulsory addiction treatment would be a major missed opportunity. It could result in another policy experiment with compulsion that falls into disuse for reasons that are not understood. If this happens, the addictions field will be no better informed after these trials about whether it is ethical, effective and cost-effective to compulsorily treat severely addicted persons.

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