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ORIGINAL ARTICLE

New Dutch Legislation and Preventive Coercive Home Health Care for Excessive Alcohol Consumers

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Abstract

Excessive alcohol consumers are in need for effective and targeted thiamine interventions to prevent the development of Korsakoff's syndrome. Coercive home health care might be a solution to reach excessive alcohol consumers. In many parts of the world, an expansion is seen of more coercive community practices. Due to new legislation in the Netherlands, *preventive* coercive home health care is permitted. The objective of this article is twofold. Firstly, to describe this new Dutch legislation and secondly, to explore literature to identify themes that might contribute to less-intrusive coercive interventions at the excessive alcohol consumer's home. Four articles have been identified which concentrate on experiences regarding coercive home health care. Preventive coercive home health care might benefit from a stable and trusting relationship. For healthcare organizations, this means that they need to pay attention to the health and safety of their employees to prevent outflow.

Keywords Preventive treatment · Alcoholism · Coercion · Home health care · Legislation · Therapeutic relationship

Alcohol use is a significant global public health issue and takes a tremendous toll on society and the individual (Nace et al. 2007). More than 3 million people died as a result of harmful use of alcohol in 2016, according to a publication released in September 2018 by the World Health Organization (WHO). This represents 1 in 20 deaths. Overall, the harmful use of alcohol causes more than 5% of the global disease burden (WHO 2018). "The overall burden of disease and injuries caused by the harmful use of alcohol is unacceptably high. Globally an

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estimated 237 million men and 46 million women suffer from alcohol-use disorders with the highest prevalence among men and women in the European region (14.8% and 3.5%) and the Region of Americas (11.5% and 5.1%)," according the WHO report (WHO 2018).

Alcohol use disorders are a chronic relapsing condition, and patient prognosis is poor (Haber et al. 2009). Harmful alcohol consumption is the third main cause of early death and illness in the EU, after tobacco and high blood pressure. It is responsible for an estimated 195,000 deaths each year in the EU (European Commission 2013).

In the Netherlands, almost 10% of the adults drink excessively, which is more than 21 glasses a week for men and more than 14 glasses a week for women. In 2015, 9.5% of the adult above 18 years of age drank alcohol excessively: 11.6% of them were men and 7.6% women. Excessive drinking is most common when people are in their twenties and least likely in the group of 70 years and older (Van Laar and Van Ooyen-Houben 2016).

Excessive alcohol consumers are at risk of developing a Wernicke's encephalopathy (WE) due to the combination of chronic alcohol abuse and concomitant thiamine deficiency. A thiamine deficiency can emerge due to consuming too few products in which thiamine is present, such as bread and grain products, potatoes, vegetables, meat and meat products, and milk and milk products (Martin et al. 2003) or in conditions where food is lost due to excessive vomiting (Oudman et al. 2018; Isenberg-Grzeda et al. 2016). As a result of WE, patients can develop Korsakoff's syndrome (KS) which is a chronic neuropsychiatric condition characterized by a severe memory disorder, lack of insight into their own illness, and reluctance to receive care (Arts et al. 2017; Kopelman et al. 2009). This reluctance is a symptom of the syndrome: patients are not aware of the memory disorder and therefore reject the care offered (Kolb and Whishaw 1985; Arts 2004). For other possible symptoms of KS, see Fig. 1 (van den Hooff and Goossensen 2015a).

If WE is diagnosed, it is important to administer a high dose of thiamine immediately. Thiamine can be easily administered in pill form, intravenously or intramuscularly. Thiamine treatment in acute WE should always be parenteral (intravenously or intramuscularly) because of the imperfect resolution of the deficiency in pill form. Patients do not have the energy reserves to absorb thiamine in pill form and often lose their vitamins through vomiting or diarrhea. In *preventing*, WE thiamine pills are sufficient (Thomson et al. 2013). When treatment is not timely and adequate, KS occurs in 85% of the cases (Oudman et al. 2014; Wijnia et al. 2012). Untreated, WE slips to death in 20% of cases (Sechi and Serra 2007). The

Textbox 1. Major symptoms of Korsakoff's syndrome (Kolb & Whishaw, 1985; Arts, 2004).

1. Anterograde amnesia. The patients are unable to form new memories.
2. Retrograde amnesia. The patients have an extensive impairment of remote memory that covers most of their adult life.
3. Confabulation. Patients make up stories about past events rather than admit memory loss. These stories are often based on past experiences and are therefore often plausible.
4. Meagre content in conversation. Patients have little to say, unspontaneous conversation, presumably in part because of their amnesia.
5. Lack of insight. Many patients are virtually completely unaware of their memory defect.
6. Apathy. Indifference and incapacity persevere in ongoing activities. The patients lose interest in things quickly and generally appear indifferent to change.
7. Central executive disorders. Problems with planning and organizing the daily activities and little sense of their own capabilities and limitations.

Fig. 1 Major syptoms of Korsakoff's syndrome

prevalence of excessive alcohol consumers combined with the potential harm of developing KS highlights the need for effective and targeted interventions.

To reach excessive alcohol consumers who still live at home and are at risk of developing KS, the intervention needs to focus on a timely recognition of WE and an adequate thiamine intervention (Thomson et al. 2013). However, excessive alcohol consumers are often reluctant to receive care.

This paper addresses the following questions: Is it possible to administer an adequate thiamine intervention by means of preventive coercive home health care? "Preventive coercive care" is used to describe coercive care necessary to prevent or avert serious disadvantage. And, how can preventive coercive care be administered without being too intrusive?

Coercive treatment has not received sufficient serious consideration as a therapeutic modality within addiction psychiatry, despite the proven efficacy of such techniques and their special relevance to the treatment of addictions (Nace et al. 2007).

The objective of this article was twofold. Firstly, to describe the new Dutch legislation that makes it feasible to provide preventive coercive home health care. Secondly, to explore the literature to identify themes that might lead to less intrusive experiences of coercion during home health care for the excessive alcohol consumer.

New Dutch Law

At this moment, the use of coercive care is only possible when the criteria mentioned in the Dutch Compulsory Admission Act (BOPZ) are met. The BOPZ is applicable in case of an involuntary admission to general psychiatric hospitals, to psychiatric departments of general and teaching hospitals, to nursing homes, and to institutions for the intellectually disabled. According to the BOPZ, only institutions designated by the Ministry of Health, Welfare and Sport may admit patients on an involuntary basis.

The BOPZ dictates three criteria governing compulsory admission. Firstly, the patient does not agree with admission. Secondly, the patient presents a danger to him/herself or others as a consequence of his/her mental condition. Thirdly, there is no reasonable alternative for the compulsory admission. Compulsory treatment within the institution of both mentally competent and mentally incompetent patients is justified when this is the only way to avert danger for the patient or others within the institution and if the danger outside the institution cannot be eliminated within a reasonable period of time without a treatment.

In many parts of the world, interventions have been moved to outpatient settings. This increase in the scope of outpatient care had led to the introduction of more coercive community practices (Pridham et al. 2016; Riley et al. 2014). The Dutch government also put great emphasis on outpatient treatment. Admission—including involuntary admission—to a mental health institution must be a last resort. In the past couple of years, the government has been working on simplifying legislation on involuntary admission, the use of compulsion in the care sector, and providing involuntary mental health care in community settings (https://www.government.nl/topics/mental-health-services). On January 23, 2018, this commitment has resulted in the acceptance by the Dutch parliament of two new acts: the *Compulsory Mental Health Care Act* (In Dutch: Wet verplichte Geestelijke Gezondheidszorg) intended for psychiatric patients and the *Care and Compulsion Act* (in Dutch: Wet Zorg en Dwang) intended for patients suffering from an intellectual disability or psychogeriatric disorder such as dementia. Approximately in 2020, these acts will replace the BOPZ. According to the

government, the implementation of two separate acts will provide better legal protection for the abovementioned different groups of patients and care can be administered in line with patients' individual needs. The main aim of this legislation is to prevent coercive care; it can only be used as a last resort.

The main elements of the Compulsory Mental Health Care Act are the following: the possibility of compulsory care in community settings; patients and their families will have more rights and more say about decisions concerning care; compulsory care as a last resort; and aftercare as a standard part of treatment. The main aims of the Care and Compulsion Act are the following: to make coercive care possible if the behavior of the person in question is leading to serious disadvantage to himself or others and to establish clear treatment guidelines for people receiving home health care who are subject to restrictive measures, for instance, locking doors at night to prevent them from wandering (https://www.government.nl/topics/mental-health-services).

Both acts offer the possibility to apply coercive care outside the psychiatric hospital: at home or in an outpatient clinic. An important fact to notice is that the Care and Compulsion Act does not require a court order for the application of coercive care. The requirements to provide coercive care are mentioned in Fig. 2.

The Care and Compulsion Act does mention one important difference in comparison with the Compulsory Mental Health Care Act: coercive care, which refers to all care resisted by the patient or the legal representative, will also be possible *to prevent* "serious disadvantage." The meaning of "serious disadvantage" is described in article 1, par 2, Care and Compulsion Act (see Fig. 3).

The criterion *prevention of serious disadvantage* might give interesting challenges for coercive care to prevent excessive alcohol consumers from developing KS. At this moment, the applicability of the Care and Compulsion Act to the group of excessive alcohol consumers is under consideration. There are good reasons to assume the applicability, because this group meets the criteria mentioned in the law (Van den Hooff 2018). The Care and Compulsion Act entails five categories of coercive care (see Fig. 4).

Textbox 2. Coercive care.

Article 3 par 4 Compulsory Mental Health Care Act

Coercive care can be provided:

a. to avert a crisis situation;
b. to ward off a serious disadvantage;
c. to stabilize the mental health of the person concerned;
d. to restore the mental health of the person concerned in such a way that he regains his autonomy as much as possible; or
e. to stabilize or restore the physical health of the person concerned if his behaviour as a consequence of his / her mental disorder leads to a serious disadvantage.

Article 10 par 2 the Care and Compulsion Act

2. The responsible healthcare professional can include **coercive care** in the care plan as a last resort if:

a. the behaviour of a client as a result of his psychogeriatric disorder or mental handicap, or as a result of a related mental disorder or a combination thereof, leads to serious disadvantage;
b. the coercive care is necessary **to prevent** or avert the serious disadvantage;
c. the coercive care is suitable **to prevent** or avert the serious disadvantage and is objective in view of the intended purpose; and
d. no less intrusive possibilities are available to prevent or avert the serious disadvantage.

Fig. 2 Coercive care in new Dutch Legislation

Textbox 3. Article 1 par 2 Care and Compulsion Act.
For the purposes of this Act and the provisions based on it, a **serious disadvantage** means the existence of:

a. social deterioration or possible social deterioration of the client;
b. a serious neglect or a threat of serious neglect of himself;
c. a serious bodily injury or a threat of bodily injury to himself;
d. aggressive behaviour or to evoke aggression from others;
e. a threat or cause of serious bodily injury to another;
f. a threat to the psychological health of another;
g. a threat to the general safety of persons or goods;
h. a substantial risk of disruptive development for the person involved or another person.

Fig. 3 Definition of serious disadvantage

Receiving coercive home health care within this context will be possible if coercive care is described and included in the care plan. This can only be done after consultation with at least one expert from a discipline other than the expertise of the healthcare professional in the area of care to be provided to the client, and after consent of a physician involved in care (article 10, par 3, Care and Compulsion Act). Coercive care can only be applied for 3 months with a prolongation of a maximum of 3 months. If coercive care needs to be continued after these second period of 3 months, the period for the application of involuntary care will be no longer than 6 months each (article 11, Care and Compulsion Act).

The above means that the Care and Compulsion Act provides the opportunity to use preventive coercive home health care. In the remainder of this article, a review of literature is described which aimed at the identification of themes that might give suggestions for less-intrusive feelings of coercion during home health care for the excessive alcohol consumer.

Methodology

This review contains a systematic search of published literature in peer-reviewed journals. A stepwise approach was applied: specification of the assessment problem, formulation of inclusion and exclusion criteria, defining a search, the execution of the literature search, selection of articles based on the criteria, and analysis of the material.

Textbox 4. Coercive care means care with which the client or his representative has not consented or which the client resists and care which focuses on (Care and Compulsion Act, article 2 par 1):

a. the administration of nutrition, moisture, or medication for treatment of a somatic disorder, a psychogeriatric, a psychiatric disorder or intellectual disability;
b. the administration of medication that affects the behaviour or the freedom of movement of the client due to a psychogeriatric, a psychiatric disorder or intellectual disability;
c. restraints of freedom such as isolation and physical restraint;
d. restraints to supervise the client at a distance, such as a video camera in the bedroom;
e. investigation of clothing or body;
f. examination of the living or accommodation space for behaviour-influencing substances and dangerous objects;
g. checking the presence of behaviour-influencing substances;
h. restraints of freedom to organize one's own life;
i. restraints to receive visitors.

Fig. 4 Definition of coercive care

Data Sources and Keywords

The online bibliographic database of the Erasmus University Rotterdam was searched (see Fig. 5). The search involved 55 databases, among which are Annual Reviews, BioOne, BMJ Journals, JSTOR, MEDLINE, OpenEdition Books, SAGE Journals, ScienceDirect, SpringerLink, Taylor and Francis Journals, Wiley Online Library, World Bank eLibrary, and WorldCat. The search was carried out from September 2017 to December 2017. Keywords used in the search were "coercion," "involuntary," "compulsory," "outpatient," "homecare," "treatment," "care," "addiction," "dependence," "alcoholics," and "community treatment." Databases were electronically searched with the following search options: peer-reviewed journal and full text available. The material was restricted to the English language, and articles should be published between 2007 and 2017 in any country. This yielded 348 articles. In addition, 15 articles from gray literature using the Google search machine were included at this stage.

Literature Searches and Short Listing

The data material was processed, analyzed, and reflected through a stepwise procedure. First, the database output of 363 citations was screened. Citations were excluded at this stage if they were duplicates, oral presentations, or essays or if the title did not refer to community treatment at all. Full text of 57 citations has been screened. At this point, 18 articles were excluded with a focus on a specific population (youth, elderly, or forensic patient population or predominantly schizophrenia and schizoaffective disorders), inpatient care, readmission, emergency care, or if the text in the abstract did not refer to community treatment at all (total of 13). Review articles were also excluded at this stage (total of 7). After this process, 32 articles remained that appeared to address the key issue: coercion and community treatment. However, more than half of them, 23 articles, concerned community treatment orders (CTO).

In literature, the most commonly described outpatient treatment settings are community treatment orders (CTO) and assertive community treatment (ACT). The main differences

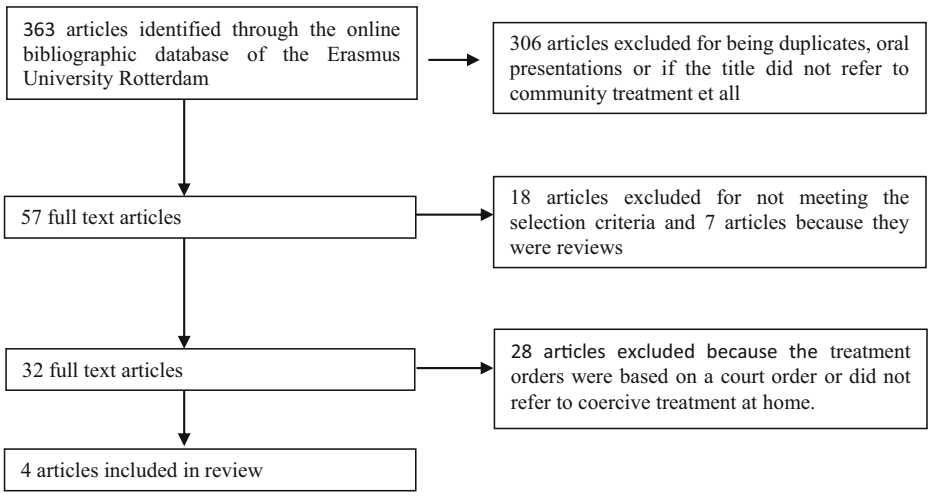

Fig. 5 Flowchart for systematic review

between CTO and ACT are described in Table 1. ACT seems to be closest to the Dutch Care and Compulsion Act, firstly, because of the non-legal form of coercion and secondly, of the possibility to monitor medication compliance (Tam and Law 2007). This comes close to the intended thiamine injections or pills given to the excessive alcohol consumers at home. As said before, thiamine can be taken orally or intramuscularly depending upon the acuteness of WE.

Hence, articles concerning CTO's were excluded from this review by means of the object of this paper. It is not aimed at legally enforced involuntary community treatment. The Care and Compulsion Act does not require a court order. One exception was made: the research of Riley et al. (2014) was included because an explicit focus on *being at home*. After this process, 4 articles remained for inclusion in this review which explicitly described *being at home*: George et al. (2016), Riley et al. (2014), Thøgersen et al. (2010), and Appelbaum and Le Melle (2008) (see Table 2).

Results

No studies were found that explored the use of coercive care during home visits in excessive alcohol consumers' own home to prevent further deterioration, among which is the development of KS. The analysis of the four studies included in this review, which explicitly explored views, perceptions, and experiences of staff and patients concerning treatment at home, revealed one essential theme to be kept in mind by the use of coercive home health care: treatment relationship. Treatment relationship is the individual relationship between the healthcare professional who visits the patient at home and the involved patient.

Participants in the study of George et al. (2016) described that a stable treatment relationship should include multiple humanistic features, such as persistence, consistency, empathy, humanism, empowerment of the client, acceptance, and a holistic view of the patient. A stable relationship can create a positive feeling while getting care living in your own living context (Appelbaum and Le Melle 2008; George et al. 2016; Riley et al. 2014; Thøgersen et al. 2010). Both Riley et al. (2014) and George et al. (2016) emphasize the possibility of more flexible, individualized care when being at home. Services seem to be better adapted to the individual needs of the patients because team members can spend longer periods of time with each patient to provide care (George et al. 2016). Frequent contact and involvement in the patients' daily activities enhanced professionals' ability to help patients actively gain control over their lives and strengthened patients' experience of independence (Thøgersen et al. 2010).

However, professionals experienced difficulty in balancing the provision of practical support and the development of a therapeutic relationship, particularly with hard-to-engage clients. Findings indicated that client engagement is a complex and multifaceted experience which integrates both adherence to a treatment model and unique interpersonal relationships with client's diverse daily lives (George et al. 2016).

A mutually trusting therapeutic relationship was crucial for counteracting perceptions of coercion (Thøgersen et al. 2010). A trusting relationship helped patients take responsibility for seeking help and actively getting involved in decisions about their treatment, while it motivated them for change (Thøgersen et al. 2010). On the other hand, patients felt overwhelmed by staffs' persistent visits, their attempt to befriend them, and the feeling that staff was intruding their privacy (George et al. 2016; Thøgersen et al. 2010). This however was almost entirely related to patients' first meeting with the healthcare professional, which shows that this can be an unsettling experience.

Table 1 Main differences between CTO and ACT

Intervention	Definition	Aim	Clinical population	Coercive elements
Community treatment order (CTO)	Legal mechanisms by which individuals with mental illness, a history of non-compliance, and potential for violence can be authorized, against their will, to participate in community-based treatment or care and supervision (Snow and Austin 2009).	• To prevent relapse • To provide a less restrictive alternative to hospital • To comply with the directed community treatment program (Churchill et al. 2007)	"Revolving door patients" with severe and enduring mental illness	• The sanction of return to hospital or institution; • To comply with certain conditions, such as taking medication (Kjellin and Pelto-Piri 2014)
Assertive Community Treatment (ACT)	Psychiatric case management in adults, characterized by, among other things, a home-based treatment (obligatory), early intervention, family support, reintegration/ vocational and educational therapy, and pharmacology. It is a practical and hands-on approach to the challenges users' experiences in their every lives (Lofthus et al. 2016; Vijverberg et al. 2017).	• To secure users' basic needs; • To enable them to cope in society; • To engage with their own lives and establish their independence; • To ensure education of community members (Stein and Test 1980)	Individuals who have poor outcomes (for example, high rates of hospitalization or homelessness) and are difficult to reach	• Visitation of member of the ACT teams when appointments are missed; • To ensure that medication is being taken; • Involvement of the treatment team in all aspects of the consumer's life and with all elements of the consumer's support system (Diamond 1995; Tschopp et al. 2011; Vijverberg et al. 2017)

Table 2 Characteristics of the 4 included articles

Authors (year)/country	Study design/research method	Study aim	Study group	Main findings related to (coercive) care at home
Riley et al. (2014)/Norway	Qualitative study: narrative approach to interviews and a thematic narrative analysis	To explore how outpatient commitment affects patients' everyday lives and how being on an Outpatient Commitment Order (OCO) affects their perceived degree of freedom	11 patients who were under an OCO for at least 3 months	➢ Flexible and better adapted care to individual needs; ➢ Patients experienced the feeling of knowing that others make decisions on their behalf as stressful; ➢ Feeling of lack of involvement in decision making processes; ➢ Incoming phone calls and visits to the patient's flats by staff were perceived as invasive; ➢ Positive was that everyday life became more independent and predictable and there was good access to assistance and stable treatment relationships.
Appelbaum and Melle (2008)/USA	Focus group	To explore patient and staff perceptions from a qualitative perspective to lay the groundwork for larger, quantitative studies in the future	4 ACT teams. Four focus groups: 2 staff groups ($n = 23$) and 2 patient groups ($n = 21$)	➢ Supporting patients and building relationships with patients were the preferred mechanisms for promoting treatment goals.
George et al. (2016)/USA	Exploratory qualitative study: focus group discussion	To understand the process of engagement in PACT services and associated challenges and strategies from the perspective of clinical staff	PACT team in central Virginia: 14 fulltime and on part-time clinical staff member, with a caseload of approximately 100 clients	➢ Positive was the providing of more flexible and individualized care. ➢ Staff experienced difficulty in balancing the provision of practical supports and the development of a therapeutic relationship, particularly with hard-to-engage clients.
Thøgersen et al. (2010)/Denmark	Qualitative research with in-depth interviews	To explore how patients experienced the treatment and what characterized perceptions of coercion in the teams	6 patients: all heavy users of psychiatric care and two had a secondary diagnosis of substance misuse	➢ Patients felt being overwhelmed by staffs' persistent visits and attempt to befriend them. ➢ They felt that staff was intruding their privacy. ➢ Mutually trusting therapeutic relationship was crucial for counteracting perceptions of coercion.

Discussion

In the Netherlands, the use of preventive coercive home health care to administer thiamine to excessive alcohol consumers might be possible due to new legislation, the Care and Compulsion Act. The conducted review revealed that a trusting and stable treatment relationship with the alcohol consumer is of great importance to make home health care less intrusive.

A stable treatment relationship seemed necessary to create a positive feeling of getting home health care (Appelbaum and Le Melle 2008; George et al. 2016; Riley et al. 2014; Thøgersen et al. 2010). This corresponds with a study of McCallum et al. (2016) who have been studying the experiences of patients receiving treatment for alcohol use disorders in different settings: inpatient and outpatient services. Their findings highlight the importance to patients for supportive, strong, and effective relationships. Also, in other studies, building a relationship was particularly valued by patients (Corring et al. 2017; Pridham et al. 2016; Priebe et al. 2005) and professionals (Rugkåsa et al. 2014). A discussion of non-treatment-related goals such as becoming a better parent or getting a job was highly valued (McCallum et al. 2016). Supportive, strong, and effective relationships might give room for specialized and holistic approaches to care to address the alcohol consumers' specific needs.

Holistic home health care should not only address thiamine intake but also the many other problems that exist in daily life of the excessive alcohol consumer, such as disruption of family life, physical and mental deterioration, and relational and vocational problems due to excessive alcohol consuming (Van den Hooff and Goossensen 2015b). If a trusting and stable relationship can be established, attention can be given to these issues and a solution can be sought on an individual basis.

For healthcare organizations, this means that they need to pay attention to the health and safety of their employees to prevent outflow. A stable and trusting relationship can only be established when the same healthcare professional shows up at each visit (IZZ 2017). The establishment of a trusting relationship might diminish the ambivalence to follow clinical recommendations. Ambivalence is a problem that often occur working with excessive alcohol consumers (Sullivan et al. 2008). Poor insight of illness, or in their own situation, is a risk factor that strongly predicts medication noncompliance (Walvoort et al. 2016; Lacro et al. 2002). Consumers just may not be highly motivated to willingly and regularly take their medicine.

A trusting relationship might decrease the feeling of coercion when this enters in the service of clinical goals. Coercion is often perceived negatively because it clashes with important values such as autonomy, informed consent, and least restrictive alternatives. The justification for coercive home health care for excessive alcohol consumers requires an assumption that the person would actually have a better life with a coercive intervention than without it (Riley et al. 2014). This assumes that the persons' condition is treatable and that they will benefit from being treated (Hall et al. 2014). The benefit excessive alcohol consumers will gain after a coercive thiamine intervention will be that they most probably will not develop KS. However, when a comparison is made between preventive coercive home health care and CTO's, a review of literature (Kisely et al. 2005) on CTO's concluded that there is insufficient evidence to support the introduction of CTO's as a mean of supervising people with severe mental disorders in the community and that there is an urgent need for good-quality RCT's in this field (Rugkåsa and Burns 2009).

An argument to claim that preventive coercive home health care can be justified is that it saves money. Preventive coercive care might decline the number of patients suffering from KS, and expensive inpatient care might decrease. However, the use of an economic rationale

for coercive care of excessive alcohol consumers does not sit well with the claim that such treatment is primarily provided in the best interests of the person (Hall et al. 2014). It implicitly gives a higher priority to reduce the economic and social costs. This requires careful ethical consideration. The necessity and proportionality of the restrictions imposed on the patients while delivering preventive coercive home health care should be weighed against the burden experienced by the patients (Szmukler and Holloway 2000; Wertheimer 1993). Munetz et al. (2003) provided a summary of the arguments and ethical positions taken in the light of the debate on mandatory community treatment (Rugkåsa and Burns 2009).

This review has a number of limitations. The study could have been strengthened by the inclusion of more criteria such as CTO studies. However, this review was not directed to legally enforced involuntary community treatment. Another limitation is that the theme was removed from its original contexts, which could invite misinterpretation. The number of databases searched as well as the search path chosen may have been insufficient to identify all relevant references.

Conclusion

Little is known about the use of coercion as a preventive measure during home health care for excessive alcohol consumers. However, there are growing possibilities for preventive coerced home health care as in the new Dutch Care and Compulsion Act. This makes it extremely important to focus on research within this area. Excessive alcohol consumers need to understand the information they get about the usefulness of thiamine and consequences if they do not take them. This requires a mutually trusting relationship with the healthcare professional. A holistic approach to care seems to be crucial for counteracting perceptions of coercion; it can help to identify the existing problems and to judge the existing level of risk. Of course, empirical research is needed to study the actual impact of this kind of new legislation which makes preventive coercive home health care possible. Theoretical research needs to focus on the new ethical dilemmas that will arise in this practice.

Compliance with Ethical Standards

Conflict of Interest The author declares that she has no conflict of interest.

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