

Pressure and coercion in the care for the addicted: ethical perspectives

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The use of coercive measures in the care for the addicted has changed over the past 20 years. Laws that have adopted the “dangerousness” criterion in order to secure patients’ rights to non-intervention are increasingly subjected to critique as many authors plead for wider dangerousness criteria. One of the most salient moral issues at stake is whether addicts who are at risk of causing danger to themselves should be involuntarily admitted and/or treated. In this article, it is argued that the dilemma between coercion on the one hand and abandonment on the other cannot be analysed without differentiated perspectives on the key notions that are used in these debates. The ambiguity these notions carry within care practice indicates that the conflict between the prevention of danger and respect for autonomy is not as sharp as the legal systems seem to imply. Some coercive measures need not be interpreted as an infringement of autonomy—rather, they should be interpreted as a way to provide good care.

However, the problem is that adoption of a wider dangerousness criterion in the new, autonomy based laws is difficult to put into practice. More frequent use of coercion raises a number of ethical, medical, and political questions. There seems to be a “catch 22” situation in the sense that neglect of languishing, chronic addicts who are reluctant to receive care is hard to accept whereas at the same time, the beneficial effects of more frequent use of coercion are difficult to predict.¹⁰ The aim of this article is to provide directions for a way out of this dilemma through a critical, philosophical analysis of the notions that are central in the debate on the use of coercion in the care for the addicted. Philosophical reflection, based on the practice of the care for the addicted, reveals that the central notions of the juridical realm are not as clear cut as is sometimes implied by the laws. A differentiated perspective is imperative because it reveals that, within their practical context, the notions carry different, often ambiguous meanings that are morally relevant. We hope to be able to indicate that this philosophical analysis is relevant for most European and American countries as many Western societies are struggling with this dilemma in similar ways. At the same time, differences are acknowledged and it must be admitted that a certain degree of generalisation is inescapable. The focus on literature and recent jurisprudence from the Netherlands is only provided as a concrete example.

Over the last two decades, many countries have adopted new laws that regulate the use of coercive measures in psychiatric care.^{1,2} These laws have been guided by the principle of autonomy. Patients are considered autonomous unless there is sufficient proof to the contrary. This also implies that patients who refuse admission or treatment cannot be coerced. In the USA, like in many European countries, the right to non-intervention is considered absolute unless harm has been caused, as a result of the disorder, or there is a high enough risk or harm.^{3,4} The new autonomy based laws reflect the philosophy of J S Mill.^{5,6} Individuals have sovereignty over themselves unless others are harmed. Yet important questions have arisen regarding the so called “dangerousness” criterion of the new laws.^{7,8} How wide should this criterion be interpreted? Is the term “dangerousness” appropriate at all? Or are other notions better equipped to render account of involuntary interventions? Narrow, libertarian interpretations of notions such as autonomy, coercion, and danger are again under discussion. It is increasingly argued that if we do not want to abandon those who need but refuse care, more frequent use of coercive measures in the care for the addicted is indicated.⁹

1. ETHICAL ISSUES

The ethical problems in the care for the addicted are complex. Understanding this ethical complexity requires a philosophical analysis of prevailing ambiguities in the way the problem of addiction is understood. Two different philosophical anthropologies underlie the ethical debates about addiction. Both raise the question to what extent the addicted should be regarded as autonomous moral agents and both, though partly incompatible, seem to be relevant. The troublesome concept of autonomy in the care for the addicted indicates the need for differentiated perspectives on autonomy. After having analysed the issue of autonomy, it will be argued in two consecutive sections that the concepts of coercion and of danger are also not as unequivocal as is implied in the law and some of the literature. The different meanings that the notions of coercion and danger carry should be accounted for.

1.1. Different anthropologies

Addiction is generally conceived of as a disease with concomitant psychosocial aspects.^{12–15}

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Addicted people are called patients, in need of medical treatment instead of punishment. They cannot be considered fully accountable for their addiction. At the same time, moral aspects are intrinsically connected with the problem of addiction. Addicts are not only considered victims of their disease, they are also regarded as autonomous agents. They have somehow chosen for a particular lifestyle.¹² Unwanted psychomedical interventions seem to violate the individual integrity of the addict. Only when others are put in danger by the behaviour of the addict is society entitled to intervention. When the danger is taken away, the addict who refuses treatment should be left alone.

In other words, the ambiguity in the care for the addicted comes forth out of the interconnectedness of two, partly incompatible, anthropologies. Within one anthropology, the addict is regarded as a patient, in need of help. Drug use is primarily seen as an individual problem. The goal of medical treatment is abstinence. If this goal is frustrated and the addict relapses again and again, palliation of the symptoms that are caused by drug use should be aimed at.¹⁶ This anthropology can be called a *medical* anthropology. It acknowledges that illness is something that can happen to you and that illness, especially psychiatric illness, can result in a partial reduction of competence. Within the other anthropology, the addict is regarded as a client and an autonomous moral agent. Addiction is a self inflicted condition; a vice. It is not regarded as an individual problem but rather as a societal problem, and society has to protect its citizens. Addicts choose to use a certain drug, realising that drug use involves certain risks. If criminal behaviour follows, the addict must be held accountable because he knew that risks were involved. Therefore, if others are being harmed by an addict, the addict deserves punishment. Neither abstinence nor palliation is the aim of treatment but the prevention of harm to others. This anthropology can be called a *legal* anthropology. Elements of both anthropologies coincide in the care for the addicted, because addiction is regarded as both an illness and as a vice.¹² In countries like the USA, the Netherlands, Sweden, and Germany, where the notion of beneficence has been pushed into the background and where courts decide the permissibility of coerced admission, the legal anthropology is dominant. In countries such as the UK and France, where elements of the older laws survived and where physicians decide about the permissibility of coerced admission, the medical anthropology is dominant.^{17 18}

The interconnection of these two different anthropologies in the care for the addicted raises the question of the competence of the addict. Typically, within the medical anthropology, the disease can be considered as an excuse for the patient's behaviour. Medical treatment is needed because it serves to restore autonomy. Within the legal anthropology, the client's chosen lifestyle makes him responsible and accountable for his acts. In other words, the old distinction between an ethic of autonomy and an ethic of paternalism presents itself. Recently, however, more differentiated perspectives on autonomy in the care for the addicted have been proposed in which elements of the old, beneficence based laws coincide with elements of the new, autonomy based laws.^{11 19}

1.2. Varieties of autonomy

Juridical discourse and laws necessarily simplify: a person is competent, partially incompetent, or incompetent. Whereas the beneficence based laws stressed that psychiatric disorders render patients incompetent, the new laws presuppose competency unless there is sufficient proof of the contrary. For instance the autonomy based laws in the Netherlands, Germany, and Austria hold that patients who refuse outright

or fail to give their consent (as is the case for many addicted patients) cannot be voluntarily admitted. Rather, they have to meet the dangerousness criteria of the laws.²⁰ Competency is closely associated with a right to non-intervention. If harm is done to others, people need to account for their acts. Thus, competent addicts who refuse care should be left alone, unless the threat they pose to themselves or others is sufficiently grave to allow for coercive intervention. The concept of autonomy that has been adopted in the new laws reflects the philosophical writings of J S Mill.^{5 6} As long as no others are harmed, the individual has sovereignty over himself. Not surprisingly, the notion of autonomy has received little attention in the debates on care for the addicted. After all, from a juridical point of view, the harm that comes forth out of the disorder is decisive for intervention, not the question of whether the subject is autonomous or not.²¹

Therefore, the concept of autonomy is conceived of as a negative right in the sense that it sets limits for others; it articulates what others are *not* allowed to do.²² This conception, important as it is within law, has limited relevance for care practice. It is based on mistrust between patient and caregiver because it only articulates the limits of care and says nothing about what proper care is or should be. In other words, it fails to appreciate practically relevant moral meanings. Alternatively, in a more positive sense, autonomy can be conceived of as a capacity to form and shape one's life together with others. This concept of autonomy stresses not only the cognitive capacities patients need in order to make respectable decisions, it also stresses the importance of patients' emotions and values. It not only focuses on the question of whether a patient's decisions are autonomous or not, it focuses on the decision making *process*, taken as a dialogue between caregiver and patient. Within this process, the patient is stimulated to make decisions that fit with his personality as it has evolved in the past and through relations with others. Then, the ability to understand the caregiver's information and to articulate good—or at least acceptable—reasons for one's decision is only a minimum requirement. More important is that there is sufficient openness in the conversation in order to allow the patient to address the values and issues that are important to him.^{23 24}

An example of an alternative, practically relevant conception of autonomy can be found in the writings of Dworkin who distinguishes between first order and second order desires. First order desires relate to impulsive, short term preferences. Autonomy is considered critical self reflection. It is a capacity of the second order because it signifies the capacity to critically reflect on first order desires and preferences. Acting upon short term desires would be considered autonomous only if there had been sufficient critical reflection.²⁵ A two layered concept of autonomy can also be found in the writings of Harry Frankfurt. According to Frankfurt, it is not so much through rational reflection that a person can take distance from his first order desires but rather it is the will. People are autonomous if they are able to want a desire to be the one that moves them effectively to act.²⁶ To be autonomous, it does not suffice to only want a desire (Frankfurt speaks of "wanton"). What is needed is the ability to want a desire to be one's will (Frankfurt speaks of "volition"). Typically, within this theory, addicts are not fully autonomous. At a second order level, they may hate their addiction and want to overcome their first order desires but in the vast majority of cases, the first order desires are decisive.

It has been argued that people suffering from recurrent mental disorders typically feel that they have two different selves.²⁷ One "self" is inclined to act upon short term desires; the other "self" is guided by longer term preferences and

goals. After having given in to their addiction, many addicted people suffer because they have (again) harmed themselves or their loved ones. In other words, their addiction can diminish their autonomy because the capacity to critically reflect on short term preferences is limited. Increasing the patient's autonomy can then be regarded as a goal of care in the sense that the caregiver, in dialogue with the patient, tries to help the patient reflect on his addiction and articulate his second order desires. Fostering the patient's autonomy can imply a persuasive or even manipulative approach, trying to bring the longer term values and goals of a patient to the surface. Criticising the cognitively oriented concept of Dworkin, Agich has linked autonomy to identity.²⁸ Respecting a patient's autonomy is not only concerned with conflict situations in which difficult decisions have to be made. The libertarian presumption of a rational and sovereign individual is an abstraction from reality. In care practice, it is more important to enable a patient to identify with the concrete situation.^{24–29} This means that actual autonomy is attributed a dynamic character, and is not something that is present or absent—rather, it has to be developed through interaction with ever changing circumstances. Within the caregiver-patient relationship, autonomy is a challenge. It is not only the patient who decides after having received and understood the caregiver's information. Rather, the patient decides together with the caregiver. The patient is stimulated to regain his identity and to make decisions that fit his identity. If the development of an identity is an interpersonal process, then autonomy too is intrinsically linked with others: actual autonomy is a social notion that presupposes a community.

In the context of the care for the addicted, this dynamic, differentiated, and positive concept of autonomy seems to carry more practical relevance than the negative concept adopted in the law. Firstly, the distinction between short term desires and long term goals is recognisable to most of us but it is of special importance for the addicted. Secondly, it acknowledges that patients have a life history behind them that has developed in and through interpersonal relationships, and that patients also hope for a (better) future. Thirdly, it provides room for solidarity in the sense that it acknowledges our common interdependency. Acknowledging this opens the way for compassion to those who rely on care from others. Finally, it provides room for persuasion when a caregiver feels that his patient is at risk of relapse. In the patient-caregiver relationship, some forms of pressure are justifiable without necessarily violating the patient's right to self determination. A crucial question then is what kinds of pressure are justifiable. As will be indicated below, the distinction between pressure and coercion is not as clear cut as is sometimes implied in the literature.

1.3. Varieties of coercion

The law typically assumes a restricted definition of coercion—that is, involuntary commitment or treatment. The concept of coercion is ambiguous. A narrow concept of coercion has been suggested by Frankfurt.^{30–31} In his view, coercion implies the absence of a possibility to choose. The victim is psychologically compelled to do what he does. The autonomy of the person is violated because he is driven by desires he does not want to be driven by. Wertheimer acknowledges that coercion is linked to a feeling of constraint but questions at the same time that this would imply the absence of autonomy.³² Even if there is only one possible decision, Wertheimer leaves open the possibility that one can still experience this decision as one's own. Coercion need not extinguish the cognitive and volitional capacities of the person coerced. Contrary to Frankfurt, Wertheimer does not define coercion in relation to the absence of choice. Instead, central to Wertheimer is that coercion implies that the

coercing person does not have a right to make the coercive proposal. In Wertheimer's view, coercion is a moral notion. Problematic in this view is that individuals can disagree over what constitutes a right or an obligation.³¹ In the context of this contribution, Wertheimer's moralised view on coercion is of limited practical relevance. It would be paradoxical to speak of proper use of coercion in the care for the addicted acknowledging at the same time that the coercing person does not have a right to make the coercive proposal. Questions can be raised against Frankfurt's narrow conception of coercion as well. In the context of the care for the addicted, coercion also denotes less extreme violations of patients' choices. It is hard to conceive of cases of involuntary admissions and involuntary treatment in which any rational consideration of the addict is absent (Wertheimer is right to acknowledge this). There is always a choice—for instance, the choice between resistance and cooperation. In the care for the addicted, coercion need not always exclude any kind of deliberation of the victim. Thus, the point where pressure becomes coercion is not so easy to determine.

Useful standards for the use of coercion have been developed that acknowledge the principle of subsidiarity.^{21–33} Experience suggests that much can be done to prevent the kinds of danger that would allow for involuntary admission.^{34–35} And if use of coercion is a *prima facie* moral evil, it is morally imperative that preventive measures are taken in an early stage of the care process.³⁶ Outpatient interventions are necessary because they support the patient in coming to grips with the situation. Many addicts will not spontaneously ask for care. When the caregiver is notified by the patient's loved ones, interference may prevent further deterioration. Caregivers, together with the addict's family, may be successful in persuading the patient to enter an inpatient or outpatient treatment programme. If caregivers foresee that the addicted patient's condition is at risk of deteriorating, pressure can be used in order to convince a patient to have himself treated. Even though from a libertarian perspective, pressure can be rejected as it manipulates the patient's autonomous preferences, from a communitarian perspective it can be defended as a form of good care.²⁴ What is more, if we adopt a positive and dynamic conception of autonomy, pressure intends to stimulate autonomy and enable the patient to articulate the longer term goals of his life. In short, pressure and autonomy can under certain circumstances go hand in hand.

Apart from persuasion and manipulation, pressure can also take the form of a coercive offer or a coercive threat. In the former case, the patient will be rewarded if he meets certain criteria. For instance, if a patient enters a treatment programme, he will receive more respect from his children. In the latter case, the patient will experience negative consequences if he does not meet certain criteria. For instance, he will be at risk of becoming homeless if he does not enter a treatment programme. It is not difficult to see that the more radical the impact of the consequences is on the life of the patient, the harder it becomes for the patient to resist the pressure. Coercive offers or threats can thus take the form of coercion, even if one adopts Frankfurt's narrow conception. Offers and threats can appeal "to desires or motives which are beyond the victim's ability to control".³⁰ Although Wertheimer limits his concept of coercion to threats (offers are called inducements), we claim that, depending on the impact of what is offered, offers can be coercive.

The use of coercive offers and coercive threats by caregivers is not ethically unproblematic and it requires a moral justification. In fact, research that was conducted in the US showed that addicts experienced various kinds of pressure outside of institutions as more coercive than legal coercive measures such as involuntary admission.³⁷ A majority of the subjects of the study expressed that the main reasons for

entering treatment were non-coercive. Instead, treatment entry was associated with positive recognition from loved ones and a positive motivation to improve oneself.

For many, pressure will not convince them to accept treatment. Their situation continues to deteriorate. Some will already have lost a social network and might even have become homeless. According to many new laws, the patient is to be left alone unless the risk of danger would be grave enough to allow for involuntary admission.^{1 3 18} The alternative of compulsory outpatient treatment would seem hard to justify within the new laws as the dangerousness criteria for compulsory treatment are more restrictive than the criteria for involuntary admission. Yet, empirical data indicate that compulsory outpatient treatment is positively evaluated because it is less restrictive than involuntary admission and it may provide a way out of the vicious circle many addicts find themselves in.^{38 39}

The options of persuasion, use of informal pressure, and the possibility of outpatient commitment are to be taken into consideration before legal coercive measures such as involuntary admission or treatment can be justified.

Yet, when legally sanctioned coercive measures are carried out, there seems to be a shift of paradigm. As described above, debates on coercive measures centre on the notion of danger. The autonomy of the patient becomes irrelevant. It is no longer the patient himself who is in the middle, it is the harm that he is likely to cause that needs to be prevented or taken away. But what kinds of danger and risks of harm would allow for legal intervention that sanctions involuntary admission or even involuntary treatment?

1.4. Varieties of danger

Self evidently, not all kinds of danger inflicted by addicts can lead to legally sanctioned coercive measures. The following discusses the requirements the Dutch law states but there is evidence that the differences with other countries that have accepted the dangerousness criterion are marginal.^{1 4 18}

Firstly, the recent laws and/or jurisprudence hold that the danger needs to come forth out of the mental disorder. And indeed, because addiction clinics are authorised to execute the law for involuntary psychiatric admissions, addiction is conceived of as a mental disorder. Precisely because of the ambiguity in our understanding of addiction (see above), it is not always easy to determine to what extent the danger actually comes forth out of the addiction or whether other factors may have been decisive. Secondly, the danger need not already have taken place even though the risk must be high. But how high should the risk be to allow for involuntary admissions? A certain degree of arbitrariness is difficult to avoid. Anticipating a court order, psychiatrists can be extremely reserved issuing medical accounts. Thirdly, jurisprudence has articulated the objects of the danger that would be conditional for an involuntary admission. Distinctions have been made between danger to oneself, danger to others, and danger to public security and public goods.⁴⁰ In many cases, the admission itself is the means that takes away the danger.⁴¹ As the patient is to be discharged when the danger has been taken away, strictly speaking, this could be the case very shortly after admission. This also means that, according to the law, the involuntarily admitted addict may refuse treatment at all times. Involuntary treatment is unjustifiable unless there is risk of *extreme* danger for oneself or for others that is a result of the mental disorder. Recently, voices were raised in the Dutch Parliament pleading to erase the adjective “extreme” in order to allow for coerced treatment in the context of a coerced admission.⁴² But currently, involuntary treatment is only allowed in cases where danger is caused or likely to be caused after admission—that is, inside the clinic. Surprisingly, in the case of addiction the

involuntary admission coincides with the start of treatment, as the detoxification automatically starts with the admission.

The criteria for danger caused to oneself are more restrictive than the criteria for danger caused to others. In most countries the dangerousness criterion is currently being widened, especially regarding danger caused to oneself. Chronic addicts who end up on the streets and are reluctant to accept care would cause sufficient danger for themselves in order to allow for coerced admission and/or treatment. But what exactly does it mean to widen the dangerousness criterion in order to allow for involuntary admissions of people who cause danger to themselves? Should it not be interpreted as a return to the beneficence criterion of the older laws?⁴⁰

2. DANGER OR BENEFICENCE

Everyday care—inpatient or outpatient—is provided in the context of interpersonal relationships. Referring to the philosophy of Lévinas, it is the Other—the addict or his loved ones—that sets the norm for the caregiver.⁴³ In a patient-caregiver relationship, the patient’s wellbeing has priority over societal benefit. In other words, for the caregiver the principle of beneficence must carry more weight than the criterion of danger.

For ethics to be practically relevant, care practice should be its starting point. Following a juridical discourse (legitimate as this discourse is) will leave important moral meanings unarticulated.⁴⁴ If there is a way out of the “catch 22” dilemma as described above, then the crucial notions of the new laws need to be reinterpreted in the context of the caregiver-patient relationship. Therefore, from an ethical point of view, it is problematic that the dominance of juridical discourse has turned the good of the patient into a taboo subject, even though it should be acknowledged that the juridical discourse resulted from the legitimate desire to give a voice to patients and protect them from maleficent interventions. It seems as if the notion of beneficence has become so much associated with the paternalism of earlier laws that it has become forgotten within the debates on the use of coercion in care for the addicted.⁴⁵ If there is not a sufficient risk of danger, the addict should be left alone. In other words, autonomy is considered as antithetical to beneficence. And it is precisely this antithetical relationship that makes it impossible to escape from and transcend the “catch 22” dilemma.

In fact, care practice itself gives clues for the limited relevance of the autonomy based laws. After all, strictly applying the law in everyday practice would lead to situations that are difficult to morally justify. Coerced treatment with an involuntarily admitted patient is hardly ever an option because, in the vast majority of cases, it is the involuntary admission itself that takes away the danger. Then, involuntary admission is not much more than a temporary measure unlikely to help the so called “revolving door” patients. Outpatient involuntary treatment has to be considered impossible because the criteria for coerced treatment are stricter than the criteria for coerced admission. If coerced treatment is administered, it should be stopped immediately once the severe danger has been taken away or prevented. So again, we face temporary measures that in the longer term will not be effective. Current appeals to widen the dangerousness criteria of the new laws can be understood and explained in this light. In fact, everyday care practice reveals that involuntary admissions and involuntary treatment are not as strictly separated as the law seems to imply. A stay in a drug free environment can be a good start to enter a treatment programme, as well as in the context of an involuntary admission. As the moral issues at stake in everyday practice seem to be far more complex and differentiated than juridical

discourse implies, it is striking that the current ethical debates on conditions that would allow for more frequent use of coercion in the care for the addicted have by far and large adopted a juridical language. The scope of the notions is under discussion, but the notions themselves are not scrutinised.

In order to transcend the apparent dichotomy between beneficence and autonomy it is imperative to introduce alternative, more differentiated concepts than is currently the case. Then, it becomes apparent that everyday care for the addicted is always interpersonal and that beneficence—that is, taking up one's responsibility in the face of the other—is the guiding criterion within this relationship. In the first place, it is the wellbeing of the other that is at stake, and this wellbeing is intrinsically related with his autonomy. If autonomy is conceived of as a dynamic challenge, to be developed and fostered through interpersonal relations, then autonomy need not be antithetical to the use of pressure or even coercion. The patient, including his history, his hopes for the future, his emotions, and his values, remains the guide. Sometimes, this implies that pressure or coercion is not indicated as it may severely damage the patient-caregiver relationship. But sometimes this implies that the current preferences of the patient are overruled in favour of other, longer term goals and values. In this sense, the autonomy of the patient is safeguarded, not by upholding his right to non-intervention but, contrarily, by intervention.

Within a narrow concept of coercion—for instance, the admission of a patient to an institution against his autonomous will—the will of the patient is put aside. Currently in the Netherlands there is a public debate, not only on the scope of the dangerousness criterion but also on the possibility to increase the number of options when coercion becomes justifiable. In a proposal for amendment of the BOPZ law, an observational court order was proposed that would allow for an involuntary admission of three to five weeks to assess the psychiatric condition in people with mental illness (such as substance related disorders).¹¹

Furthermore, in the context of a socialisation of mental health care, members of parliament have pleaded for the possibility of a conditional legal court order.⁴² If there is a sufficient risk of danger but the danger can be averted outside institutions, the judge can issue a conditional legal court order that makes it possible for the patient to remain at home if (and only if) certain conditions are met. In most cases, these conditions will involve the use of medication but in the care for the addicted, a concomitant condition can involve abstinence from alcohol or drug use. If the patient does not meet the conditions he will be admitted to a clinic even if he refuses at the time of admittance. These conditions must have been negotiated with the patient and the physician. As is the case with court orders, the conditions have to relate proportionately to the (risk of) danger. Not all kinds of conditions can be enforced. Contrary to the narrow concept of coercion in the law, the will of the patient is not completely eliminated. Even in such extreme situations, where the threat of danger is high enough to justify coercion, there remains the possibility of a choice even though the advantages of accepting the conditional court order stand for the vast majority of patients in no proportion to the disadvantages of an involuntary admission. Apart from the advantage that the will of the patient is not eliminated, other advantages are that the patient can stay in his own environment and keep contact with his loved ones. More than in institutions, he will be able to keep some control of his daily activities. In other words, his autonomy, regarded as a capacity for identification, is respected and can be fostered during the time of the conditional court order. Necessarily, this option implies a widening of the dangerousness criterion

as the current Dutch law explicitly requires that coercive measures cannot be justified if the danger can principally be averted in the outpatient situation. For many caregivers however, it will first and foremost imply a good possibility to provide empathic care taking the autonomy of the patient into account.

A second option that has been included in the law from the beginning but has only recently been given attention is concerned with court orders at the request of the patient. This coercive measure has been designed specifically for the addicted. Those who are willing to be admitted and treated in institutions can, together with their physician, request the court to issue an order for half a year to one year that regulates continuing admission when the patient wants to be dismissed and/or continuing treatment if the patient wants to stop treatment. Moreover, and similar to the conditional court order, it is possible that the patient and his physician request the court to issue an order, saying that the patient can be involuntarily admitted when he stops his outpatient treatment or when he starts using drugs again. Contrary to the conditional court order, it is the patient himself who requests coercive measures under well circumscribed conditions. For the court to meet the request, danger must be present but it need not necessarily come forth from the mental disorder. From a juridical point of view, these orders are difficult to regulate because good reasons can be given to be reluctant about enforcing private agreements that limit personal freedom.⁴⁶ From an ethical perspective however, it can be argued that this option does not harm the patient's autonomy, at least if we adopt alternative conceptions of autonomy that were analysed above. The patient allows his longer term goals and values to prevail over his short term desires, and in doing so, he hopes that his capacity to identify himself with the situation is fostered. Again, even in extreme situations when danger lurks, the patient's self determination does not necessarily have to be neglected. Chronically addicted patients particularly, who tend to be reluctant to professional care and for whom use of legal coercion is contraindicated, may profit from less restrictive options than strictly coerced admission or treatment. For the patient-caregiver relationship, beneficence and trust are not necessarily harmed if the patient himself has requested to be involuntarily treated if well circumscribed conditions are met.

3. CONCLUSION

The moral dilemmas regarding use of coercion in the care for the addicted cannot only be understood within a juridical realm but need also input from well trained caregivers themselves. It will then appear that, in order to be of practical relevance to caregivers, notions that are central in the juridical realm need to be reinterpreted. In this contribution, differentiated perspectives have been sketched out on the notions of autonomy, coercion, and danger. Whereas the notion of beneficence seems to have been abandoned in the new, autonomy based laws on involuntary admission, for the caregivers themselves this notion may be more adequate than the notion of danger. In the face of a severely addicted patient in need of care, caregivers may not have the experience to realise when danger has to be averted. Rather, they want to provide beneficial care. If autonomy is regarded as a positive capacity to identify oneself with the situation, pressure and even some coercive measures are not necessarily antithetical to respect for autonomy. Strict coercion—that is, admitting or treating a patient against his will—can be indicated. Research mentioned above has revealed that the efficacy of coercive measures is not less, and sometimes even higher, than the efficacy of voluntary measures and thus, coercion can be beneficial on the longer term. Yet, less restrictive alternatives that have not been given sufficient

attention thus far can sometimes be applied. Recently, a debate began on alternative coercive measures that do not completely overrule or neglect the will of a patient. Further discussion on measures such as a conditional court order, allowing the patient to be treated in the outpatient situation, and a court order at the request of the patient, seems imperative because these measures reveal that, even in extreme situations, there is still a possibility of choice and the will of the patient need not be fully put aside.

REFERENCES

- Legemaate J. Onvrijwillig opneming. Europese ontwikkelingen [Involuntary admission. European developments]. *Maandblad Geestelijke Volksgezondheid* 1992;12:1329–43.
- de Miranda S. The ethics of statutory coercion in treatment of chemical substance abuse/dependence (addiction). *Med Law* 1989;7:427–32.
- Kelk C, Legemaate J. *Rechtsbescherming in de psychiatrie. Een rechtsvergelijkend perspectief [Legal protection in psychiatry. A comparative law viewpoint]*. Kluwer: Deventer, 1990.
- Appelbaum PS. Almost a revolution: an international perspective on the law of involuntary commitment. *J Am Acad Psychiatry Law* 1997;25:135–47.
- Raad voor de Volksgezondheid en Zorg. *Beter (z)onder Dwang? [Better with or without coercion?]*. Achtergrondnota. Zoetermeer: RVZ, 1997.
- Mill JS. *On liberty*. New York: Norton, 1975.
- Kortmann FAM. Dwang in de psychiatrie. Patiëntenrechten en beroepsethiek [Coercion in psychiatry. Patient rights and professional ethics]. *Tijdschrift voor Psychiatrie* 1995;37:759–68.
- Kjellin L, Nilstun T. Medical and social paternalism. Regulation of and attitudes towards compulsory psychiatric care. *Acta Psychiatr Scand* 1993;88:415–19.
- Gostin LO. Compulsory treatment for drug-dependent persons. Justifications for a public health approach to drug dependency. *The Milbank Quarterly* 1991;69:561–91.
- Langelaan M. Terughoudend met dwang [Reserved with coercion]. *Psy* 1997;1:7–11.
- Dutch Parliament 2000–2002. *Wijziging van de Wet bijzondere opnemingen in psychiatrische ziekenhuizen (voorwaardelijke machtigingen) [Revisions of the Law for involuntary admission in psychiatric hospitals (conditional court order)]* (Rep No 27289). Gravenhage: Sdu-uitgevers, 2002.
- Lucas JJ, Loutsch E, Frances RJ. The drug addict as chronic patient. *Psychiatr Med* 1985;3:427–44.
- Leuw E. Legitimiteit en effectiviteit van verslavingszorg in justitiële kaders [Legitimacy and effectivity of addiction care in legal perspective]. *Tijdschrift voor Alcohol en Drugs* 1990;16:142–9.
- Gerdner A. *Compulsory treatment for alcohol use disorders. Clinical and methodological studies of treatment outcomes*. Lund: Lund University, 1998.
- Leshner AI. Addiction is a brain disease, and it matters. *Science* 1997;278:45–7.
- Ten Have HAMJ. Drug addiction, society and health care ethics. In: Gillon R, ed. *Principles of health care ethics*. Chichester: John Wiley and Sons, 1994:895–902.
- Kullgren G, Jacobsson L, Lönne N, et al. Practices and attitudes among Swedish psychiatrists regarding the ethics of compulsory treatment. *Acta Psychiatr Scand* 1996;93:389–96.
- Rüdiger HR, Lepping P. Zwangsunterbringung und behandlung psychisch Kranker in Grossbritannien und Deutschland [Involuntary admission and treatment of psychiatric patients in Great Britain and Germany]. *Psychiatrische Praxis* 1999;26:139–42.
- Noorlander E. Verslafdten en de Wet BOPZ [Addicts and the law for involuntary admission]. *Maandblad Geestelijke Volksgezondheid* 1994;11:1233–7.
- Legemaate J. De BOPZ en de vrijwillige opneming [The law for involuntary admission and voluntary admission]. *Maandblad voor Geestelijke Volksgezondheid* 1994;7:668–78.
- Berghmans R. *Om bestwil. Paternalisme in de psychiatrie [For your benefit. Paternalism in psychiatry]*. Amsterdam: Thesis Publishers, 1992.
- Ten Have HAMJ, Gordijn B, eds. *Bioethics in a European perspective*. Kluwer: Dordrecht, 2001.
- Berghmans RLP. Wilsbekwaamheid in de psychiatrie. In: Kortmann FAM, Den Hartogh G, eds. *Weldoen op contract. Ethiek in de psychiatrie [Beneficence on contract basis. Ethics in psychiatry]*. Assen: Van Gorcum, 2000:93–105.
- Verkerk MA. Over drang als goed zorgen. Een zorgethische beschouwing [About pressure as good care. A view from care ethics perspective]. *Tijdschrift voor Geneeskunde en Ethiek* 2001;11:101–6.
- Dworkin G. *The theory and practice of autonomy*. New York: Cambridge University Press, 1988.
- Frankfurt H. Freedom of the will and the concept of a person. *J Philos* 1971;68:5–20.
- Dresser R. Bound to treatment. The Ulysses contract. *Hastings Cent Rep* 1984;14:13–16.
- Agich GJ. *Autonomy and long-term care*. New York: Oxford University Press, 1993.
- Widdershoven GAM, Berghmans RLP. Autonomie in de hulpverlening [Autonomy in healthcare]. In: Graste J, Baudoin D, eds. *Waardenvol werk. Ethiek in de geestelijke gezondheidszorg [Valuable work. Ethics in mental healthcare]*. Assen: Van Gorcum, 2000:47–59.
- Frankfurt H. *Coercion and moral responsibility*. Cambridge: Cambridge University Press, 1997.
- Arnold D. Coercion and moral responsibility. *Am Philos Q* 2001;38:53–67.
- Wertheimer A. *Coercion*. Princeton: Princeton University Press, 1987.
- Olsen DP. Toward an ethical standard for coerced mental treatment. Least restrictive or most therapeutic? *J Clin Ethics* 1998;9:235–46.
- Baars J, Kal D, eds. *Het uitzicht van Sisyphus. Maatschappelijke contexten van geestelijke (on)gezondheid [The view of Sisyphus. Social contexts of mental (un)health]*. Groningen: Wolters Noordhoff, 1995.
- Henkelman L. Woord en daad. Een wereld van verschil [Word and act. A world of difference]. *Passage* 1998;7:60–7.
- Nationale Raad voor de Volksgezondheid. *Weldoen of niet doen [Beneficence or abstinence]*. Zoetermeer: RVZ, 1992.
- Marlowe DB, Kirkby CK, Bonieskie LM. Assessment of coercive and noncoercive pressures to enter drug abuse treatment. *Drug Alcohol Depend* 1996;42:77–84.
- Sensky T, Hughes T, Hirsch S. Compulsory psychiatric treatment in the community. *Br J Psychiatry* 1991;158:792–9.
- Hiday VA, Scheid-Cook TL. Outpatient commitment for 'revolving door' patients. Compliance and treatment. *J Nerv Ment Dis* 1991;179:83–8.
- Ginneken P. Een zodanig 'gevaar'. Het gevaarscriterium bij gedwongen opneming in een psychiatrisch ziekenhuis [Such a "danger". The dangerousnesscriterion for involuntary commitment in a psychiatric hospital]. Utrecht: Nederlands Centrum Geestelijke Volksgezondheid, 1993.
- Legemaate J. Dwangtoepassing op grond van de BOPZ [Coercion and the law for involuntary commitment]. *Maandblad Geestelijke Volksgezondheid* 1994;49:710–16.
- De Roode R. Hulp onder dwang [Help under coercion]. *Medisch Contact* 2002;57:124–7.
- Lévinas E. *De totaliteit en het oneindige. Essay over de exterioriteit [Totality and infinity: an essay on exteriority]*. Ambo: Baarn, 1987.
- Zwart HAE. *Ethische consensus in een pluralistische samenleving [Ethical consensus in a pluralistic society]*. Amsterdam: Thesis Publishers, 1993.
- Pellegrino ED, Thomasma DC. *For the patient's good. The restoration of beneficence in health care*. Oxford: Oxford University Press, 1988.
- Van Ginneken P. De juridische merites van het zelfbindingscontract [Legal merits of advance directives]. *Maandblad Geestelijke Volksgezondheid* 1996;51:36–41.