McMaster University | HEALTH FORUM

Rapid Synthesis

Use and regulation of involuntary substance-use treatment for adults

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Context

- Substance-use-related deaths continue to increase in Canada, as does the toxicity of the illegal drug supply and the rate of hospitalizations and emergency department visits as a result of opioid poisoning.(1)
- Comprehensive adult care strategies for substance use are typically framed as being grounded in a harm-reduction approach and include a range of approaches including prevention and education, early identification and intervention, screening assessment and care planning, substance-use treatment and care, and health promotion.(2)
- Recent proposals in Canada to use involuntary substance-use treatment have been made, but there is a need to consider the evidence about such models to inform decisions.(3)
- According to the literature on substance-use treatment, an involuntary referral is made by civil law, while mandated treatment is made by penal law, both of which are forms of legal coercion and represent compulsory treatment.(4)

Question

What is known from the best-available evidence and from experiences in other jurisdictions about the use and regulation of involuntary substance-use treatment for adults?

High-level summary of key findings

High-level summary of outcomes of involuntary substance-use

- From seven evidence syntheses and 53 single studies, we found:
  - outcomes related to care experiences were mixed, with some studies noting concerns of violence and violation of human rights, and some studies not endorsing of the involvement of the criminal justice system in treatment
  - conflicting findings for substance-use outcomes, with patients in mandated treatment being two to 10 times more likely to complete treatment, but evidence of reducing substance-use and relapse rates showed either no beneficial effect of involuntary treatment or an effect that was similar to those from voluntary treatment
  - worse health-related outcomes in involuntary treatment as compared to voluntary treatment, including increased risk of non-fatal overdose after follow-up and increased risk of dying after discharge
  - moral distress in providers of involuntary treatment as well as a perception of it being ineffective and inconvenient for establishing a therapeutical environment with the participant
  - conflicting findings for social outcomes related to crime (criminal recidivism and arrests) and employment.

Key findings from research evidence

- We identified 60 relevant evidence documents, which include seven evidence syntheses (one high quality, four medium quality and two low quality) and 53 single studies (39 observational studies, nine qualitative studies) that were principally conducted in the U.S. (n=24), Australia (n=6) and Sweden (n=5), but also including studies from Norway, China, Vietnam, Canada, Mexico, Brazil, Iran, Thailand and Switzerland, and a multi-country study in Europe.

- Three syntheses addressed more than one drug, three addressed only opioids, and one addressed only methamphetamines. Most of the 53 single studies addressed involuntary treatment for several substances (n=25), only alcohol (n=4), only opioids (n=6), injected drugs (n=3), crack (n=1), and 14 did not specify the substance.
- The criteria for admission were usually severe substance use and being deemed to represent a danger to themselves or others; however, criteria were noted as being used discretionarily by the court or clinicians, who tended to admit more immigrants and people of low socio-economic status.
- Overall, involuntary treatment was paid with public funds, and the length of time of treatment included a short term of inpatient care of 21-28 days followed by voluntary aftercare of four to six months of in-patient/residential or outpatient treatment.
- Details of treatment approaches used were limited, but we noted that some studies included a counsellor for weekly sessions, group therapy, and pharmacological and behavioural therapy.
- Outcomes related to care experience were mixed, with positive experiences found in Norway but negative experiences noted in evidence from other jurisdictions, including being viewed as violent and in violation of human rights in Mexico. There was a lack of support in British Columbia and China, where participants were noted as not endorsing involuntary care or criminal justice system involvement in treatment.
- Regarding the outcome of use of substances, we identified conflicting findings.
    - Evidence syntheses and single studies reported that patients in mandated treatment were two to 10 times more likely to complete treatment than those enrolled in voluntary treatment.
    - Most studies reported no beneficial effect of involuntary treatment in comparison to voluntary treatment for reducing substance-use and relapse rates, but three studies reported a beneficial effect that was similar in magnitude to voluntary treatment.

Box 1: Approach and supporting materials

We identified evidence addressing the question by searching the Cochrane Library, Health Systems Evidence and PubMed to identify evidence syntheses, protocols for evidence syntheses and primary studies. All searches were conducted on 18 May 2023. The search strategies used are included in Appendix 1. We identified jurisdictional experiences by hand searching government and stakeholder websites for information relevant to the question from five countries (Australia, New Zealand, Portugal, Sweden, U.K.), four U.S. states (California, Colorado, Massachusetts, Washington) and eight Canadian provinces and territories (Alberta, Saskatchewan, Manitoba, Ontario, Quebec, PEI, Newfoundland and Labrador, Nunavut).

In contrast to our rapid evidence profiles, which provide an overview and insights from relevant documents, this rapid synthesis provides an in-depth understanding of the evidence.

We appraised the methodological quality of evidence syntheses that were deemed to be highly relevant using AMSTAR. Note that quality appraisal scores for evidence syntheses such as rapid syntheses/reviews are often lower because of the methodological shortcuts that need to be taken to accommodate compressed timeframes. AMSTAR rates overall quality on a scale of 0 to 11, where 11/11 represents an evidence synthesis of the highest quality. It is important to note that the AMSTAR tool was developed to assess evidence syntheses focused on clinical interventions, so not all criteria apply to evidence syntheses pertaining to delivery, financial or governance arrangements within health systems or to broader social systems.

This rapid synthesis was prepared in a 60-business day timeline.

A separate appendix document includes:

1) methodological details (Appendix 1)
2) a framework to organize what we looked for (Appendix 2)
3) a summary table of evidence organized by type of substance used (Appendix 3)
4) a summary table of experiences from other countries and select Canadian provinces and territories (Appendix 4)
5) findings from each evidence document, organized by document type, and sorted by relevance to the question (Appendix 5)
6) documents excluded at the final stages of reviewing (Appendix 6)

- As compared to people who stayed in the judicial system without treatment, one evidence synthesis found reduced drug use among people in involuntary treatment.
- For health-related outcomes, three evidence syntheses reported that those in involuntary treatment have an increased risk of a non-fatal overdose after follow-up (especially for heroin and methamphetamines users) compared to those that attend voluntary treatment
  - One study conducted in Sweden reported that those that attended involuntary treatment had an increased risk of dying immediately after discharge than those that attend voluntary treatment.
- We identified conflicting findings for social outcomes.
  - One study performed in five countries in Europe (U.K., Italy, Austria, Germany, Switzerland) reported similar reductions in crime and improvements in employment status among those in voluntary and involuntary treatment, while another study conducted in Sweden found an increased likelihood of imprisonment after involuntary care.
  - One study in the U.S. found that people with substance-use treatment mandated by the justice system have less criminal recidivism than those with substance-use issues that go to jail without mandated treatment.
  - Another study in the U.S. with a five-year follow-up reported no significant difference in arrests between people with substance-use mandated treatment by the justice system and those that go to jail without treatment, and between those not involved in the criminal system and not mandated to treatment.
- Only one study in Vietnam reported on costs and found that community-based voluntary methadone maintenance treatment cost US$4,108 less than centre-based compulsory rehabilitation, and voluntary methadone maintenance treatment participants had 344.2 more drug-free days than compulsory rehabilitation participants.
- Five studies considered the providers' perceptions about involuntary treatment, and studies overall reported moral distress in providers of involuntary treatment as well as a perception of it being ineffective and inconvenient for establishing a therapeutical environment with the participant.
- The evidence showed that involuntary treatment is more frequent among those who are homeless, younger, less educated, low income, of Hispanic ethnicity in the U.S. (or who had at least one parent born outside of the Nordic countries in Sweden), or have severe mental health conditions (schizophrenia and mood disorders) or a history of psychiatric hospitalization.

Jurisdictional scan

- Regulations for involuntary treatment are largely a Mental Health Act (or similar legislation) in each jurisdiction, with the exception of the Canadian federal government, where the very limited use of involuntary treatment is detailed in the *Criminal Code*.
- All jurisdictions, including Canadian provinces and territories as well as other countries, have criteria for admission that are generally based on the presence of a severe substance dependence, significant risk of harm to the individual or to another, and the inability to make informed decisions about their treatment.
- However, in Portugal, involuntary admission is not permitted and can only be recommended by Dissuasion Commissions in exchange for no sanctions being imposed.
- All jurisdictions require an assessment to be completed by a healthcare provider, but the assessments vary both on how they can be initiated (either upon recommendation by a family member, health professional or as part of court proceedings) and who is permitted to undertake the assessment.
- The number of days for which individuals may be admitted for involuntary treatment differed between jurisdictions, ranging from a minimum of 10 days to a maximum of six months, with additional variation and possibility of extension following a reassessment at end of the admission.
- Reassessments can result in an extension of individuals' involuntary admission, the length of which vary by jurisdiction and in some jurisdictions by the number of extensions that have been previously provided (e.g., first extension of initial admission may be one month, but the third extension may be up to three).
- In many jurisdictions, community treatment orders and involuntary outpatient care are also identified as options, which frequently follow involuntary admission to a healthcare facility.

- Very limited information was identified on the treatment approaches used in each jurisdiction, but we did identify a that in some countries, such as Australia, and in some states, such as Massachusetts, a significant emphasis placed on discharge supports to enable community-based follow-up.

Framework to organize what we looked for

We organized our findings using a framework that we provide in Appendix 2 and includes categories related to:

- Criteria for admission to involuntary treatment
- Types of substance(s) used
- Priority populations
- Features of treatment approach
- Outcomes as compared to other alternatives (e.g., involuntary treatment)
- Findings in relation to one or more equity-deserving groups from PROGRESS-Plus framework

What we found

We identified 60 evidence documents relevant to the question, of which we deemed 19 (all seven evidence syntheses and 12 single studies) to be highly relevant and 41 to be of medium relevance.

Among the seven evidence syntheses, one was high-quality,(5) four were medium-quality,(6-9) and two were low-quality.(10; 11) Three of the evidence syntheses addressed more than one drug, three addressed only opioids, and one focused only on methamphetamines. The 53 single studies included observational studies (n=39), qualitative studies (n=9), and the rest of the studies were experimental (n=1), economic evaluation (n=1), and focused on perspectives or experiences with implementation (n=3). Studies were conducted in the U.S. (n=24), Australia (n=6), Sweden (n=5), Norway (n=3), China (n=3), Vietnam (n=3), Canada (n=2) and Mexico (n=2), one study for each of Brazil, Iran, Thailand and Switzerland, and a multi-country study including five countries in Europe (U.K., Italy, Austria, Germany, Switzerland). Overall, 25 studies addressed involuntary treatment for several substances, four addressed only alcohol, six only opioids, three only injected drugs, one only crack, and 14 did not specify the substance.

We outline in narrative form below our key findings related to the question from highly relevant evidence documents and based on experiences from eight Canadian provinces and territories (Alberta, Saskatchewan, Manitoba, Ontario, Quebec, PEI, Newfoundland and Labrador, Nunavut), five countries (Australia, New Zealand, Portugal, Sweden, U.K.) and four U.S. states (California, Colorado, Massachusetts, Washington).

Key findings from highly relevant evidence sources

Criteria for admission to involuntary treatment

Criteria for admission was typically defined as severe substance use that represented a danger to the individual using substances or others.(6; 12; 13) However, this criteria was used discretionarily by courts or clinicians.(14-16) For instance, one study in Vancouver found that incarceration, non-fatal overdose, and cocaine use were significantly associated with an increased hazard of referral to involuntary treatment, while daily cannabis use and employment were negatively associated with referral to involuntary substance use.(15) Other criteria identified included required treatment for anaesthesiologists with opiate use disorders who were contractually obligated to take naltrexone for two years,(17) and mandated alcohol treatment for college students violating campus alcohol policies.(18)

Features of the treatment approach

Overall, only five papers explicitly mention who pays for involuntary treatment, all of which noting that public funds were used,(12; 19-22), with a study conducted in Vietnam also noting the role of international donors in funding.(22) Four studies noted the length of time of treatment, which included a short-term inpatient stay of 21-28 days, followed by voluntary aftercare of four to six months.(13; 23-25) Studies also evaluated and compared different modalities of in-patient/residential treatment,(5; 7; 23; 25-30) outpatient treatment,(7; 15; 26-30) or a mix.(5; 23-25)

Treatment approaches were mentioned in a few studies and included a counsellor for weekly sessions, group therapy three times a week for three or four months,(23) referral cards and methadone maintenance treatment while still in compulsory detoxification,(29) and medical and behavioural interventions.(13)

We did not identify evidence related to any 'safeguards' in place to ensure adherence to a Mental Health Act, criteria for transition to voluntary treatment, or supports provided after discharge.

Outcomes as compared to other alternatives

Achievement of client goals

We did not identify literature specifically addressing this outcome.

Care experience

The care experience was perceived as positive in Norway (31) but negative, violent and in violation of human rights in Mexico.(32) In Norway, a multidisciplinary treatment approach was implemented in specialized wards for patients with substance-use disorders and co-occurring mental disorders. The treatment included various components such as physical and mental health assessments, pharmacotherapy, cognitive therapy, individual motivation enhancement and routine drug screenings. Patient perspectives on coercion and treatment experiences were gathered through interviews and discussed with the team.(31) In Mexico, the study identified five themes related to power dynamics and human rights violations. The themes identified included: uncertainty and fear about the degree of extrajudicial violence the policy would resort to; discretionary selection of people taken into treatment; discrimination and violence at drug centres; lack of oversight at the treatment centres; and treatment effectiveness.(32) Among studies only addressing opioids, two studies reported on care experiences. One study in British Columbia and another in China found that participants did not endorse involuntary care or criminal justice system involvement in treatment.(33; 34)

Use of substance

We identified conflicting findings among the studies included. Overall, evidence syntheses and single studies reported better rates of completing treatment (i.e., finishing all sessions and the time planning for the treatment program) among patients mandated to treatment than in patients under voluntary treatment.(23; 35) Regarding the reduction in substance-use patterns and relapse rates, most studies reported no benefits of involuntary treatment in comparison to voluntary treatment (7; 9-11; 36-39) or in comparison to patients not treated.(15; 25) One study with a five-year follow-up found that the justice-mandated participants did not differ significantly from the justice-no-mandated and the justice-no-involved groups in terms of abstinence, remission and clinical consequences.(25) The only high-quality evidence synthesis included evaluated different compulsory treatment modalities (drug detention facilities, community-based, group-based outpatient, prison-based, 21-day treatment, six-month inpatient treatment), and most studies did not detect significant positive impacts on drug use or criminal recidivism over other approaches.(5) One study included in this review found that incarceration and voluntary drug treatment were

both associated with long-term cessation, though involuntary treatment was only associated with ceasing injection drug use for less than a year and subsequent relapse into injecting.(40)

In contrast, three studies, one evidence synthesis of articles published in French, German, Dutch and Italian and two single studies, reported benefits similar to voluntary treatment.(9; 28; 41) Additionally, one synthesis found reduced drug use among people under involuntary treatment compared to those who stayed in the judicial system without treatment (note that length of follow-up for this evaluation was not specified).(11)

Among studies only addressing opioids, one study reported reductions in heroin use for both inpatient and outpatient treatment,(7) while two other studies reported an increase in methadone maintenance dropout (11) and high relapse rates following release from involuntary treatment.(38) Among studies only reporting on stimulants, one study found that treatment completion, relapse within six months, time to relapse and percentage of days with methamphetamine use in 24 months following treatment did not differ significantly in simple comparisons between voluntary and involuntary treatment groups.(39) However, when client and treatment characteristics were controlled, the short-term outcome of relapse within six months was worse for those reporting legal pressure (from the criminal justice system or from child protective services).(39) In this study, treatment completion was related to the type of treatment, with odds of completion 2.4 times greater for residential than for outpatient treatment.(39) Among studies only addressing alcohol abuse, one study reported no significant relationship between the motivation for treatment (i.e., voluntary or mandated) and length of sobriety following treatment among veterans.(41)

Health-related outcomes

Three evidence syntheses reported increased risks of a non-fatal overdose after follow-up (varying between six and 12 months),(6; 8; 42) especially for heroin (8; 42) and methamphetamines users.(39) One single study in Sweden reported an increased risk of dying immediately after discharge in people that attended compulsory care, especially in younger clients.(43) Among studies only addressing alcohol abuse, one study in Australia reported that involuntary and voluntary treatment showed a reduction in emergency department visits, with no statistical difference between both.(27)

Social outcomes

We identified conflicting findings for this outcome. In comparison with participants that attended voluntary treatment, one study in five European countries (Austria, Germany, Italy, Switzerland, U.K.) reported reductions in crime and improvements in employment status to be similar in both groups,(28) while another in Sweden found an increased likelihood of imprisonment post-care.(12) When compared with participants involved in the justice system but not mandated to treatment, one study in the U.S. with a five-year follow-up reported that those in justice-mandated substance-use treatment did not differ significantly in arrests from those in non-justice-mandated treatment and those with no justice system involvement.(25) However, those in justice-mandated treatment were more likely to be employed at five years post-treatment than the other two groups.(25) Another study in the U.S. found that criminal recidivism in people mandated from two highly structured programs was at less than half of clients in a non-structured program.(44) Structured programs included well-implemented protocols for informing the client and defense attorney about the legal contingencies of participation and strict rules and protocols for monitoring and enforcement, but all programs (structured and non-structured) provided well-established residential treatment programs for substance abusers.(44)

Costs

We only identified one study addressing costs, which found involuntary treatment to be not cost effective. The study in Vietnam, with 504 participants, found that the average thee-year total cost for a centre-based compulsory rehabilitation program was more than three times higher than that for a community-based voluntary methadone

maintenance treatment program, a difference of US$4,108 per three years of program.(22) Additionally, voluntary methadone maintenance treatment participants had 344.2 more drug-free days than compulsory rehabilitation participants.(22) The incremental cost-effectiveness ratio for voluntary methadone maintenance treatment was US$11.99 per drug-free day, suggesting that this alternative is more cost effective than centre-based compulsory rehabilitation.(22)

Provider experience

Five studies considered the providers' perceptions about involuntary treatment, of which four were conducted in the U.S. (14; 26; 45; 46) and one in Australia.(47) Overall, studies reported moral distress in providers of involuntary treatment as well as a perception of it being ineffective and inconvenient for establishing a therapeutical environment with the participant.(14; 26; 45-47) A study in California reported many problems when implementing the Substance Abuse and Crime Prevention Act given that providers planned the program according to clinical criteria and assumptions. However, the population was noted as being different than expected, given that the courts have the final word rather than healthcare providers. For instance, the program was planned for clients with minor substance abuse histories and no recent arrest for violent or other disqualifying charges, but many clients who attended the compulsory programs had significant substance problems and previous arrests for violent crimes.(14) Another study in California reported that providers perceived the assessment of client populations with multiple needs (such as dually diagnosed, women and homeless clients) as particularly challenging when not in the hands of the clinicians themselves.(26) One study in Massachusetts reported some or high moral distress with the use of involuntary commitment and reported inconsistent approaches to its use (e.g., team-based decision, last resort petition).(45) A national study found that some addiction medicine physicians considered civil commitment for substance-use disorders to be an effective approach for treating certain disorders, while others opposed the approach because they felt it would jeopardize patient rapport and be ineffective for unmotivated individuals.(46) One study in Australia reported that clinicians saw a tension between their goals to save someone's life and practicing in a culturally safe way when considering the referral of Aboriginal Australians to involuntary drug and alcohol treatment.(47)

Priority populations and equity-deserving groups

The evidence reviewed showed that involuntary treatment is more frequent among the homeless population;(13; 48) younger people;(13; 27; 43) those less educated;(13; 27) those with schizophrenia, mood disorder or a history of psychiatric hospitalization;(13; 20) those with less income;(27) and those of Hispanic ethnicity in the U.S. (27) or who had at least one parent born outside of the Nordic countries in Sweden.(13)

In Sweden, clients who were previously mandated to compulsory care as minors,(13; 49) sentenced to prison or on parole,(13; 49) or those who had children involved in the child welfare system(49) were more likely to experience repeated compulsory-care entries for addiction.

One study reported that women did better with integrated treatment (i.e., comprehensive, gender-specific and trauma-informed services compared to usual care) and mandated treatment (in comparison to voluntary treatment) regardless of treatment conditions for psychiatric, trauma and substance use outcomes.(28) Another reported that criminal justice referrals increase program completion rates among pregnant women,(19) and one study in Sweden reported that females and young adults are at an increased likelihood of being admitted to compulsory care via court order, and admission to compulsory care has been associated with an elevated risk of substance-use mortality.(50)

In Vietnam, both incarceration and compulsory rehabilitation substantially decreased the odds of individuals with HIV reinitiating medication for opioid use disorder and HIV treatment upon release.(51)

Key findings from jurisdictional scans

We examined regulations for involuntary treatment at the federal level in Canada, as well as from eight Canadian provinces and territories (Alberta, Saskatchewan, Manitoba, Ontario, Quebec, PEI, Newfoundland and Labrador, Nunavut), five countries (Australia, New Zealand, Portugal, Sweden, U.K.) and four U.S. states (California, Colorado, Massachusetts, Washington).

Jurisdictions differed in the amount of information available on involuntary treatment, with very few providing details on features of the treatment approach. The following two sections provide a summary of the key findings. Additional details for each jurisdiction can be found in Appendix 4.

Key findings from Canadian provinces and territories

At the federal level, there is no option for involuntary treatment as mental health and addictions services are provided at the provincial level. However, if an individual is charged with a crime under the *Criminal Code of Canada*, as part of the process of being found either not 'criminally responsible' or 'not fit to stand trial,' prosecutors may request an assessment of mental competence that could require an individual to be confined within a healthcare facility for up to thirty days (up to a maximum of 60 days with an extension). In these cases, treatment is not provided. Similarly, treatment may be a condition imposed on an individual's parole or part of a disposition provided by provincial review boards once found not criminally responsible. In both instances though, the individual must consent to being treated.

In all included Canadian provinces, individuals can be admitted for involuntary treatment based on the recommendation of a physician following an assessment or based on the recommendation of a judge as part of a court order. In Quebec, Newfoundland and Labrador and Nunavut, recommendations for involuntary treatment can be provided by other types of health professionals apart from physicians including psychiatrists, psychiatric residents and qualifying nurses. In Newfoundland and Labrador, two certificates – one each from a physician or nurse practitioner and one from a psychiatrist or psychiatric alternate – are required. In all included provinces and territories, certificates for involuntary treatment may be issued if the individual:

- has persistent and severe abuse of one or more drugs
- has significant physical or psychological health deterioration arising from drug use
- has a mental disorder and is at risk of severe harm to themselves or others
- is unable to make informed decisions about their treatment
- requires treatment that can only be received in a psychiatric unit (Newfoundland and Labrador only).

Provinces and territories have different durations for which involuntary admission is permitted. Durations range from no more than 14 days (Ontario) up to 30 days (Newfoundland and Labrador, Nunavut) – with Saskatchewan (21 days), Manitoba (21 days), Quebec (21 days) and Prince Edward Island (28 days) falling in the middle. In addition, different regulations are in place regarding renewals, with most provinces and territories allowing for multiple renewals for an increasing number of days (i.e., the first renewal is for 30 days while the fourth renewal is for 120 days). In Newfoundland and Labrador, an unlimited number of renewals is allowed, with two assessments – one each from a physician and a psychiatrist or psychiatric alternate – required between each renewal.

Three provinces (Alberta, Saskatchewan, Newfoundland and Labrador) and a territory (Nunavut) specified that in some cases Community Treatment Orders can be used with individuals being evaluated based on threshold criteria. These orders permit individuals to seek outpatient treatment. Community Treatment Orders frequently involve a large group of providers, ensuring care beyond mental health and addictions, such as housing, income and employment supports.

Few Canadian provinces and territories identified the treatment approaches being used. In all provinces and territories, a treatment plan is required that sets out the type of treatment that is to be provided and specific release criteria.

Key findings from other countries

The included countries varied on whether regulations for involuntary treatment were set at a national (New Zealand, Portugal, Sweden, U.K.) or sub-national (Australia, U.S.) level.

Portugal is the only included country where involuntary admission is not permitted. However, Dissuasion Commissions can suspend proceedings and impose no sanctions on an individual in exchange for them agreeing to undergo treatment. In each of England, Northern Ireland, Scotland and Wales, involuntary treatment cannot be exclusively based on the use of drugs or alcohol, and must be combined with a mental health condition that places them or others at significant risk of harm.

In other countries, criteria for admission are generally based on:

- severe substance dependency
- risk of considerable harm to the individual or to another
- previous refusal of treatment
- whether other appropriate, less restrictive means are available.

All countries require an assessment to be completed by a healthcare provider, which may be initiated by a provider, judge through court proceedings, or, in the case of the four U.S. states, may be recommended by a spouse, family member or guardian.

The duration of involuntary treatment differs across countries ranging from 10 days in New Zealand up to six-months in Sweden.

Details of the treatment services provided were found in Australia and Sweden, which included:

- a comprehensive medical and psychiatric assessment
- substance withdrawal management under medical supervision
- psychoeducational and therapeutic education
- brief interventions including motivation interviewing
- aftercare and discharge planning.

In addition, New South Wales in Australia provides discharge supports whereby individuals are transferred to community care by a local health district for up to six months. A new compulsory alcohol and drug treatment program has been proposed in Western Australia, which includes up to 12 weeks of inpatient care following nine months of voluntary residential rehabilitation, transitional housing and/or aftercare support. In Massachusetts, once a patient is assessed for the completion of a withdrawal management program, counsellors and case managers create a community-based aftercare plan.

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References

1. Canada Go. Canadian Alcohol and Drugs Survey (CADS): summary of results for 2019. 2022. https://www.canada.ca/en/health-canada/services/canadian-alcohol-drugs-survey/2019-summary.html (accessed June 27 2023).
2. Klaire S, Janssen RM, Olson K, et al. Take-home drug checking as a novel harm reduction strategy in British Columbia, Canada. *Int J Drug Policy* 2022;106: 103741.
3. News C. Alberta weighing involuntary treatment law for people with addiction. 2023. https://www.cbc.ca/news/canada/edmonton/alberta-weighing-involuntary-treatment-law-for-people-with-addiction-1.6816153 (accessed June 28 2023).
4. Hachtel H, Vogel T, Huber CG. Mandated Treatment and Its Impact on Therapeutic Process and Outcome Factors. *Front Psychiatry* 2019;10: 219.
5. Werb D, Kamarulzaman A, Meacham MC, et al. The effectiveness of compulsory drug treatment: A systematic review. *Int J Drug Policy* 2016;28: 1-9.
6. Messinger JC, Ikeda DJ, Sarpatwari A. Civil commitment for opioid misuse: do short-term benefits outweigh long-term harms? *J Med Ethics* 2022;48(9): 608-610.
7. Stevens A, Berto D, Heckmann W, et al. Quasi-compulsory treatment of drug dependent offenders: an international literature review. *Subst Use Misuse* 2005;40(3): 269-83.
8. Vo AT, Magana C, Hickman M, et al. Assessing HIV and overdose risks for people who use drugs exposed to compulsory drug abstinence programs (CDAP): A systematic review and meta-analysis. *Int J Drug Policy* 2021;96: 103401.
9. Wild TC, Roberts AB, Cooper EL. Compulsory substance abuse treatment: an overview of recent findings and issues. *Eur Addict Res* 2002;8(2): 84-93.
10. Coleman M, Ridley K, Christmass M. Mandatory treatment for methamphetamine use in Australia. *Subst Abuse Treat Prev Policy* 2021;16(1): 33.
11. Meng J, Burris S. The role of the Chinese police in methadone maintenance therapy: a literature review. *Int J Drug Policy* 2013;24(6): e25-34.
12. Grahn R. The association between history of civil commitment for severe substance use and future imprisonment: A Swedish registry study. *J Subst Abuse Treat* 2022;134: 108613.
13. Lundgren L, Brännström J, Armelius B, Chassler D, Morén S, Trocchio S. Association between immigrant status and history of compulsory treatment in a national sample of individuals assessed for drug use disorders through the Swedish public welfare system. *Subst Use Misuse* 2012;47(1): 67-77.
14. Wiley D, Beattie M, Nguyen H, Puckett K, Banerjee K, Poon W. When you assume...the reality of implementing a legally mandated substance abuse treatment program. *J Psychoactive Drugs* 2004;Suppl 2: 175-80.
15. Pilarinos A, Barker B, Nosova E, et al. Coercion into addiction treatment and subsequent substance use patterns among people who use illicit drugs in Vancouver, Canada. *Addiction* 2020;115(1): 97-106.
16. Christopher PP, Pridgen BE, Pivovarova E. Experiences of Court Clinicians Who Perform Civil Commitment Evaluations for Substance Use Disorders. *J Am Acad Psychiatry Law* 2021;49(2): 187-193.
17. Merlo LJ, Greene WM, Pomm R. Mandatory naltrexone treatment prevents relapse among opiate-dependent anesthesiologists returning to practice. *J Addict Med* 2011;5(4): 279-83.

18. Yurasek AM, Borsari B, Magill M, et al. Descriptive norms and expectancies as mediators of a brief motivational intervention for mandated college students receiving stepped care for alcohol use. *Psychol Addict Behav* 2015;29(4): 1003-11.

19. Smith WT. Women with a substance use disorder: Treatment completion, pregnancy, and compulsory treatment. *J Subst Abuse Treat* 2020;116: 108045.

20. Vine R, Tibble H, Pirkis J, Spittal M, Judd F. The impact of substance use on treatment as a compulsory patient. *Australas Psychiatry* 2019;27(4): 378-382.

21. Ardill A. Mandatory Welfare Drug Treatment in Australia. *J Law Med* 2019;26(4): 800-814.

22. Vuong T, Shanahan M, Nguyen N, et al. Cost-effectiveness of center-based compulsory rehabilitation compared to community-based voluntary methadone maintenance treatment in Hai Phong City, Vietnam. *Drug Alcohol Depend* 2016;168: 147-155.

23. Coviello DM, Zanis DA, Wesnoski SA, et al. Does mandating offenders to treatment improve completion rates? *J Subst Abuse Treat* 2013;44(4): 417-25.

24. Vuong T, Gillies M, Larney S, Montebello M, Ritter A. The association between involuntary alcohol treatment and subsequent emergency department visits and hospitalizations: a Bayesian analysis of treated patients and matched controls. *Addiction* 2022;117(6): 1589-1597.

25. Kelly JF, Finney JW, Moos R. Substance use disorder patients who are mandated to treatment: characteristics, treatment process, and 1- and 5-year outcomes. *J Subst Abuse Treat* 2005;28(3): 213-23.

26. Niv N, Hamilton A, Hser YI. Impact of court-mandated substance abuse treatment on clinical decision making. *J Behav Health Serv Res* 2009;36(4): 505-16.

27. Clark C, Young MS. Outcomes of mandated treatment for women with histories of abuse and co-occurring disorders. *J Subst Abuse Treat* 2009;37(4): 346-52.

28. Schaub M, Stevens A, Berto D, et al. Comparing outcomes of 'voluntary' and 'quasi-compulsory' treatment of substance dependence in Europe. *Eur Addict Res* 2010;16(1): 53-60.

29. Yan L, Liu E, McGoogan JM, et al. Referring heroin users from compulsory detoxification centers to community methadone maintenance treatment: a comparison of three models. *BMC Public Health* 2013;13: 747.

30. Guerrero EG, Campos M, Urada D, Yang JC. Do cultural and linguistic competence matter in Latinos' completion of mandated substance abuse treatment? *Subst Abuse Treat Prev Policy* 2012;7: 34.

31. Opsal A, Kristensen Ø, Clausen T. Readiness to change among involuntarily and voluntarily admitted patients with substance use disorders. *Subst Abuse Treat Prev Policy* 2019;14(1): 47.

32. Rafful C, Medina-Mora ME, González-Zúñiga P, et al. "Somebody Is Gonna Be Hurt": Involuntary Drug Treatment in Mexico. *Med Anthropol* 2020;39(2): 139-152.

33. Chau LW, Erickson M, Vigo D, et al. The perspectives of people who use drugs regarding short term involuntary substance use care for severe substance use disorders. *Int J Drug Policy* 2021;97: 103208.

34. Liu Y, Li L, Zhang Y, et al. Assessment of attitudes towards methadone maintenance treatment between heroin users at a compulsory detoxification centre and methadone maintenance clinic in Ningbo, China. *Subst Abuse Treat Prev Policy* 2013;8: 29.

35. Pickard JG, Sacco P, van den Berk-Clark C, Cabrera-Nguyen EP. The effect of legal mandates on substance use disorder treatment completion among older adults. *Aging Ment Health* 2020;24(3): 497-503.

36. Sant'Anna WT, Mitsuhiro SS, Figlie NB, Diehl A, Pillon SC, Laranjeira R. Relapse in involuntary substance treatment: a transversal study. *Rev Colomb Psiquiatr (Engl Ed)* 2020;49(4): 255-261.

37. Messinger JC, Vercollone L, Weiner SG, et al. Outcomes for Patients Discharged to Involuntary Commitment for Substance Use Disorder Directly from the Hospital. *Community Ment Health J* 2023.

38. Vuong T, Ritter A, Shanahan M, Ali R, Nguyen N, Minh KP. Quality of life as a predictor of time to heroin relapse among male residents following release from compulsory rehabilitation centres in Vietnam. *Drug Alcohol Rev* 2021;40(2): 296-306.

39. Brecht ML, Anglin MD, Dylan M. Coerced treatment for methamphetamine abuse: differential patient characteristics and outcomes. *Am J Drug Alcohol Abuse* 2005;31(2): 337-56.

40. Fairbairn N, Hayashi K, Ti L, et al. Compulsory drug detention and injection drug use cessation and relapse in Bangkok, Thailand. *Drug Alcohol Rev* 2015;34(1): 74-81.

41. Boit H, Palmer GA, Olson SA. A Comparison Between the Involuntary and Voluntary Treatment of Patients With Alcohol Use Disorder in a Residential Rehabilitation Treatment Program. *J Addict Nurs* 2019;30(1): 57-60.

42. Rafful C, Orozco R, Rangel G, et al. Increased non-fatal overdose risk associated with involuntary drug treatment in a longitudinal study with people who inject drugs. *Addiction* 2018;113(6): 1056-1063.

43. Ledberg A, Reitan T. Increased risk of death immediately after discharge from compulsory care for substance abuse. *Drug Alcohol Depend* 2022;236: 109492.

44. Young D, Fluellen R, Belenko S. Criminal recidivism in three models of mandatory drug treatment. *J Subst Abuse Treat* 2004;27(4): 313-23.

45. Walt G, Porteny T, McGregor AJ, Ladin K. Clinician's experiences with involuntary commitment for substance use disorder: A qualitative study of moral distress. *Int J Drug Policy* 2022;99: 103465.

46. Jain A, Christopher PP, Fisher CE, Choi CJ, Appelbaum PS. Civil Commitment for Substance Use Disorders: A National Survey of Addiction Medicine Physicians. *J Addict Med* 2021;15(4): 285-291.

47. Lee KSK, Bullen LM, Zheng C, Dawson A, Munro A, Conigrave KM. Beliefs and attitudes of drug and alcohol clinicians when considering referral of Aboriginal clients to involuntary drug and alcohol treatment: A qualitative study. *Drug Alcohol Rev* 2023;42(1): 169-180.

48. Coffey KE, Aitelli A, Milligan M, Niemierko A, Broom T, Shih HA. Use of Involuntary Emergency Treatment by Physicians and Law Enforcement for Persons With High-Risk Drug Use or Alcohol Dependence. *JAMA Netw Open* 2021;4(8): e2120682.

49. Grahn R, Lundgren LM, Chassler D, Padyab M. Repeated entries to the Swedish addiction compulsory care system: a national register database study. *Eval Program Plann* 2015;49: 163-71.

50. Scarpa S, Grahn R, Lundgren LM. Compulsory care of individuals with severe substance use disorders and alcohol- and drug-related mortality: A Swedish registry study. *Front Psychiatry* 2023;14: 1106509.

51. King C, Cook R, Giang LM, et al. Incarceration and compulsory rehabilitation impede use of medication for opioid use disorder and HIV care engagement in Vietnam. *J Subst Abuse Treat* 2022;134: 108451.