

The research on the effectiveness of mandated treatment for substance abuse/dependence is mostly positive with some factors identified that may affect both dropout rates and outcomes, such as psychiatric co-morbidity, employment status, and preferred drug. Research has suggested that mandated treatment outcomes in general are at least equivalent to that obtained in voluntary treatment. This may be partially due to the meaning of the word “voluntary.” That is, many individuals who present for treatment do so as a result of some level of coercion from friends, family, or business associates. A further complication arises when individuals in the criminal justice system “voluntarily” enter a treatment program to gain judicial or prosecutorial favor. Thus, the real difference between mandated (legally coerced) and voluntary (socially coerced) is still unclear. Coercion may lie along a continuum with personal guilt at one end and specific legal mandates at the other.

Due in part to this definitional ambiguity, research on the effectiveness of mandated treatment suggests that these programs are at least as effective as voluntary programs in both the short and long term (Kelly, Finney, & Moos, 2005). This is particularly interesting in that it implies that external motivational factors (e.g., social pressure, meeting sentencing requirements, etc.) may be as important as internal motivations (e.g., readiness to change) to reduce hazardous levels of alcohol and drug consumption. Kelly et al. (2005) found no differences in outcomes between mandated and voluntary treatment groups after 5 years and suggested

that although initial internal motivation of the mandated group was low, it evolved over time as they identified with other patients in treatment. Regardless of the motivational condition (extrinsic or intrinsic) the results demonstrate clearly that mandated treatment can be effective.

Perron & Bright (2008) analyzed data from the National Treatment Improvement Evaluation Study (1993-1997) and found across a range of treatment modalities (e.g., residential, outpatient) that mandated patients do not have elevated levels of initial clinical severity compared to voluntary patients. They also showed that dropout rates were lower for those legally mandated to treatment. They go on to suggest that the length of treatment is likely a factor in treatment success in general and in prior findings of positive post-treatment outcomes for mandated patients (Anglin, Brecht, & Maddahian, 1989; Brecht, Anglin, & Jung-Chi, 1993; Burke & Gregoire, 2007; Kelly et al., 2005).

While the scientific research literature appears to support the effectiveness of mandated treatment there have been questions raised about the role of coercion in a patient-oriented philosophical approach that emphasizes self-determination and decision-making autonomy (Caplan 2006). The fact that mandated treatment reduces the societal burden of substance abuse may or may not be secondary to the associated ethical issues it raises. The answer to these concerns is likely not within the scope of a scientific inquiry.

References

- Anglin, M.D., Brecht, M, and Maddahian (1989). Pretreatment characteristics and treatment performance of legally coerced versus voluntary methadone maintenance admissions. *Criminology*, 27, 537-557.
- Brecht, M., Anglin, M.D., and Jung-Chi, W. (1993). Treatment effectiveness for legally coerced versus voluntary methadone maintenance clients. *American Journal of Drug and Alcohol Abuse*, 19, 89-106.
- Burke, A.C., and Gregoire, T. K. (2007). Substance abuse treatment outcomes for coerced and noncoerced clients. *Health and Social Work*, 31, 7-15.
- Kelly, J. F., Finney, J. W., and Moos, R. (2005). Substance use disorder patients who are mandated to treatment: Characteristics, treatment process, and 1- and 5-year outcomes. *Journal of Substance Abuse Treatment*, 28, 213-223.
- Perron, B. E., and Bright, C. L. (2007). The influence of legal coercion on dropout from substance abuse treatment: Results from a national survey. *Drug and Alcohol Dependence*, 92, 159-176.