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Addiction, Competence and Coercion

ABSTRACT

In what sense is a person addicted to drugs or alcohol incompetent, and so a legitimate object of coercive treatment? The standard tests for competence do not pick out the capacity that is lost in addiction: the capacity to properly regulate consumption. This paper is an attempt to sketch a justificatory framework for understanding the conditions under which addicted persons may be treated against their will. These conditions rarely obtain, for they apply only when addiction is extremely severe and great harm threatens. It will be argued also that to widen the measures currently in place in some jurisdictions, though philosophically well-motivated, would require very strong evidence of a set of conditions disposing a person to an addictive future. It is doubtful that any such currently available evidence is strong enough to justify coercive treatment. Nevertheless, coercive treatment of addiction is already a reality, with the potential for more, and so some discussion will be presented regarding the extraordinary safeguards necessary to prevent misapplication of such treatment policies.

Addiction, Competence and Coercion

I. INTRODUCTION

Imagine that someone very close to you is walking barefoot along a path headlong towards the edge of a cliff. Let’s call this person ‘your son’. He walks forward reaching for the fruit overhanging the path. As he edges closer to the vertical drop there appears nothing can be done to stop him. He knows of the imminent danger, for he can see the edge in the distance. The path is strewn with broken glass, which he cannot always avoid, his bloody feet somehow warning him of the brutal fall ahead. But his eyes are on the fruit. There seems little you may do to halt this strange march. You call out, you try to persuade, and you cajole, but to no avail. To your eternal frustration your son appears to be an ally to his own destruction. Each step taken appears to be voluntary and desired, but he now says, oddly, that the fruit holds no real value for him anymore. When you explain to your son that all these small steps inevitably amount to one large step over the edge he may, in a reflective moment, agree with you. But that knowledge, when he needs it most, is almost never sufficient for him to refrain from taking this small additional step *now*. His problem is an inability to see and appreciate the large step long enough that he may sustain the motivation to stop, turn around, and walk away from the danger.

So instead he continues forward, seemingly unstoppably, to the edge. Yet perhaps it is not too late to stop him, now that he is very close, just by physically blocking the path. That is the thought that occurs to you as you step in. It works for a while, but he resists. You can’t physically stop him and, as he points out, the law is on his side. There is nothing more to be done.

­­Each year thousands of cliff-bound addicted persons fall over the edge.[[1]](#endnote-1) The question I want to raise concerns the philosophical grounds, if any, for legal coercion of (a small subset of) addicted persons into treatment. I will do so by asking, of drug addicted individuals, whether they are competentto refuse treatment. The view I arrive at is that in what I will call the hardcore cases of addiction, and with the necessary legal safeguards and incentives in place, there *may* be a case for compulsory treatment of individuals, but the area is extremely fraught.[[2]](#endnote-2) Central to the problem is that the criteria for incompetence in another relevant area, mental health legislation, is harm, very significant harm, and once that point is reached involuntary treatment of an addicted person just seems to come too late, at least in adults. The good that might have been done from an order to treat an addicted person on the way to the edge of the cliff should have come earlier, but not enough harm has been done earlier to warrant involuntary treatment. Can someone be declared incompetent before significant harm is done and because they appear not to be able to control their consumption of a substance? Almost certainly not. *That’s* the problem.

Currently in many jurisdictions legislation indeed permits coercive treatment for those whose mental condition (that would include a drug dependence disorder) places them or others at risk of harm. The motivation for coercive treatment in such cases is the risk of *imminent* harm, and that is why such measures do not really attract much controversy. Far more controversial is the idea that medico-legal measures be put in place that would enforce a treatment plan for someone with an addiction who is not yet at the point of hospitalisation, and perhaps not even close. Those who reject the disease model of addiction, and particularly those with a liberal view, presumably would regard the idea of involuntary treatment for addicted persons as outrageous.[[3]](#endnote-3) In contrast there are those who regard addiction as a disease of the brain, and as such, it would appear assimilable to other conditions where coercive treatment would not be regarded as controversial. My own view is that we need to make distinctions within the population of addicted persons in order to focus on those with a distinct susceptibility to substance dependence due to a pre-existing vulnerability that includes a complex set of risk factors: genetic, neurological, and social (Carter and Hall, 2012: 55-9). If, for instance, someone in the early stages of addiction has testing that reveals “red flag” conditions across a range of vulnerabilities, important information would appear to then be available in relation to her capacity in the future to control her consumption. What, really, is the predictive power of such information? That would appear to be the central epistemic difficulty, and much of what I say reflects the fraught nature of this question.

If we just focus on genetic screening, we see a number of problems. Consider the idea of mass genetic screening for vulnerability to lung cancer (Collins (1999)). It seems at least theoretically possible that we might identify those who are both at risk of becoming addicted to smoking and a cancer risk. Other identifications of addiction and physical disease also seem possible. This information would be important to have, but what do we do with it? Would we coerce people into “segregated” at-risk communities? Obviously not. Although there is evidence of a genetic *contribution* to the risk of developing an addiction, as Hall and Carter point out (2012: 199), (and many others, e.g., Khoury et al 2004), there is no gene for addiction. More specifically, “single alleles are poor predictors of addiction risk”, and testing for combined allele susceptibilities is not better than taking a family history.[[4]](#endnote-4) As they point out, this kind of identification – triaging through a family history filter – followed by further genetic testing might indeed serve to reveal persons who are at genuine high-risk for developing harmful addictions. What then? They argue that it might lead to teenage experimentation to *test* the veracity of the result, and others may feel freed up to then recklessly indulge. They also cite studies showing that those who have been tested for a genetic susceptibility to lung cancer do not modify their smoking behaviour in response. The take home message here is threefold: we must not rush in to screening en masse; we must be extremely clear about the *degree* of vulnerability to addiction of those persons whose vulnerabilities we do test; and finally, if there is to be a policy response to public health information on this data, it cannot rely on the decision-making capacities of those so identified to change their behaviour. In other words, on the face of it, there seems little point in some types of screening without a concomitant paternalistic plan.

The position I present, then, applies to an addiction subgroup of highly vulnerable people (‘addiction’ is an elastic term, and not all addicted persons are *highly* vulnerable), and I will suggest that, epistemic difficulties aside, there is at least an in-principle case for involuntary treatment in cases that fit very strict criteria. The test for coercive treatment in domains related to addiction is competence, and so I will preface discussion of our question by situating it in the wider literature related to competence.[[5]](#endnote-5) As we will see the standard justification for a judgement about competence in relation to addiction is problematic since the normal criteria (typically cognitive testing results) do not properly apply, and that is because addiction is centrally a defect of the will (Wallace 1999).[[6]](#endnote-6) The difficulty is that usually our evidence for competence derives from assessments of cognition based on how a patient presents in the clinic. A defect in the will cannot be assessed that way because such a defect is manifested as a longitudinal distortion involving cyclical failures of a person to control their consumption.

An important further preliminary is to state clearly what is meant here by ‘involuntary’ or ‘coerced’ treatment (I will use these terms interchangeably). First, these terms of course do not denote a single mode of forced admission into treatment. In reality, the pathway for a person with an addiction that has advanced to the point where treatment is being considered typically involves encounters with their family or employer, addiction professionals, the mental health system, the welfare sector, the police and criminal justice system, or other allied agencies.[[7]](#endnote-7) A decision over treatment – forced or not – will often then be a collective enterprise, and may involve input from several agencies and protracted negotiations between them and the addicted person. So the discussion here should not proceed with the naive presupposition that in general an addicted person may suddenly find themselves the subject of an inflexible treatment order imposed unilaterally.

Second, we may, technically, distinguish pure cases of compulsory treatment for addiction where the criminal justice system has not become involved, from cases where an addicted person finds themselves the subject of a court-ordered mandate.[[8]](#endnote-8) The position being discussed here has implications for both kinds of case, though with a stronger focus on the former. Later we will discuss the question of early intervention where it is more likely that the cases in question do not involve threats of jail on pain of refusal to accept treatment. The cases of compulsory treatment I mainly have in mind do not have to involve an ultimatum, and even for something called the alternative consequences model, Miller and Flaherty (2000:10) remark that

[a]s practiced, coerced...addiction treatment is rarely forced on the individual...In actuality, coercion occurs when an alcoholic, or drug abuser is given the choice to choose between an opportunity to comply with addiction treatment or receive the “alternative consequences” prescribed by the enforcement or the law, policy, or agency (e.g., jail time, or probation, loss of child or custody, loss or receipt of employment or benefits.)[[9]](#endnote-9)

Thus understood, coercive interventions where drug courts have become involved constitute a relatively common treatment practice for those whose addictions have led them to engagement with the non-medical agencies, such as police, mentioned above. The alternative consequences model presupposes an entry point to the system within the area of criminal justice. Drug *offenders* are diverted into drug treatment programs. Their perception of what is happening to them is tinged with a sense that the imposition is for wrongdoing. For jurisdictions that allow involuntary treatment for hardcore addiction cases simply on the basis of the harms of addiction, the entry point to the system is the health sector. It may be resisted and resented, but the perception is not that one’s treatment is the result of criminal wrongdoing. There are mixed data on the success of alternative consequences programs versus compulsory treatment programs of this latter type.[[10]](#endnote-10) This is due to two factors. First, the concept of success is not univocal when comparing outcomes. Sometimes it means staying clean; sometimes it means staying out of the criminal justice system. Second, there is great variety across the jurisdictions in the ways the different programs are instituted, and success in either sense mentioned above is highly sensitive to these modes of institution. To take a single example, in Victoria (Australia) the Severe Substance Dependence Treatment Act 2010 (the Act), was passed that:

...provides for the detention and treatment of people with severe substance dependence in a treatment centre where this is necessary as a matter of urgency to save the person’s life or prevent serious damage to their health. Detention must be the only means by which treatment can be provided and there must be no less restrictive means reasonably available to ensure the treatment. In addition, the person must be incapable of making decisions about their substance use and personal health, welfare and safety due primarily to their substance dependence. The purpose is to give the person access to medically-assisted withdrawal, time to recover, capacity to make decisions about their substance use, and the opportunity to engage in voluntary treatment. Detention and treatment must always be an option of last resort. Detention and treatment is limited to a maximum of 14 days.[[11]](#endnote-11)

Although too early to really determine its success at keeping addicts clean, treating doctors report that around 40% of those treated have remained abstinent. Tellingly, these doctors say that these relatively low rates would improve if detention times were *longer*. The lesson here is that involuntary treatment is better than no treatment, and rates of success improve by paying close attention to detail, such as the length of the detention period. This last point deserves great emphasis. A recurring theme in the literature on treatment of addiction, including compulsory treatment, is that success in terms of harm minimisation and just outcomes depends crucially on the detailed *ways* in which policy decisions are either enacted in law or implemented.[[12]](#endnote-12) In this connection, Wild (1999: 87) drew attention to the repeal of the 1978 *Heroin Treatment Act* in British Columbia within one year of implementation, due to constitutional and public perception problems. In this instance police powers to identify drug dependent individuals had the potential effect of removing a methadone-dependent mother from her family for six months (as was indeed argued in court on civil rights grounds by such an individual).

 A third distinction in this area is important for assessment of the success of compulsory treatment, viz., between a *perception* of being treated against one’s will on the one hand, and a treatment that is mandated by a referring agency.[[13]](#endnote-13) Wild (1999: 92) cites evidence supporting the claim that around 35% of court-mandated referrals did not involve a sense of coercion, while a similar percentage of “self-referrals” did report such a sense. Thus, the *perception* of coercion, something very important for treatment success, need not accompany actual coercion.

Now, given that the approaches I have described are already widespread, readers may wonder what motivates the present work. First, this is a position paper looking into the *philosophical-cum-ethical* underpinnings and justification of the practice in question. Second, if involuntary treatment of addicted persons is defensible, a *prima facie* case exists for *extension* of its use. And third, although what I say has implications for practices utilising the “alternative consequences” approach, the main question will focus on the philosophical justification of coercive treatment of persons just for their addiction. So the question here is: can we force a patient into treatment for their addiction, simply where that *addiction* is seriously harmful, though they otherwise have not broken the law, except in so far as they may be in possession of an illegal substance? If not – and I will present reasons for that case as well – why not?

The paper will proceed with an outline of competence and addiction, and then I will introduce a dilemma raised by our question: standard competence criteria do not regard addicted persons as incompetent; so treatment professionals seem powerless when an addicted patient refuses treatment only to then continue their habit which results in mortal harm or death. Thus: either they respect patient autonomy, adhering to a central tenet of medical ethics, and risk great harm to a patient; or, they override patient autonomy, thereby flouting an important professional ethic, and provide (forced) care to the patient.[[14]](#endnote-14) The suggestion to avoid this dilemma is to formulate *conative* competence criteria that are designed specifically for disorders of control, including addiction. Standard competence assessment tools currently measure synchronic cognitive capacities and are ill-suited for measuring task performance that has a diachronic dimension. Lastly, I will sketch some of the difficulties, conceptual and practical, arising from a policy that would allow coercive treatment of addicted individuals.

1. WHO ARE WE TALKING ABOUT?

The position presented here applies only to the hardest hit by addiction, and it is important at the very start to have a clear picture of this subgroup of addicted persons in terms of epidemiology, addiction neuroscience, and simply what things are like for this group, including the experiences of their families. (I don’t claim that the ‘hardcore’ form a subgroup, separable as a natural kind from others who experience milder addictions, although I think it is an interesting open empirical question whether such a natural kind exists.) Let’s begin with some description of what things are like for those at the high end[[15]](#endnote-15). Consider the following description from Crispin Sartwell.[[16]](#endnote-16)

Addiction, I tell you, isn't an epic tale of redemption, material for your amazing memoir and appearance on Oprah...It's dying by choking on your own vomit. It's common as excrement and as profound: reeking, valueless, purposeless, pointless, meaningless…My father was an alcoholic...He died of his addictions at 52, which I believe is longer than his own father lasted. I lost a brother in 1983 to an incomprehensible murder fueled by PCP...I lost a brother in 1991 to suicide by heroin overdose, after watching him turn from a hopeful little kid to an utterly despairing addict, a liar and a thief. My third and last brother spent five years in the state pen for armed robbery. He was a junkie, crackhead and so on, and then a recovering junkie, crackhead, and so on for many years. He expired two years ago in his sleep, his body ravaged by hepatitis, diabetes, and heart disease...Putting it mildly, I'm not alone in these sorts of experiences, and a lot of people have been through even worse. What it's like being a meth addicted person or actually dying of alcohol poisoning, I don't literally know, yet. But if you think people are doing things like that in order to feel good, I say you're crazy… (“Detritus.” – Crispin Sartwell)

Kennett (2013) uses this example in an attack on the claim that addictive actions are voluntarily chosen. For the voluntarist claim to carry weight, there has to be something about the object of a person’s motivation leading to their behaviour (in this case drugs or alcohol) of which the person can say something positive, and in a way that makes rational sense, *for him*. In other words, for the behaviour to fit within a kind of economic model – or rationalizing explanation-type – of motivated behaviour, we must view the world from the perspective of the consumer and see, from his point of view, the attractiveness of what he does. Sartwell’s account is not typical of all hardcore addicted persons to be sure, but neither does it mischaracterise the lives of many. And it is not just that the state an addicted person finds himself in can’t quite be made to fit with the voluntarist model, so that for those theorists supporting that model there is somehow a contestable thesis in play about genuine rational deliberation. That would misunderstand the fundamentally *a*rational condition of those, like Sartwell, I am describing as hardcore. Those who attempt to assimilate the behaviour of (apparent) addicted persons to the voluntarist model are certainly correct to do so across a range of milder, though still serious, cases, but the existence of such a heterogeneous group ought to motivate at least a prima facie acceptance of the distinction I am keen to bring into play between the hardcore and the rest. Yet, having said all that, let’s be clear: it is not the case that addictive actions are performed automatically; and they are not the product of irresistible desires. Sartwell’s hyperbole notwithstanding, I take it no one believes that persons well advanced down the path of an addiction lack completely something positive they can say about their substance of choice during consumption, and during the ritualised period to secure and deliver the drug of choice. An awful part of (unwilling) addiction is the loss of self-respect from recognising the kind of person one has become: endlessly chasing something worthless.

So, one certainly might object here that the emotional and political tone of Sartwell’s take on addiction is misleading in hinting that those with hardcore addictions *never* have anything positive to say about the object of their addiction.[[17]](#endnote-17) I agree of course that one can be at the high end of addiction – that is, in terms purely of impaired control – and not be facing the horrible circumstances described by Sartwell. To think otherwise would be to rule out the possibility, for example, of a rich, relatively rational, addict, with a regular clean source of a substance like heroin, who is besotted by the lifestyle. But how common is such a willing and able addict? It is very hard to know because such addicted persons do not typically register among standard epidemiological measurements where the focus is often on social determinants (socioeconomic status, homelessness, incarceration) and health.[[18]](#endnote-18) It is surely the case that a rich addict has more resources available to address their condition and this explains partly the slippage we see in diagnostic criteria in which usage despite negative consequences thereby places into the class of addicts the poor and homeless. This is not to say the rich do not use despite negative consequences, but, because of the law of diminishing marginal utilities, such consequences are far harsher and more salient for the poor. The effect of this is that the *definition* of addiction disproportionately includes poor people. Recognition of this fact makes it even more important to tread carefully in a context where we are considering coercive treatment of addicted persons.

Is there evidence from within addiction neuroscience for a hardcore subgroup of addicts? The literature is of course teeming with evidence which helps to explain the neurological changes that accompany addiction.[[19]](#endnote-19) A theory supporting the existence of a hardcore natural kind would combine evidence of genetic vulnerability with *highly generalised* social stressors, to be of any value as a predictive theory. But it seems it is too early to tell whether evidence exists for a natural kind difference, one of such magnitude that having hardcore property P (a genetic property) would predict an addiction pathway of monozygotic twins (who have P) separated at birth into very different family environments, though within common enough cultures that an addictive drug like heroin might be sought out with some effort.

A theory of the hardcore natural kind variety would have to presuppose a genetic vulnerability linked to a type-specific neurologic profile. It would, in addition, have to identify something in addition to the already well established neuroscience describing the ways in which addictive substances affect brain chemistry, thereby disrupting synchronic choice-making behaviour, as well as more long term habits in deliberation, planning and the capacity for imagining oneself in the future as a different person – a *non* addict. This last point seems important. There is anecdotal evidence that persons who defeat their addictions initially became able to imagine in some deep sense a sober future. The real possibility of personal change to sobriety is seen as a clearly imagined path of personal identity over time between an addicted stage thinking now and a future non-addicted stage. Conversely this possibility fails to be seen by someone in the grip of hardcore drug life.[[20]](#endnote-20)

On my reading of current neuroscience, there is no evidence for a hardcore subgroup of addicted persons. What we see from the epidemiological work is that most people, even with severe addictions, spontaneously remit. Yet these persons, and their families, may have experienced fifteen years or more dealing with their condition. Why didn’t they remit earlier? *Could* they have done so? The epidemiology cannot tell us. Moreover, it cannot explain the existence of the residue of persons who do not remit, and go on, sometimes into their 50s or 60s as addicted persons. What explains that? Something seems to be missing. Good models of addiction ought to incorporate genetic, neurological and psycho-social aetiologies. Addicted brains don’t live in disconnected vats, to be sure, but addictive social environments don’t contain cotton wool either.[[21]](#endnote-21)

Whether or not there is a neuro-biologically separable subgroup, the social evidence for such a group is strong. An important part of the social dimension is stigma. The hardcore subgroup contains individuals whose impaired control affects their identity to such an extent that it is extremely difficult for them to see a future containing themselves as a functional non-addict. Phenomenology aside, the social reasons for this are manifold, but three stand out: socio-economic disadvantage, homelessness and incarceration. Enough time spent as an addict when one is poor, homeless, in and out of detention, is physically damaging. Addicted persons’ health disadvantages further cement their sense of themselves as addicts. Stigmatisation exacerbates this. Erving Goffman (1963) argued that stigma took three forms, two of these being the negative stereotyping of physical deformity, and character deformity. The stigma concept originates from a Greek idea in which negatively regarded others – e.g., slaves, or criminals – had their skin literally marked for identification. Addicted persons who are poor and homeless often present to the social world as marked in both ways, with all the resulting ostracism, avoidance, and rejection. Gaining self-respect requires at least a toehold to begin the process, and the effect of stigmatisation is the removal of the places for it. Stigma is damaging to positive social personhood – that sense of identity others may reinforce long enough for genuine change to take hold.

Let me finish this section by addressing an objection one might raise.[[22]](#endnote-22) Since we are talking about compulsorily treating people with severe addictions we had better be sure not only that their addiction is what constitutes their incompetence (in some sense of that term), but also more basically that they do not make an unconstrained choice, in a cool moment of reflection, to regularly secure and consume their drug of choice. Perhaps they *choose* to do the very thing we thought was the product of their addiction in the same way one might choose to partake in activities related to some hobby, sport, or pastime. Certainly, the objector might continue, we cannot rule out such a possibility *a priori*, and indeed, surely there are real cases of persons whose behaviour appears addiction-like, but in fact this behaviour is competent rational choice-making for an addiction-like lifestyle. I reply that, yes, it seems mistaken to rule out such cases *a priori*, which is why any policy to treat addiction cases paternalistically must take care not to include them. But saying that disguises an epistemic difficulty: the behaviour of the willing participant and the addict may be hard to separate. The difficulty is that an addict *here and now* may express a preference against quitting, and a willing participant in the regular consumption of a substance may similarly express such a preference here and now. What divides the cases?

I make three points. First, I take seriously the diagnostic condition that addictive actions persist through negative consequences. The cases we are talking about are ones where persons present either in the medical or legal domains because their consumption has become severely dysfunctional. Does our willing participant rationally choose to continue despite such dysfunction? That’s certainly possible, but this tightened criterion increases our confidence that their numbers are lower than our objector might have thought. Second, let’s now suppose we are dealing with a *physically debilitated* person who claims to consume their drug of choice unhindered by the forces of addiction, yet whose family members (and perhaps other social members) attest to the extraordinary nature of the negative consequences his behaviour has brought about. Again, this makes it more likely we are not targeting the wrong group. Third, let’s ask whether it is at all plausible that this person – at risk of mortal harm and with a family member begging for help – has any genuine *insight* into his predicament. In particular, should this person here and now be given authority over the state of his future self when we know from other contexts that there are at least some people who have been coercively treated who later express endorsement of the treatment they received?[[23]](#endnote-23)

I do not rule out *a priori*, then, the possibility there might be persons who willingly consume large quantities of a substance (in ways identical to those we know are addicted), yet do not count as addicts. But my reply to the question of whether we can tell such a person from an addicted person is that questions of function, family relations and the like, and insight, provide an important guard against getting this wrong. Finally it must be added that coercive treatments in addiction are not forever. In many jurisdictions they are very brief periods of weeks. I am not persuaded by the force of this objection but it is nevertheless an extremely important one to be raised in the context of *getting the safeguards right*.

So, then, for this group: is there a sense in which their incompetence as agents provides a sufficient ground to treat them for addiction against their will?

1. COMPETENCE AND CONTEXT

As much literature points out, talking about competence in an unqualified way is not very helpful because, although the concept of competence has an intuitive baseline meaning, we need to know the specific task being invoked by that question.[[24]](#endnote-24) The baseline meaning of competence refers to a generalised aptitude to perform a task. The important questions in relation to competence in medicine and the law must specify the ways in which these aptitudes are being evaluated, for a particular population, and for the purposes of some institutional practice. Thus, we might begin by asking about the respects in which drug-addicted individuals are competent (or not), and what the purpose is in raising this question about them. The different contexts in which such a question is put matter a great deal to the test for competence. For example, readers may be familiar with a recent literature that discusses the question of whether drug addicted individuals are competent to *consent to research* in which they are prescribed heroin.[[25]](#endnote-25) In the present work we are asking whether addiction *per se* may provide grounds for *involuntary treatment*.

There is an alternative literature on this question, in relation to mentally ill patients, and I will make some direct comparisons to one highly relevant example there, the case of anorexia nervosa.[[26]](#endnote-26) Such cases are much trickier than ones involving psychoses because addiction (that is *addiction*, not its effects) is not thought to impair cognition; it is thought to disrupt the system of control. So before we get to the comparison to anorexia we should say something about voluntariness and control.

I am concerned here about an individual for whom the inclination to secure and consume their drug of choice forms part of what Edmund Henden (2012) has recently called “compulsive drug-oriented actions”. There is of course a large philosophical literature devoted to the question of whether addictive actions exemplify weakness of will or compulsion, and having an answer to this question has implications for choosing between the disease model (where compulsion is presupposed) or the moral model (where weak addictive behaviour is potentially blameworthy). Henden persuasively argues that once we recognise the patterned features of addictive behaviour – emanating from habit-laden inclinations (not irresistible desires) – we will see the right sense in which they may be understood as compulsions. The important point, Henden emphasises, is not to focus on the strength of the motivating states in addiction but rather the fact that,

...compulsive inclinations are triggered directly by environmental cues via a process that is dissociated from the person’s desires, deliberations, and, in many cases, even conscious beliefs. As a result of repetition and reinforcement they become entrenched. It is their frequency, cue-dependence, and dissociated nature, along with their disruptive impact on the normal psychological functioning of the person’s deliberative and volitional processes, which set them apart and make them more difficult to control. (2012: 10)

How difficult? At certain points in the narrative cycle of addiction the level of difficulty seems materially equivalent to what we might have believed under the ‘irresistible desires’ view. The difference, though, is that Henden provides a sense in which addictive actions are compelled, while not claiming such actions are, so to say, physically impossible to resist.

Competence in self control is a matter of exercising volitional resistance, which I take to be a dispositional property that comes in degrees. Understanding the degree to which one is conatively competent is a matter of knowing the various ways in which this disposition has been shaped, or indeed damaged, by one’s prior consumption. A hardcore addict’s self control has been compromised to the limit. To understand the degrees of control that are in play it is useful to register and compare different counterfactual situations for addicts and non addicts. So, for example, not being addicted to alcohol I often resist the inclination I might have for a drink. An alcoholic in the same circumstances – there’s a beer in the fridge, he thinks about consuming it, and no one is around to stop him – has less resources to effect the resistance. The alcoholic’s inclination and inability to deploy self-control techniques, exhausts his already frail resolve much more easily than I. There is empirical evidence for this view. Some readers will be familiar with work done by social psychologist Roy Baumeister (e.g., 2003) that tests subjects’ capacities to sustain resistance to a tempting stimulus under varying conditions of stress. A fairly robust and repeatable finding is that self control, like a muscle, tires, ultimately to the point of failure. If one is called upon to exercise one’s willpower – say attend to some will-sapping task – one’s later capacity to exercise willpower is diminished relative to controls who have not worked on an earlier will-sapping task. The implications for addiction appear to be that since the addicted person’s capacity for self-control is compromised already, in the form of unrelenting, invasive cravings that non-addicts do not experience, their resources for resisting temptation cannot match the non-addict. If I decide against drinking the beer in the fridge, I can spend the evening in peace, but a not-in-treatment alcoholic may spend the entire evening in a fight against temptation, a fight they almost always lose.

Because I am concerned here with hardcore addiction, the range of cases for which it is true (at some point in their addiction) the associated behaviour is said to be compelled is therefore, in my usage, fewer than the range of cases falling under the head of ‘addiction’ as it is normally used. This is important, for it means that arguments against the compulsion idea, using cases of addiction not falling within the hardcore sub population are straw man arguments.

Those in the so-called ‘liberal model’ camp such as Heyman (2009) or Foddy and Savulescu (2010), like to cite statistics showing the great rates at which (alleged) addicted persons voluntarily give up drugs. Typically this occurs in their thirties when they gain social responsibilities. This approach has been, in one sense, enormously helpful to the debate, partly because it provides a focus on ways to best characterise addiction sub populations. But what goes unremarked here are two important points. First, the question is: could these individuals voluntarily, and without social incentives, give up drugs prior to this? The answer is surely: maybe, maybe not. The question is an open empirical one. But it seems plausible *anecdotally* that many would find it extremely difficult, and plausible also from the accumulated data regarding the many addicted persons under the age of (around) thirty who in fact do not give up. Second, the claim the liberals make is not that voluntarily giving up is universal. What is plausible from the neuroscience is that those who do not, are unable to do so, given their particular brain-based vulnerability coupled with their social circumstances. The claim that individuals within this group *could* give up, is sometimes cashed by saying they *would* give up in different social circumstances. It is like saying that a victim who is held at gunpoint by a robber could refuse to hand over the money because there are some circumstances where she would do so (if say she needed the money to save the life of her child). Yes, in that circumstance she would refuse. But let’s suppose she is not in that circumstance. Then her choice there is highly constrained – this is the sense of ‘cannot’ that is relevant. But don’t say she *could* refuse there because she would refuse in some *other* circumstance, when it is known that this relevant behaviour-changing incentive is genuinely unavailable in the actual circumstance. (The example is from Foddy and Savulescu (2006: 6-7) who say the robber victim’s choice is not irresistible. But what matters here is that there is a kind of compulsion, as explained by Henden, for which resistance is all-but-impossible given the nearby worlds in which it is not exercised.)

Why have I spent so much time arguing against the misleading simplicity of the claim that addicted persons act voluntarily? Simply to show that if it is not true that hardcore cases are able to refrain from consumption – in the way described – no ground exists for claiming that at least in that sense they are up to task of self control.

I am wary and uncomfortable using the language of disease when talking about addiction. Are addicts, patients to be cured? The language is jarring, but is that all? Notwithstanding earlier speculation about kinds, part of the problem is the seemingly vague boundaries dividing the hardcore from the rest; there are also vague boundaries dividing a person in a recovery phase from her earlier addicted self (is a person clean for six months an addict?). Another part of the problem is the internalising effect of pathologization on treatment: an addicted person gets to blame their consumption on a disease (a negative effect), though this is balanced against their possibly gaining an insight into what they thought was moral weakness, that turns out to have a biological explanation (a positive effect). A third part of the problem is that re-framing addiction as a disease is disrespectful, because it seems to reduce much of their apparently voluntary behaviour to mechanisms that bypass the autonomous control of the person. Our view of the addicted person is now of a puppet with their drug of choice pulling the strings. Yet addicted persons aren’t puppets or zombies or anything like it, and obviously many lead interesting, active, artistic, even relatively responsible lives during full blown periods of addiction.

The disease ascription is fraught, then, unless we call into service our distinction between hardcore cases and the rest. As Sartwell’s description shows, many addicted persons lead horrible, hopeless, dangerous, boring, or soul-destroying lives.[[27]](#endnote-27) (And yes, some addicted persons do not; which reminds us that the heterogeneity in phenotypic expression of addiction is part of the problem of understanding it, or even assessing whether addiction itself is a kind.) But when focusing on the hardcore cases of extreme dysfunction my hesitation in calling addiction a disease wanes. It is also the case that many severely addicted persons themselves will (and do), in moments of candid reflection, agree with the disease tag; and although we should weight these claims with great care, an argument is required for the conclusion that we ought to discount *completely* the addicted person’s insight into the pathological nature of his affliction.[[28]](#endnote-28)

A residual complaint, though, is that the term ‘disease’ carries a connotation of a disease *entity*, such as a microbe, an infection that may be caught. Yet, although this is not a universal feature – diabetes, for example, involves no such entity – connotations are hard to shake. So perhaps ‘disorder’ is a better term; and after all diagnostic manuals use it, and indeed the term will be retained in the DSM V. There are advantages to be gained from considering the theoretical connections between certain disorders of control, such as kleptomania, and addiction. For example, kleptomaniacs do not steal out of self interest, but to relieve the itch to steal.[[29]](#endnote-29) They will often claim that they do not know why they do it, and this leads to self-loathing, frustration and depression. This is the case, at least anecdotally, for some addicted persons as well: they do not really know why they consume the substance that is wrecking their lives, and this leads to profound losses of self-respect. ‘Disorder’ also shares the important property of degree, and I note that the working group on DSM V have proposed a classification of addicts based on severity: mild, moderate and severe, depending on how many of the criteria for the condition are met. There does, then, appear to be some justification for using the description ‘brain disorder’ for the hardcore cases where we have patients with a special vulnerability to start with.

Returning to an earlier point: the specific respects in which competence issues (per se) are raised relate to what appear to be four salient contexts: a forensic context, in which drug-addicted individuals are subject to criminal proceedings (e.g., competence to stand trial), a civil legal context in which drug-addicted individuals must negotiate some legal or administrative dealing (e.g., enter into a contract, sign a will etc), a medical context in which a drug-addicted person is asked to participate in research (competence to give informed consent), and finally the context of particular focus here: a medical context in which a determination of incompetence provides sufficient warrant to institute an order of involuntary treatment (competence to refuse treatment).[[30]](#endnote-30)

In each of our four contexts, what we need to do is to make the basic meaning of competence operational by setting out standardized criteria for determining whether or not a person is competent to sign a contract, to give consent, or contrastingly, *in*competent, thereby rendering him or her a suitable patient for involuntary treatment, or a suitable person for whom an insanity provision applies. This last distinction would seem to nitpick, but we should notice that the first two contexts test a person to determine whether they are capable of rational thought or action – are they fit for some active role, can they do something? The last two ask something a little different – can we do something to them? Can we, for example, detain them in a treatment facility until it is clear their competence is restored? The distinction is important in real world settings because treatment and legal professionals usually act with a certain presumption about the state of mind of the person as it relates to competence.[[31]](#endnote-31) In many situations making a presumption is inevitable and understandable given certain background information about a person and where checking for competence has the de facto function of confirming a view, rather than truly testing it. Nevertheless many situations are not like this. When a preconceived view, often the product of unchecked habit, is brought into a context it represents hazards for those making a judgement if they allow their own agenda, or institutional interests to colour their opinion about the competence of a patient or an accused. Illegitimate presumptions about competence may sneak in. The suggestion here is not that there is a deliberate practice of second guessing competence ­– examples where this might be deliberate are surely in the minority – but rather that certain contexts dispose treating professionals to make a presupposition about competence, and that this sets up the conditions for mistakes to be made.

Informed consent settings give rise to a presumption of competence. Informed consent contexts are predicated on the need to respect autonomy because *giving consent* requires it. It is thought that competence is required to *process the information* in order that one’s decision to accept or refuse treatment is made cogently, specifically to evaluate the risks of treatment. This connection – between competence and autonomy – is the central one when we are considering the role of competence in the arena of the voluntary. In this context the presumption is that the person *is* competent, and we are *utilising* that condition in order to enable something else – their freely, and intelligently given permission to treat them or avail ourselves of their participation in some research. The context is different when there is a presumption, or at least the very strong suspicion, that the person *is not* competent. Consider, say, a forensic context, in which an accused is unfit to partake in criminal proceedings. What I will claim is that non-competent addicted persons are generally presumed to be competent given the context in which an assessment of their case is made, and that this presumption is ill-founded. It is ill-founded because it is based around the wrong criteria of cognitive ability, and so assessments will miss the defect that is really at the core of the incompetence.

I finish this section with a comment in relation to the importance of (largely) setting aside the *effects* of a substance when considering the competence of the *addicted* person. There is a set of paradigm cases of involuntary treatment and they are the mentally ill psychotic patients who are a danger to themselves or others, and it is this that warrants overriding in the strongest possible way the patient’s autonomy, or to be more accurate, *hypothetical* autonomy, for the patient’s psychosis renders them currently non-autonomous, and we are trying to restore their autonomy.[[32]](#endnote-32) There are cases from the world of substance dependence that we can assimilate to the psychotic examples we see in the mental health system. Consider, for example, a highly intoxicated delusional individual brought into a hospital after overdosing on methamphetamine. Yet the judgement to involuntarily treat in such cases is made easy only because the warrant for the order stems from their being a danger as a result of being drug-*affected*, not drug-addicted, notwithstanding the fact that their intoxication might not have occurred unless they had been addicted. When making judgements of competence in cases of addiction, then, it is always important to distinguish between drugs that by their nature distort a (substance) consumer’s perception and interpretation of their environment. Tobacco does not do this (notwithstanding its internal distorting effects on the will), but alcohol and crystal methamphetamine taken in sufficient quantities will. It is also important to add, obvious as it is, that the direct effects of a drug’s psychoactive properties on the consumer are distinct from the effects of withdrawal, and the effects on the consumer’s will prior to ingestion, such as an elevated valuing of the drug itself, or aspects of one’s environment that may help access to the drug, such as the local hotel.

1. HARDCORE CASES AND A DILEMMA

The role of the drug-adapted brain in disabling the will of an agent both synchronically and over time is critical in understanding why the choice model of addiction is oversimplified. In a recent critique of Heyman’s (2009) work Marc Lewis (2011: 150) nicely sums up much of the best recent work in relation to “cue-triggered wanting” and the role of dopamine.

...dopamine-based craving peaks when drug (or alcohol or gambling) rewards become available, in the moment, and this rapid increase in attractiveness pre-empts rational judgment...repeated dopamine enhancement modifies brain structures to maximize the appeal of addictive activities, minimize the appeal of competing rewards, and undermine the cognitive capacities to choose between them.

This is a story about the machinery of the will and of practical reason. Addiction neuroscience, says Lewis, is not opposed to a story about choice and the social factors that influence choice. Rather, having an understanding of what is going on neurologically fills out in the fullest possible way what constitutes the causal field within which the inclinations of an addictive action are undertaken. It is the damage to the machinery underpinning willpower that provides the critical evidence for claims about incompetence. Because of this damage, hardcore addicts lack an ability most of us possess which is to access, and consistently act on reasons over a period of time. Such diachronic agency enables the extended agent to have, or get, control for periods of their life where consumption is stopped or reduced.[[33]](#endnote-33)

Policies that sanction treating people against their will for an addiction are radical, and extending their application I suspect would be robustly opposed by many, certainly outside this field of work but also within it. The fundamental difficulty is that in western liberal democracies such as our own we may force treatment on persons who are *cognitively* incapacitated where it is clear and undeniable that such damage compromises their own and perhaps others’ liberty, and risks harm. So in law and psychiatry, persons may, and are, forcibly treated or detained when say belligerently drunk, or deluded, and (so) possibly dangerous. But a pattern of behaviour that harms no one but the consumer herself, where that behaviour does not place the consumer of drugs or others in any imminent danger of harm, almost never provides a sufficient ground for coercive medical treatment under our politico-legal system. To put it colloquially in relation to alcohol, in liberal societies individuals have the right to drink themselves to death. (Note here of course that we are assuming such individuals really are the only ones harmed, but this is almost always in fact false when nearest and dearest are involved. We are assuming also that great imprudence is not immoral. This is disputed by some Kantians.[[34]](#endnote-34))

Cognitive deficits, but not conative ones, justify a treatment order, even though both types have deleterious effects on the will.[[35]](#endnote-35) Why the difference? Partly, I suspect, because at presentation a cognitive deficit of a magnitude that threatens a patient’s understanding for consent is clear for all to see, but a loss of willpower can only be “seen” by repeated observations over a period in which a person might move from abuse of a drug to dependence on it. To call on an earlier distinction: faced with an obviously deluded patient who expresses the desire to harm herself or others we have no trouble judging that this person is incompetent and we may detain them; but the (hardcore) addicted person may present coherently during periods between intoxication and withdrawal. It is thus very difficult to make the presumption that such a person’s will is sufficiently disordered to warrant action that detains this person (against their presently expressed desires). The trouble is that a treating professional sees a temporal fragment of a patient that in the hardcore addict’s case grossly misrepresents the nature of the extended agent of which it is a part. That explains in this case the danger of a presumption of competence.

The problem, then, is that there appears to be a group of addiction patients for whom involuntary treatment is impermissible even where we know failure to treat them will result in great harm or death, and even though there is a sense – though not the relevant sense for legal purposes – in which these patients are incompetent. The trouble is they are incompetent at running their lives, and those are not the grounds we may cite to detain, or coerce a person.[[36]](#endnote-36)

This problem is not an isolated one. For, there are other patient groups in which the medical fraternity face a similar dilemma. One group are the anorexia nervosa patients, and indeed it was interest in those cases that partly motivated the present enquiry. Jillian Craigie (2009: 2) has highlighted the difficulty by identifying a clinical dilemma arising from, on the one hand a requirement of medical ethics to pay due respect to the autonomous wishes of an anorexic patient who may be refusing treatment, and on the other hand, in adhering to their refusal decision, placing that patient at great risk of further harm or death. Standard criteria for competence in these contexts – understanding and appreciating medical facts, reasoning, and expressing a choice – are insufficient to show that the patient with the anorexic condition is a candidate for involuntary treatment. Altering those criteria so that a desire for thinness (a hallmark of the condition) is deemed pathological would seem sensible but is fraught.

As Craigie points out, to deem certain preferences the product of a mentally disordered mind we run the grave and real risk of pathologizing what may be legitimate, though unusual values.[[37]](#endnote-37) Craigie mentions the fact that it was not until 1973 that homosexuality was removed from the DSM. Other cases can be found that often look like the misuse of medical authority to disguise unjustified moralising. Consider one of the more infamous cases of mis-pathologizing the practice of masturbation: in 1760 Samuel Auguste Tissot published “Onanism, or treatise on the diseases that result from self-abuse”.[[38]](#endnote-38) Tissot thought the practice produced ‘disorder’ and that secret and excessive ‘venery’ had ‘dangerous effects’. A century later, John Harvey Kellogg opined that:

Covering the organs with a cage has been practiced with entire success. A remedy which is almost always successful in small boys is circumcision, especially when there is any degree of phimosis. The operation should be performed by a surgeon without administering an anæsthetic, as the brief pain attending the operation will have a salutary effect upon the mind, especially if it be connected with the idea of punishment, as it may well be in some cases (1867: 295)
…In females, the author has found the application of pure carbolic acid to the clitoris an excellent means of allaying the abnormal excitement, and preventing the recurrence of the practice in those whose will-power has become so weakened that the patient is unable to exercise entire self-control. (1867: 297)

This amazing passage has a salutary effect on our minds: it represents a clear paradigm of the dangers of inserting culturally contingent or moralistic beliefs into medical criteria for judging mental disorder.

The challenge, then, is to define what it means to be competent without invoking controversial, potentially politically charged, or moralistic values, and to define it sufficiently robustly to capture cases in which failure to intervene leads to avoidable harms. It is useful here to first consider very clear cases that fit this schematic suggestion. Consider an agitated dishevelled patient who presents at a clinic with symptoms of an undifferentiated type of schizophrenia that is later shown to include disordered thoughts, paranoia and hallucinations. Here we have a clear example of someone assessable for involuntary hospitalisation. The salient moral grounds for involuntary treatment are that the patient is a high risk for self harm or harm to others. This case represents a clear paradigm of a condition in which the regard for the abnormality exhibited by the behaviour does *not* depend on cultural norms. Why? First, because the abnormality of schizophrenia is exhibited in all cultures and socioeconomic groups, and rates of occurrence are equivalent to one percent of a population (Versola-Russo 2006).[[39]](#endnote-39) These figures are stable because the abnormality arises from a biological mechanism whose operation is independent of cultural norms or memes. Human beings have experienced the harmful symptoms of schizophrenia for millennia prior to its cultural denotation by Eugen Bleuler in 1911, albeit symptoms not always filtered through the same social understanding. Did human beings experience the harmful symptoms of masturbation at any time other than its being marked out as harmful by a cultural belief? No; its occurrence *qua* (alleged) pathology is completely culturally determined.

Thus, we have here the hint of an important test with which to meet the challenge of the dilemma. In considering competence, the following counterfactual test ought to be heeded: when a person presents in a clinic with an alleged pathology, we need to consider what *would happen* to this person were we not to categorise them as incompetent and instead allow them to decide potentially against treatment and thereby subject themselves to the effects of their behaviour. Would they be harmed by this refusal? Would this harm be sufficiently great that the reasonable person would later regret his or her decision to remain untreated? Would this regret itself have a basis in reason?

Something like a test of this nature, admittedly difficult to operationalise, would provide a helpful addendum to competence criteria for those longitudinal cases where the pathology in question targets a person’s conative psychology.

1. THREE CASES

With this in mind let’s consider three cases of individuals who present for treatment where the treating professional faces a dilemma over whether to act against the person’s wishes. As we consider the cases it is worth bringing to bear each of the complexities we have discussed. First, what criteria of competence are relevant to the decision in relation to addiction? Second, what level of addiction do we have? Third, how does the distinction between drug-affectedness and drug-addiction figure in our judgement? Fourth, what presumptions regarding competence, if any, should we make? And fifth, how do the cases stack up against our counterfactual test?

*Case 1, the smoker*: A long term heavy smoker since his teenage years, Toby, now 50, visits a medical practitioner complaining of weight loss and increasing difficulty breathing. A recent cold has exacerbated his symptoms. The doctor takes the patient’s history and after examination establishes that the patient is suffering from chronic obstructive pulmonary disease. Toby’s condition is relatively advanced. His difficulty breathing was formerly only exertion-induced but now he finds it difficult even when resting. He experiences headaches and tiredness, and he has noticed some physical changes, blueness around the lips and an expanded chest. The doctor is worried that unless Toby ceases smoking his exacerbations will increase, and he may experience a severe airflow obstruction, and in the worst case he risks death. Toby says he is now more aware of the extent of his condition, and the risks of continuing to smoke. He says he has a lot to live for, and his family relies on him as a breadwinner. He does not want to die. But he has tried many times to quit his tobacco habit without success. He understands it is possible to quit, and that others seem able to, but he has come to believe that his own addiction is rather more severe than others. Besides, he enjoys smoking, particularly as most of his workmates also smoke and at the end of a hard day a drink and a cigarette with your buddies at the pub is one of the great pleasures in life, and one Toby does not plan on giving up any time soon.

*Case 2, the withdrawing alcoholic*: Beverly, 45 years of age, attends her local medical practice seeking treatment. She is known to the staff as a person diagnosed with a relatively severe alcohol dependence syndrome. It is clear from her clinical presentation that Beverley is in the throes of alcohol withdrawal, and is experiencing hallucinations, tremors, high pulse and sweats. She is visibly anxious and agitated. She consumed her last drink some 24 hours earlier, she thinks, and because pension day is not for another three days she has been unable to secure the alcohol she needs to prevent her current symptoms. The treating physician addresses her current symptoms, but she strongly believes that unless Beverly goes into a detoxification program with follow up rehabilitation her alcohol dependence will be fatal. However, Beverly’s desire is simply to alleviate her current symptoms to get her through to pension day so that she may purchase some cheap cask wine. Although expressed with a degree of uncertainty and incoherence she is apparently quite resistant to the doctor’s insistent urge for her to go into long term treatment.

*Case 3, the psychotic crystal methamphetamine addict*: Mathew, a 24 year old unemployed man, arrived at the emergency ward in a police car. He was dishevelled, disoriented, and aggressive. His appearance was typical of those addicted to crystal methamphetamine – abnormally thin, pallid complexion, facial sores. The police explained that he had been picked up after reports he had been wandering the streets and abusing passers-by. Mathew was sedated and then made comfortable. Later he explained he had been experiencing bugs crawling on or under his skin – a product of long term methamphetamine abuse – and the night he was picked up he had earlier overdosed and was experiencing disturbing delusions, voices compelling him to acts of abuse and violence. He also experienced some bizarre hallucinations, for example, he said he smelt his ‘brain rotting’. The treating doctor recognised that Mathew’s addiction was severe and it placed him at great risk of injury or death. After contacting his parents – by now at their wits end – the doctor contacted the drug and alcohol service attached to the hospital to enquire about a place. Subsequently after Mathew’s psychosis resolved he was strongly resistant to the idea of being put “in the nuthouse”; his craving still high, he just wanted to go back with his mates.

In Case 2 and Case 3, there is an intuitive and strong presumption that both Beverly and Mathew fulfil criteria for incompetence and a prima facie rationale exists for an involuntary order. Yet this intuitive response is based surely on a judgement that is substantially sourced via the psychotic symptoms at presentation. Are these relevant though? As earlier argued we need to place, as it were, a discount rate on what are the symptoms of drug affectedness, since they are the product of the addiction, not constitutive elements, which, as I have assumed throughout, requires neuropsychological changes that are highly compromising to volitional resistance. Ironically when Mathew apparently comes to his senses, expressing a desire to return to his mates (presumably to score again and get high), that is the evidence of note for incompetence that would justify a decision to force him into treatment for his addiction. For upon being told of his psychosis and behaviour (let’s assume he was told), he then insists that he should be returned into the situation that brought it all about. This insistence is part of a pattern of inclination despite negative consequences, and so it seems there is a case for regarding *it* as partly constituting the addiction, and so prima facie grounds for treatment.

Is Mathew’s decision properly responsive to the reasons that are available? Responsiveness of this kind is a matter of degree. It is one thing to entertain a reason, and another thing to appreciate its force, including its implications. We know from addiction neuroscience that chronic drug use: (1) heightens sensitivity to drug reward at the expense of conscious control, (2) distorts the evaluation processes in relation to a drug reward, and (3) may induce memories that are biased in favour of a drug. In other words there are neuro-biological changes that underpin the failure of deliberation here, and this provides a causal explanation – one that is outside the field of reasons – for the failure to make a choice that is in the best interests of the addicted individual.[[40]](#endnote-40)

It might be objected that since Mathew’s decision is not fundamentally different to other cases in which persons knowingly participate in activities that are risky and harmful – e.g., ocean yachting, extreme mountain climbing, and so on – we have no more right to intervene by force than in those cases.[[41]](#endnote-41) I reply, first, that we might well decide to prevent people by force from engaging in harmful activities once the scale of the harm became commensurate with what we see in severe addiction. We have to be very clear and careful when making these comparisons. The comparison in play here is not between, say, the dangers of horse riding and consuming MDMA (ecstasy). David Nutt (2012: 9) has made this comparison to make a point about the relative harms of these activities. The comparison for us, however, juxtaposes the harms of severeaddiction to a substance with habitually undertaken dangerous (though legal) recreational activities. Nutt provides evidence for the claim that taking one ecstasy pill is less dangerous than going horse riding on some occasion. The comparison we are making considers a cohort of severely addicted persons to a certain kind of drug and a cohort of fanatical mountain climbers (say). Now heroin is commonly thought more harmful than marijuana, and mountain climbing is more dangerous than say cycling. And even within these categories, batches of heroin vary in purity (and so the potential for harm), just as the normal route up Mount Everest – the South East Ridge, with a 7% fatality rate – is thought less dangerous than say climbing Mount Annapurna with a 41% fatality rate. The right comparison might then consider the relative harms of having a hardcore addiction to potent opiates to an obsession with climbing dangerously high mountains. Annapurna is the most dangerous mountain in the world, Everest the ninth most dangerous.[[42]](#endnote-42) Someone who obsessively climbs mountains won’t always climb these mountains, and so the fatality rates quoted above will be significantly lower when distributed over a full spread of mountain ascents across the lifetime of an average climber. On the other hand, severe addiction to a dangerous substance like alcohol, left untreated, is certain to reduce one’s lifespan by a considerable degree.[[43]](#endnote-43) There is, of course, an obvious difficulty in all this once we realise that the purpose of making the comparison is to ascertain the relative harms as a justification for coercing people into treatment to stop the activity. I am here claiming this justification obtains in severe addiction because of the relative levels of harm, and that it does not obtain for these other cases. But who, how many, and over what period of time, should count as belonging to a cohort of severely addicted persons? And who, how many, and over what period of time, should count as belonging to a cohort of participants in dangerous activities? It is not just a comparison between heroin and mountain climbing since my argument is supposed to support a principled distinction for the purposes of policy formation and drug law reform. It is frighteningly difficult to work out the constitutions of these cohorts and then to calculate the exact level of risk of harm. So all I can claim, based on the comparison of mountain climbing and hardcore alcoholism, is that the latter is much more harmful in relative terms, and to use this as a basis for the plausibility that all those with a severe addiction to a substance are in much greater danger than all those who habitually engage in legal, dangerous, recreational activities.

But I have other arguments. So, second, to make this analogy carefully we need to consider like-cases. The addicted person we are considering here has sustained a brutal and highly persistent pattern of drug-taking activity that has (typically) resulted in failed relationships, lost employment, and severely damaged health. They continue to take drugs, even though they find nothing to value about that activity. By contrast, the (possibly physically battered) round-the-world sailor almost always has something grand to say about that activity.[[44]](#endnote-44) In addition, we are not talking about an addiction group who willingly participates, as discussed before. Our group does not value in any way what they are doing, yet they also reject coercive treatment.

Third, although it is true that an extreme sport or activity may, like an addictive substance, give way to an organising principle for one’s life activities, there is something inherently “monochrome” about a drug delivery ritual, and this is something that is absent from the former. This is not a point about the planning of one’s life around the object of one’s dependence, but rather the fact that the dependence itself is boring, closed off, and repetitive. It doesn’t have much going for it as an activity, whereas the analogous cases mentioned here are stimulating (and remain so), unpredictable, open-ended, and challenging in ever-varying ways. A commitment to them involves a kind of narrative arc from novice to master. It is not a counter-response here to say that drug dependence also has these exciting or interesting elements. I am not talking about the early “party” years of addiction; I am not talking about substance use in response to an intellectual curiosity; nor am I talking about substance use as part-means to artistic expression. I am talking about addiction in which these kinds of concomitant elements play no role in motivating the addictive action. In short, I am talking about hardcore addictions as earlier defined.

 Fourth, notably even some who support the liberal model accept that drugs are the most likely of substances to cause addiction (Heyman 2009: 150). Lewis (2011: 152) explains why: “...the motivational thrust or urge associated with drugs results from the excessive and repeated dopaminergic highlighting of an experience that is enormously exciting or pleasurable. Drugs are designed for maximum hedonic impact. The greater the hedonic impact of a stimulus, and the more it is repeated, the more rapidly and intensely dopamine will amplify the salience of its cues.”

Now, returning to our cases, Toby the smoker is more difficult, for our intuitions are not being pumped by the features of psychosis that are present in the other cases. So, this case is a good test for working out whether a sound basis exists for involuntary treatment of a person whose addiction is extreme. On the face of it, the conditions are present for involuntary treatment. First, let us assume Toby is a hardcore case, with a neurological profile to match. Second, Toby is in real and imminent danger of mortal disease, and he is already significantly harmed by his habit. He appears a strong candidate to pass our counterfactual test. Third, it is not just Toby who has been, and will be harmed, for his family depends on him as father and breadwinner. Fourth, in the light of all these factors, Toby continues to assert his unwillingness to cease smoking. Again, as with Mathew, this seems not to be evidence of his competence, but rather, evidence of its opposite.

Is there a jurisdiction in any liberal democratic state in the world that would force Toby into treatment for his tobacco addiction? Not to my knowledge. Now if Beverley and Mathew should be subject to treatment of their condition against their expressed desires, then why not Toby? Either we are inconsistent in our approach or there is something morally relevant about cases 2 and 3 that we have not acknowledged. (One possible difference is that Toby is not exposed to the dangers of bingeing, dangers that are present in the other cases. We return to this below.) Yet the cases seem by and large similar enough as cases of addiction. The alcohol and methamphetamine cases involved a cognitive impairment *effect* in addition to drug addiction, but we already ruled that out. Still, a further possibility is that the conditions for involuntary treatment in these kinds of cases require the *conjunction* of an addiction with cyclic periods of cognitive dysfunction – during intoxication or withdrawal – brought on indirectly by that addiction. If that is the case, then indeed addiction *per se* cannot provide justification for involuntary treatment. Can this be right though? It seems likely that Toby will die without intervention because he lacks the will to rescue himself. It seems also true that a case such as his, and the others considered above, are not particularly rare.[[45]](#endnote-45) In other words, in our liberalized societies we currently lack a robust medico-legal institutional framework for an intervention that almost certainly will save many lives.

Having noted the similarities between the cases, to be absolutely clear: am I advocating the forced treatment of a patient like Toby? Absolutely not. We have arrived it seems at a philosophical impasse. Consistency would seem to suggest I am wrong and that the case of Toby is relevantly similar to those of Beverly and Mathew. Yet what may separate his case from the others is not something in the nature of the addiction itself, but rather something epistemic, and something particular to tobacco: because of its delivery method, and its lack of intoxicating properties, tobacco mortalities do not result from acute episodes the way, say, binges on alcohol do.[[46]](#endnote-46) Yet is this simple difference enough to think the tobacco case should escape scrutiny? That is hard to say but if it is not a sufficiently morally relevant difference this *may* be an interesting example of a significant social cost we tolerate in a liberal democratic state.

However, the question is: should we tolerate this social cost, given the benefits of the pleasures of smoking? Here is not the place to address that ethical question directly, but simply to acknowledge that the best harm minimization approaches, by a long stretch, depend on manipulation of supply and demand, through controls over packaging, distribution, tax and regulation. (The current work *assumes* the status quo.) It is noteworthy that while writing this article the High Court of Australia rejected a challenge by a consortium of tobacco companies against legislation by the Australian Federal Government for plain packaging of all tobacco products.[[47]](#endnote-47) This plain packaging measure means that no branding is possible on any tobacco product, eliminating the last place for direct advertising of tobacco in the country. The continued drop in smoking rates in Australia is gradually eliminating the need to make harder (at least prima facie) illiberal policy decisions on the demand side.

1. FORMULATING COMPETENCE CRITERIA IN ADDICTION

The basic challenge we have raised is to formulate criteria for competence in cases of hardcore addiction that would admit the right cases – those answering to our counterfactual test. As Craigie (2009) has demonstrated, the standard criteria for assessing competence in treatment settings are ill-suited to cases of anorexia nervosa in which a person at least appears sufficiently coherent, and autonomous. Prima facie this makes it extremely difficult in many cases to override their wishes. Things are even worse than this for treatment professionals however, because difficulties in judging competence already arise in all standard medical contexts, say, when a patient refuses life saving treatment. It is worth digressing from our main line of argument to consider such a case. I quote at length from an editorial by Irwin Kleinman in the Canadian Medical Association Journal where he mentions a case debated by the Royal College of Physicians and Surgeons in Canada:

A 52-year-old woman had a heart attack and within 4 days showed signs of acute mitral regurgitation. After initially refusing she agreed to undergo cardiac catheterization. The findings led the treating physician to tell her that she would die within days without mitral valve replacement. She refused the operation, and a psychiatrist was called in. He concluded that she had a personality disorder, and although frightened of dying she was probably more frightened of the surgery. He felt that she could be declared incompetent, although both he and the treating physician thought she understood the consequences of her action. The patient survived surgery and agreed to a second operation when the replacement valve failed a few months later. (Kleinman is here quoting from Chouinard 1988: 1180)

Kleinman goes on to recount the conclusion of the panel discussing the case which thought the physician acted inappropriately. He then reprises – I take it with scepticism – the argument ‘that one cannot overrule a competent patient’s decision on the chance that the person might be grateful later’. Kleinman sensibly goes on to express the view that a different definition of competence would pick up the emotional disturbance that was clear from the psychiatrist’s report and that seems relevant to the judgement of competence in this case. Clearly the patient’s anxiety had hindered her capacity to fully process the information needed to make a decision that would save her life. For, even though she (apparently) understood the fatal consequences of no surgery, she still refused the valve replacement – this is a case of an extraordinary bias towards the interests of a “local” person stage, and as such partially shares some features with our current topic. The case thus has important lessons: having an incomplete or inappropriate concept of competence may lead to the misapplication of criteria for treatment, or *ad hoc* decision-making in this area.

In formulating competence criteria for addiction it is worth reflecting again on the difficulty posed by the background political conditions of our liberal democratic setting. In this connection it is noteworthy that there remains a strain of thought, often sourced to the work of Thomas Szasz (1961), which is highly sceptical of the existence of mental illness, including addiction (Szasz (1997)). In recent times, Foddy and Savulescu (2006, 2010) have also argued for the highly liberal and relatively sceptical view that people habituated to the taking of potentially addictive drugs are no different, at least from a neuro-psychological perspective, to individuals habituated to any other kind of regular appetitive activity, such as extreme sports. So against this backdrop of not regarding addiction as some kind of pathology, consider how standard criteria for competence would almost certainly fail to test the defect in the will we find in the addiction cases. These include:

(1) an understanding of the relevant medical facts

(2) an appreciation of the relevance of medical facts to the patient

(3) an ability to reason, and

(4) an ability to communicate a decision

(Craigie 2009:2; Tan et al 2006: 268.)

These criteria are mirrored by the Macarthur model for competence that utilises something called the Macarthur Competence Assessment Tool—Treatment (MacCAT-T). The tool focuses on decision-making and choice. Roughly: (1) understanding information that is relevant to a condition and its treatment (2) reasoning about the potential risks and benefits of a choice (3) appreciating the nature of one’s situation and the consequences of making a choice (4) the ability to communicate a choice. (Grisso et al 1997)

Craigie has shown that what goes wrong in the case of the anorexic patient cannot be captured by such criteria, and that the incompetence must be located elsewhere as a failure to identify one’s values and to operationalise those values in a well-functioning system of practical rationality. What goes wrong in the case of addiction also cannot be captured by these criteria. Non-intoxicated addicted persons pass this test of competence, and even those in withdrawal may do so. What are needed, then, are criteria marking out the dysfunction in the will, and yet prior to this, it is important to be clear about what competence criteria are meant to do. Although such criteria should refer to those mental capacities that have been damaged or compromised, competence criteria and capacity criteria are not the same thing. Understood in the present context competence is a legal test. It should refer to *enough* losses in capacity to thereby warrant a statutorily constituted order for treatment; it does not have to identify all such losses. What justifies involuntary treatment at the core is the idea that the state acts as proxy decision-maker on behalf of a person for whom there is a systemic failure of decision-making capacity leading to significant harm. The anorexia and addiction cases are similar at this general level, though whether there is a single coherent and practicable formulation of competence criteria for both is doubtful.

Formulating competence criteria for (hardcore) addiction is going to be difficult, and the suggestion being put forward here is to be taken merely as a preliminary sketch. Because addiction is longitudinal, it makes no sense to try to ascertain a level of competence by asking a patient a set of questions to determine something about their present state of mind. Rather, a determination of competence should rely on records and testimony related to the history of a person’s addiction in combination with a brain imaging test, or tests. Medical records and testimony must show that the person meets some recognisable diagnostic criteria for a substance-related disorder. We need, in addition, objective evidence in the form of brain imaging results. Fowler et al (2007: 4) write that “[c]linicians may one day – perhaps sooner rather than later – use brain imaging to assess addiction, to assign patients to appropriate care interventions, and to monitor response to therapy.” Well, maybe. But surely a brain imaging test should be seen as necessary (but not sufficient) and that is partly to avoid the dangers of introducing culturally tainted criteria into competence testing. A counterfactual condition must obtain, that were such a patient not treated, significant harm would result. Brain imaging ensures a degree of certainty that the patient indeed has incurred damage from their addiction.

One might raise two objections here. First, one might object that a competence test is supposed to determine a patient’s aptitude for a task, and that these criteria do not test *that*. Rather, they identify functional deficits and behavioural changes. That is true, but it is a short step from those observances to an inference about a lack of competence. And after all, we already do this. For instance, we do not need to test a blind person for his or her aptitude as an air traffic controller. My own lack of cranial hirsuteness makes me a poor choice as a model for hair care products. We move easily from recognition of a functional, or biological, deficit, to a view about capacity, to a conclusion in relation to competence. Indeed, this is a good thing, since it provides a much more objective underpinning for a legal test of the sort we are concerned with here, and this is important given that the dangers of misusing such a test are lurking close by.

A second objection might go as follows. These criteria are designed to show that an addicted person is simply not capable of controlling their consumption. But what if they *recognise* this weakness? In its most extreme form some addicted persons simply give up on a vision for the future in recognition of the fact that their own future selves are not up to the task of carrying out a plan. Asked about how he saw himself in the future, one person said,

...No, not other than what I’ve just told you, that I’ve got to ... when I do that, if I plan for big things I find I get overwhelmed and I don’t do any of it, so what my caseworker and I are doing is baby steps...[[48]](#endnote-48)

Now one might say that this is (after all) cogent behaviour in so far as this person’s actions reflect an understanding of his limitations; so, no incompetence there! However, the person (fragment) speaking here is in treatment, reflecting upon their past incompetence in effectively carrying out their life plans. Far from evidence of competence his statement presupposes knowledge of his own incompetence.

1. ASPECTS OF THE PROBLEMS ATTENDING COERCIVE TREATMENT FOR ADDICTED PERSONS

The institution of coercive treatment for addicted persons raises the following questions. First, will it in fact work? (By ‘work’ here is meant to successfully treat a patient’s addiction for some significant period of time thereby removing the danger of mortal harm.[[49]](#endnote-49)) Second, how do we ensure that coercive treatment does not turn into *de facto* incarceration of drug addicts, a measure for the benefit and protection of the social order, rather than a measure that is to benefit the addicted person and her family? Third, how do we ensure that coercive treatment utilises a safe, legal pharmacological-cum-therapeutic means? Fourth, coercive treatment subjects addicted persons to a regime of forced detention during which they undergo medical treatments, potentially leading to resistance and a sense of deep resentment at what is taking place.[[50]](#endnote-50) Clearly, apart from the intrinsic disvalue of this, it potentially strongly undermines the effectiveness of any treatment.[[51]](#endnote-51) What measures can be utilised to prevent or minimise this? Fifth, if it works in late stage hardcore cases, then don’t we have good reason to coerce addicted individuals as part of an early intervention regime?

Clearly, having in place legally required protocols for treatment, and a court-supported appeals mechanism, would address to some extent a worry that hardcore addicted persons are being unsafely dealt with to remove them from society. However, this would still not overcome the problem of resentment, something that, it seems to me, is central if such programs are to work. Hall et al (2004) mention work done by Fox (1992) and Gerstein and Harwood (1990), in which the choices, say, of a defendant in a drug-related crime are “constrained”. As discussed earlier, in this system strong incentives are put in place to ensure a material outcome largely equivalent to an involuntary order, yet the rules of the system are so structured that the addicted person has a sense of having a stake in what happens, and so some semblance of control over her life. Now on the face of it, this could be interpreted as punitive because ‘constrained’ is really a weasel word for something else: the threat of jail for failure to undergo treatment. Yet it is nonetheless true that the offender must indeed choose, and so their *perception* of what in reality is a lighter form of coercion is significantly altered.[[52]](#endnote-52) As Hall et al put it (p1487), “There is some empirical support for these recommendations in that there is better evidence for the effectiveness of coerced treatment that requires some ‘voluntary interest’ by the offender”. This again reminds us of the importance of designing institutions carefully, and that treatment options need not be thought of as falling neatly either side of the voluntary/involuntary divide. Imaginative institutional arrangements can provide relatively effective solutions to what would otherwise be a problematic impasse.[[53]](#endnote-53)

Finally, consider our last point: if we did indeed develop careful protocols for the involuntary treatment of addicted persons (albeit late-stage hardcore addicts) it might seem tempting to move to a situation in which we intervene earlier. Two reasons might motivate such a change: (1) A legal framework would already be in place, and (2) Late stage interventions might seem to be too little too late, whereas early ones might well provide statistically much better long term outcomes for those who are vulnerable. Needless to say early forced interventions of this nature would face political and legal hurdles that are significantly higher than those involving what amount to late stage emergencies. This would be so particularly in the case of adult early interventions. Yet, a justification for early intervention teenage cases would seem available in extreme circumstances where parents, guardians, treating professionals, and the criminal justice system have tried and failed. The difficulty again is the capacity to predict the drug pathway of someone so young, and to disentangle the social conditions that dispose someone to addictive drugs from the neuro-psychological conditions. This distinction is critical to make for reasons we have already explored above: the slide from treating a person for the benefit of them and their family, to removing this person from society for the good of us, is a real one. If it is true that there is an identifiable profile revealing a person who is vulnerable to hardcore addiction regardless of their socio-economic position, this would go a long way to avoiding the illegitimate slide that is of no doubt a risk in the formulation of a public policy on this issue.

Though radical, early intervention involuntary treatment has a rationale that is not present in late stage cases. The whole point of treatment in these cases is to minimise harm to the patient and to save lives, and with late-stage cases like Toby, the damage may be advanced to the point of irreversibility so that clinical measures may simply delay the terminal phases of his emphysema. So, in such a case, isn’t the point of involuntary treatment now lost? The additional rationale in the early intervention cases is simply that it makes sense *then* to take an addicted adolescent out of the cycle of consumption and withdrawal because it is not too late to save a life.

Unfortunately, however, the earlier we might be emboldened to coerce a person into treatment, given the limited amount of damage already done, the less warrant we have to coerce them into treatment since the evidence for their irrationality is that they persist with their drug-taking behaviour despite the harm it does to them. Would this paradoxical situation be addressed once advances in neuroscience provide treatment professionals with a tool for identifying those patients at strong risk for developing substance dependence problems?[[54]](#endnote-54) What we lack are strong epistemic grounds for an order. Being able to identify an addiction neuro-profile, coupled with evidence of an emerging tendency to use and abuse drugs, would greatly assist those who might have to make difficult decisions in relation to a person for whom the current situation offers no help.

A final unavoidable element in consideration of widening addictions programs is cost. Indeed, it might be objected that the cost is prohibitive given the already-stretched nature of health budgets in most countries.[[55]](#endnote-55) This is of course a real and difficult problem, addressed perhaps by first instituting pilot programs that test the waters in two ways: first, how well do they work? Second, given our best actuarial estimates, will such a program, instituted more generally and over a long period of time, in fact *save* money? If the answers to these questions are ‘yes’ and ‘yes’, then one would envisage a gradual introduction in order to carefully monitor costs and benefits. In addition to this, there are the hidden savings from avoidable costs, for example, keeping a person in prison is more than four times the cost of treatment, and the avoidable health costs, such as HIV/AIDS are significant. As Gostin remarks (1991: 582), commenting on cost-benefit studies, “...every dollar spent on treatment will reap many more dollars because of reduced costs stemming from fewer arrests, prosecutions, and incarcerations and because of reduced social costs stemming from theft and the economic benefits of an improved labor market and reduced medical costs...”

1. CONCLUSION

The arguments considered here point to the following results. Any policy change that would introduce or extend coercive treatment of addicted persons needs to make a connection between competence and a vulnerable will; it needs to be evidence-based; and it needs to build in the necessary legal and institutional safeguards. Above all it must deal with two paradoxical inherent problems: coercion of adult addicted persons *for their addiction* is only justified when the addictive behaviour predictably will lead to harm to themselves or others, but then it seems too late, and so, pointless. Coercion into treatment of pre-adult addicted persons seems unjustified because it is at that point too early to really determine the extent of their addiction. However, at least in these cases, it is not too late, and politically early intervention is not *as* jarring to libertarian sensibilities in the way coercion of adults most definitely is. It seems, then, that increasing our evidence base for predicting vulnerable addicted persons is required before we may seek legislative changes. Until that occurs, despite having sound philosophical motivations, we currently lack good empirical grounds for making broader changes in this area.

It is hard to underestimate the fraught nature of this issue, yet the issue cannot be ignored either, since plainly there are many lives that might be saved if only an intervention had been sought that forced a person out of an addictive destructive cycle. With the advances in neuroscience we must anticipate a situation where we will come to have stronger evidence that this cycle may be avoided but only if we may force a person off the street and into the clinic. Is it worth the potential costs? That depends entirely on having a clear sense of what we mean when we say a drug addicted person is no longer competent, and it depends equally on making operational a system of enforcement that properly identifies the right cases, and pays close attention to any potential pitfalls or abuses in the system that would inevitably result if incorrectly implemented or mismanaged. These considerations need to be balanced against those of addicted persons and their loved ones, a demographic of huge proportions. All of these persons continue to walk along precariously close to the cliff-top we referred to at the start. This is the group whose interests and emotions are at the centre of our topic, so let me finish with a voice from that group[[56]](#endnote-56):

We need to band together and change the laws. Why is it voluntary to go to treatment? Why aren’t there more services in our government for families and teens? Jail is more expensive than rehabilitation. Yet the government will pay for jail but will mandate treatment but not pay for it. Most treatment programs last only 1 month...and we all know 1 month, or 1 treatment program is not effective...We need to save our children and this lost generation.

- Allie[[57]](#endnote-57)

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X. Notes

1. An Australian Institute of Health and Welfare report from 2007 reported that in Australia fatalities for opiate overdose alone range from around 100 deaths per million (1999) to around 30 deaths per million (2001). (See <http://www.aihw.gov.au/publication-detail/?id=32212254712&tab=2>.) These figures are dwarfed by both alcohol-related and tobacco-induced disease mortalities. The total figure for all drug and alcohol related mortalities, according to the National Drug Strategy survey currently averages around 1000 deaths per million head of population. See <http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/aaedt> [↑](#endnote-ref-1)
2. It’s also highly controversial. For a recent sustained and withering attack on the idea that neuroscience might provide evidential support for coerced treatment, see Wild et al (2012). [↑](#endnote-ref-2)
3. See, for example, Foddy and Savulescu (2006, 2010), Thomas Szasz (1961, 1997), Stanton Peele (2007). Stephen Morse (2012) rejects involuntary treatment because he thinks other non-coercive social measures ought to be put in place instead that are more cost-effective and less of a threat to liberty. [↑](#endnote-ref-3)
4. See Goldman et al (2005) for an analysis of heritability as well as timely warnings about the pitfalls of misinterpreting the studies, e.g., heritability claims need to distinguish genetic disposition to use compared with heritable dependencies, and they need to temper heritability claims with a recognition that subjects from similar (say) stressful social environments create higher exposure to non genetic addiction causes than less stressful environments (Hence the obvious importance here of carefully chosen and analysed twin studies.) Yet as they remark (p. 522), “[a]ddictions are among the most heritable of psychiatric disorder, as shown in studies of large, carefully characterized cohorts of twins from Virginia, USA and Australia. Heritabilities range from 0.39 (for hallucinogens) to 0.72 (for cocaine).” [↑](#endnote-ref-4)
5. As I later discuss, this depends on certain presumptions, that, e.g., this person is questionably competent in the first instance. Also, competence is not the only consideration, and in many jurisdictions the question is primarily one of danger and safety to the patient and others. [↑](#endnote-ref-5)
6. There is an important complexity here though. First, as Fowler et al (2007) show, addiction to alcohol and methamphetamine does damage cognitive systems, but as Matser et al (2000) have shown, so does boxing, and this level of damage does not render people sufficiently cognitively incompetent to justify coercive treatment. Second, neuro-adaptational changes in addicted persons are detrimental to their capacity for effective agency (having a non defective will let’s say) partly due to neural changes making them more sensitive to drug-related cues (Berridge and Aldridge 2008), and changes to the brain circuitry implicated in value and judgement (Goldstein and Volkow 2002). Addictive actions are in a sense *a*rational; there are alternative, non-addictive, and valued actions that, *systematically*, the addicted person does not find attractive enough to compete with the cigarettes, scotch, heroin etc. Wallace’s highly nuanced account views the addicted person as in a state of ‘intense and systemic temptation’ in which the agent chooses consumption that he believes is ill-advised (see 1999: 648). I agree with Wallace’s general approach involving addiction as a problem in the will, though I see the addictive agent as having been colonised more completely by an addictive substance than he does. Addictive routines lock a person into a pattern of behaviour that for long periods of time give way to a kind of continuity of dissociation from the things they may value. In this scenario the phenomenology of temptation, though present at the start, loses its salience. [↑](#endnote-ref-6)
7. An excellent taxonomy of the range of coercive measures can be found in Carter and Hall (2012: 135-6). [↑](#endnote-ref-7)
8. Gostin (1991: 565) called compulsory treatment not involving arrest or charge ‘pure civil commitment’. [↑](#endnote-ref-8)
9. The “alternative consequences” model is also referred to as “constrained choices”; I discuss the latter in the final section. [↑](#endnote-ref-9)
10. Cf. Gostin (1991: 577), Wild (1999: 91). [↑](#endnote-ref-10)
11. See <http://www.health.vic.gov.au/ssdta/index.htm> [↑](#endnote-ref-11)
12. See Gostin (1991: 579), Wild (1999: 88). [↑](#endnote-ref-12)
13. See Wild (1999: 92) who underscores the importance of this, though he uses the expression ‘coerced treatment’ to mean treatment where it is perceived as an imposition. [↑](#endnote-ref-13)
14. The dilemma is expressed clearly by Jillian Craigie (2009: 2). [↑](#endnote-ref-14)
15. An anonymous referee rightly objected to an earlier version of this article in which my only cited evidence for the existence of what I am calling hardcore addiction was the account by Sartwell as well as qualitative analyses of not-yet-published work involving interviews with addicts themselves. The question of whether addicts hold, at least to some extent, the object of their addictive inclinations, in positive regard is highly significant. Voluntarist, or liberal positions on addiction (e.g., Foddy and Savulescu (2006/2010)), and those with a reward account of addictive motivation (e.g., Ainslie (2001)), presuppose it. I won’t argue that addictive actions involve irresistible desires, and I agree that any account ought to admit that the object of substance dependence has *something* to be said for it from the addicted person’s perspective. [↑](#endnote-ref-15)
16. Thanks to Jeanette Kennett for pointing me towards Sartwell’s account. [↑](#endnote-ref-16)
17. An anonymous referee made just such an objection. [↑](#endnote-ref-17)
18. See Sandro Galea and David Vlahov (2002). [↑](#endnote-ref-18)
19. A small subset would include Bechara, A. 2005; Berridge, K.C., & Aldridge, J.W. 2008; Goldstein, R.Z., & Volkow, N.D. 2002; Hyman, S. E. (2005); Leshner, A. 1997; Lewis, Marc. 2007; Volkow, N.D. and Ti, T.K. 2004. [↑](#endnote-ref-19)
20. The points here are made salient in Marc Lewis’s recent (2011) book (see especially p. 295). George Graham discusses the converse possibility explicitly in an upcoming commentary on Gabriel Segal’s target piece “Alcoholism, Disease and Insanity” to appear in *Philosophy, Psychiatry and Psychology*. [↑](#endnote-ref-20)
21. See Marc Lewis (2007) for an excellent and careful expression of the false dichotomy argument. [↑](#endnote-ref-21)
22. The objection I discuss here is one an anonymous referee did raise. [↑](#endnote-ref-22)
23. See Craigie (2009) [↑](#endnote-ref-23)
24. See for example Tom L. Beauchamp & James F. Childress (1994: 134), or Robert Young (2007: 147). [↑](#endnote-ref-24)
25. A 2002 issue of *American Journal of Bioethics* contained a target article by Louis Charland titled “Cynthia’s dilemma: consenting to heroin prescription”, together with commentaries. Charland argued that heroin-addicted persons were not competent and so unable to provide informed consent for the prescription of heroin as treatment for their condition. I will not here discuss the very specific case of heroin prescription. [↑](#endnote-ref-25)
26. See Tan et al., 2006. [↑](#endnote-ref-26)
27. Owen Flanagan talks about such losses in an account of his own addiction. See his (2011). [↑](#endnote-ref-27)
28. This is confirmed from personally interviewing addicted persons across a range of drug types in a current study using empirical methods to analyse questions about moral identity. How do addicted persons view themselves in moral terms? There are many other valuable anecdotal sources. The case of Ben is particularly instructive, since it involves long term addiction with repeated lost opportunities for getting control. See http://www.youtube.com/watch?v=7thZbHTvZIQ [↑](#endnote-ref-28)
29. DSM IV – TR, p669. [↑](#endnote-ref-29)
30. These are contexts individuated on the basis of the significant moral considerations in play. Legally, the test for competence may collapse the last two mentioned. Thanks here to Jill Craigie. [↑](#endnote-ref-30)
31. I am speaking here about the de facto situation. The legal situation is a separate yet relevant one. The jurisdictions with which I am familiar contain a legal presumption of competence and this of course disposes treatment professionals and legal actors accordingly for it places the onus on those professionals to demonstrate non-competence. In general we should therefore expect professionals’ de facto presumptions to be affected by this knowledge. [↑](#endnote-ref-31)
32. This distinction is very important for the justification of coercion. If we are restoring a patient’s autonomy, then we are not overriding their autonomy in so far as it might obtain for this person here and now. So, paternalism is *not* the right concept we should appeal to in justifying coercion in these cases; rather the appeal must be in line with more general public health/public goods criteria. [↑](#endnote-ref-32)
33. An anonymous referee wondered whether a failure of practical reason amounted to a failure of cognition, in which case, it does not look like addiction is the central problem after all. The failures we are talking about are typically due to what the neuroscientists call hyper-salience of drug reward cues that have the effect of focusing the addict away from alternative options, as well as discounting non-drugs rewards in the further future. That’s partly what it means here to have a defective will. Unfortunately, however, the territory here is slightly complicated by the fact that certain drugs do indeed bring about cognitive deficiencies (outside the period of intoxication), and an obvious example is the effects on memory of chronic alcohol intake, for example amnesia or confabulation in Korsakoff’s syndrome. (See Marlene Oscar-Berman (2012) for a discussion of its effects on control and executive functioning.) [↑](#endnote-ref-33)
34. For example, Christine Korsgaard (1989: 125) [↑](#endnote-ref-34)
35. The difficulty is mirrored in the criminal context where successive formulations of the insanity provisions in criminal codes have vacillated over inclusion of a volitional component in which an alleged offender’s incapacity to conform his or her conduct to the law may lead (in extremely rare circumstances it should be said) to a ‘not guilty’ verdict. For an account of the issue and the history of the insanity provision see Matthews (2004) [↑](#endnote-ref-35)
36. Cf. Gary Watson (1999: 589): “One of the main objections to criminalizing the use of certain addictive...substances is that doing so is illiberal: it interferes unduly with the liberty of citizens to govern their own lives as they will.” [↑](#endnote-ref-36)
37. A background debate to all of this arises in questions about whether defining disease is a purely scientific enterprise or a (partially) normative one. My own view is that it is ineliminably normative, because the starting point – the state of being well – is normative, and we can only understand that something is pathological set against this norm that provides the initial point of comparison. (Of course, *that* argument is question-begging, but there is no space here for a non-circular justification.) [↑](#endnote-ref-37)
38. At least, this was the English translation from the original *L’onanisme: Dissertation sur les maladies produites par la masturbation*. [↑](#endnote-ref-38)
39. This is not to claim that there are not cultural variations expressed through the course of the disease. For instance, catatonia appears more prevalent in patients in developing countries compared with developed countries. See Jablensky et al. [↑](#endnote-ref-39)
40. Cf. A.D. Redish et al on the question of vulnerabilities in decision-making capacity from addiction. [↑](#endnote-ref-40)
41. An anonymous referee raised such an objection. [↑](#endnote-ref-41)
42. http://www.bogley.com/forum/showthread.php?45514-11-Most-Dangerous-Mountains-in-the-World. [↑](#endnote-ref-42)
43. See <http://pubs.niaaa.nih.gov/publications/arh27-1/39-51.htm>. This NIH epidemiological study describes both the chronic and acute effects of alcohol intake for males and females across three categories of mild, moderate and heavy drinking. It would be fair to say that all-cause mortalities in the high range would approximate to an alcoholic group described here as ‘hardcore’. [↑](#endnote-ref-43)
44. Indeed this author recently contributed to an edited collection on this very subject, in Patrick Goold (2012). [↑](#endnote-ref-44)
45. In western countries, lifetime prevalence rates for substance dependence disorder are in the order of 15% (Kessler et al, 2005). [↑](#endnote-ref-45)
46. Thanks to Jeanette Kennett for this suggestion. [↑](#endnote-ref-46)
47. See <http://www.hcourt.gov.au/assets/publications/judgment-summaries/2012/hca30-2012-08-15.pdf> [↑](#endnote-ref-47)
48. This was expressed by a participant as part of study funded by the Australian Research Council, entitled “Addiction, Moral Agency and Moral Identity”. [↑](#endnote-ref-48)
49. Despite my stipulation it is unfortunately easy to appear glib on this highly vexed question. In checking the available data on treatment success rates caveats are the order of the day. There are conceptual problems and measurement problems. Is one-year clean a significant period of time? From what, and relative to what? A good measurement would include a representative set of treatments from the same cohort. Does successful treatment mean controlled consumption or abstinence? Measuring either is difficult because of client anonymity, dropout rates, inconsistency in numbers at follow up, and evaluative differences between agencies. [↑](#endnote-ref-49)
50. Work done in relation to this issue using something called the MacArthur Perceived Coercion Scale showed that a critical element of treatment – regardless of its being legally voluntary or non-voluntary – is that the patient experiences it as instituted under a regime of procedural justice. Part of the procedure must allow the patient a voice, and an experience that includes respect, concern and good faith. See Poythress et al (2002). [↑](#endnote-ref-50)
51. David Farabee et al (1998) and Leukefeld and Tims (1988: 243) emphasize the unsurprisingly low treatment success rates when only external motivational measures are in place. This is particularly strong when an involuntary patient self-assesses as a recreational drug user, rather than someone with an addiction problem. [↑](#endnote-ref-51)
52. Cf. Poythress (2002). [↑](#endnote-ref-52)
53. An excellent example of this imaginative approach in the treatment of (adolescent) anorexia nervosa (AN) is the Maudsley approach, described here: <http://www.maudsleyparents.org/whatismaudsley.html>. In this approach the disease is externalised and ‘made the enemy’ and in the early phase of treatment the patient is not blamed for failing to eat. Families of adolescent AN sufferers are made allies with professionals and supported and coached around not blaming the patient while at the same time encouraged to “force” their child to re-feed by being verbally persistent at mealtimes to explain to the child that starvation is not an option. The model has many aspects of an involuntary approach, but is not monolithically coercive. It is reported to be extremely successful with nearly 90 percent recovery at five year follow up. [↑](#endnote-ref-53)
54. According to Wild, et al., (2012), the current state of neuroscience is insufficient for determining whether addicted persons are able to make treatment decisions. They are also pessimistic about an in-principle evidential connection between neuro-scientific findings and judgments about the effectiveness of coerced treatment itself. I haven’t spoken here about the latter, but their first claim is compatible with developments in neuroscience progressing to a favorable stage in which valuable insights may be gained. [↑](#endnote-ref-54)
55. An anonymous referee raised this. [↑](#endnote-ref-55)
56. See http://intervene.drugfree.org/2010/06/your-teen-drug-addict-on-the-fringe/ [↑](#endnote-ref-56)
57. I thank two anonymous referees for some very thorough and thoughtful treatment of an earlier version. Their objections to that version have forced me to re-think, and soften, my previous position, though I have sought to defend some of the claims originally asserted. But on the whole the very generous quantity of lucid feedback has greatly improved this article. [↑](#endnote-ref-57)