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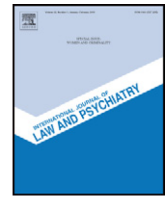

Commitment without confinement. Outpatient compulsory care for substance abuse, and severe mental disorder in Sweden

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ABSTRACT

In Sweden, a person with severe substance abuse or a severe mental disorder may be committed to compulsory care according to two different legislations. Both acts include an option of providing involuntary care outside the premises of an institution — care in other forms (COF) and compulsory community care (CCC), respectively. As co-occurring disorders are commonplace many individuals will be subject to both types of compulsory care. The structures of both legislations and their provisions for compulsory care in the community are therefore scrutinized and compared. Based on a distinction between "least restrictive" or "preventative" schemes the article compares COF and CCC in order to determine whether they serve different purposes. The analysis shows that COF and CCC both share the same avowed aims of reducing time spent in confinement and facilitating transition to voluntary care and the community. But they also serve different purposes, something which is reflected in disparate scopes, eligibility criteria, rules, and practices. Overall, COF was found to be a more "least restrictive" and CCC a more "preventative" scheme. The distinction is associated with COF being an established part of legislation on compulsory care for substance abuse with a universal scope and CCC being a recent addition to compulsory psychiatric care legislation with a selective character.

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1. Introduction

Following economic setbacks in Western welfare states from the 1970s on, deinstitutionalization came to set its mark on basically all welfare areas, aiming for shorter periods of hospitalization and more outpatient and community services (Becker & Vázquez-Barquero, 2001; Lerman, 1985; Tøssebro et al., 2012; Winick, 2003). Within the mental health and substance abuse fields this development was closely linked to the introduction of new treatment programs and the expansion of psychotropic drugs, greater awareness about the hazards of institutions, and ethical considerations. Even within involuntary frameworks treatment in the community has, then, become increasingly commonplace. Such provisions are known under different names internationally, e.g. compulsory community care, community treatment orders, involuntary outpatient treatment, and outpatient commitment (Geller, 2006; Hiday, 2003; O'Brien & Kydd, 2013; O'Brien, McKenna, & Kydd, 2009; Rugkåsa & Burns, 2009; Saks, 2003) — but will in this article generically be referred to as community treatment orders (CTO). Although provisions for temporary or conditional leaves and similar arrangements under civil commitment have been a longstanding practice in many jurisdictions, CTOs are usually described as a relatively new phenomenon. After being introduced in the United States in the 1960s, they remained a mainly North American and Australasian phenomenon until Scotland, England, Sweden, and France introduced them successively from 2005 on (Churchill, Owen, Singh, & Hotopf, 2007; O'Brien & Kydd, 2013; O'Brien et al., 2009; Winick, 2003). CTOs and conditional leaves may also co-exist, as in the case of two Canadian provinces — the difference being that a patient did not have to be hospitalized when committed to CTO. Moreover, unlike a conditional leave, the CTO patient would not have to meet the same involuntary criterion as an inpatient (Gray & O'Reilly, 2001).

CTOs have been widely debated, primarily in terms of efficacy, legality, and ethical considerations. Apart from ethical challenges related to any form of coercive care, questions have been raised about whether CTOs simply disguise coercion or perhaps impose even more far-reaching invasions of personal integrity because of their pervasive character (Dawson, 2006; O'Brien et al., 2009; Rugkåsa & Dawson, 2013). The discussion about CTOs has also been closely linked to a debate about whether deinstitutionalization is an apt description of developments in recent years, suggesting that *trans*-institutionalization and *re*-institutionalization are more valid concepts. Many studies have shown how former patients are simply found in prisons and other types of residential or institutional settings instead (Drake, 2013; Prins, 2011; Salize, Dressing, & Schanda, 2008), or end up in community care

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where cutbacks in welfare services have left them with little community and not much care (Hiday, 2003).

There has, however, been less attention paid to the actual construction of the CTOs and how they balance different considerations, assumptions, and expectations. The structure and organization of health care and social services is a reflection of interests, ideology, technology, resources, etc. However, eligibility criteria, models for financial reimbursements and monitoring systems and so forth are also important determinators of service delivery and outcomes (Flood & Fennell, 1995). In two rare studies of CTOs from this kind of structural perspective Dawson, Romans, Gibbs, and Ratter (2003) show how CTO legislation may be designed in a "self-defeating fashion from the start, i.e. in a manner that ensures its failure or nonuse" (p. 247). In another study he identifies "fault-lines" in CTOs and the varying use of CTOs in different jurisdictions (Dawson, 2006).

With a high frequency of co-occurring disorders ("dual diagnoses") and a wide array of social, mental, and physical problems (Chan, Dennis, & Funk, 2008; Flynn & Brown, 2008) mental health care patients are bound to come into contact with a range of services and legislations over a lifetime. The target group in question is therefore likely to be found in e.g. substance abuse treatment, mental health care, and in the criminal justice system — warranting a broad approach to treatment systems (Stenius, 2008). The aim of this article is, then, to compare the legislative structure of two forms of compulsory care in the community in Sweden aimed at persons with mental disorders and persons with severe substance abuse respectively: Compulsory community care (CCC) was introduced into the Compulsory Psychiatric Act in 2008, and so-called care in other forms (COF) has been a part of the Care for Substance Abusers (Special Provisions) Act since it was introduced in 1982. The comparison of these two provisions in terms of being "least restrictive" or "preventative" will shed light on how CTOs may be structured and ultimately serve different purposes.

The analysis is based on a close reading of the relevant laws and the documents that are part of their legislative histories (inquiries, propositions, and court rulings), statistics on and evaluations of the practice of COF and CCC, as well as international research in the field.

2. Compulsory care in an historical and international perspective

2.1. The history of involuntariness is the history of buildings and places

The involuntary placement of people with mental disorders and/or substance abuse has a long, but not particularly glorious, history. Compulsory treatment has usually been synonymous with *buildings*, also known as asylums, hospitals, prisons, workhouses, homes, or simply institutions. Asylums have existed since the Middle-Ages and were mainly used to deal with a nuisance, before the psychiatric discipline and the notion of the therapeutic institution started to emerge in the 18th century (Shorter, 1997). In contrast to modern-day understanding of asylum as protection from persecution, the asylum as a building is associated with filthy, overpopulated places in the outskirts of the community, where patients could spend their lives exposed to hard labor, maltreatment and dehumanization, fulfilling every criteria of a total institution (Goffman, 1961).

Services for persons with substance abuse or mental disorders are no exception from the general trend of deinstitutionalization during the past decades. However, comparative studies of changes in treatment systems, legislation, target groups, and outcomes are far more prevalent within the psychiatric field compared to the substance abuse field. One explanation may be that psychiatric services (compulsory or not) have historically also encompassed substance abusers (Edman & Stenius, 2014; Pritchard, Mugavin, & Swan, 2007) even though legislation on compulsory commitment for substance abusers is found in most countries. In many Western countries laws on compulsory incarceration were introduced during the first decades of the century as one of several responses to the growing social problem of excessive alcohol use. Even here the concept "asylum" was used, and the resemblance with mental asylums was not only nominal. Similar systems later evolved in Eastern European countries under communist rule, and also in East Asia following drug epidemics after World War II. The same societal processes as mentioned above led to an increased focus on therapeutic communities, outpatient programs, and community care models (Israelsson & Gerdner, 2010). Depending on the stated aim of the legislation and a country's political and social history, substance abusers may presently be committed to care within the criminal justice system or civil commitments within the mental health system or according to special (social) legislation (Porter, Argandoña, & Curran, 1999). In their study of 90 countries and territories, Israelsson and Gerdner (2010) found that laws on *civil* rehabilitative care were found in almost half the cases. They were mainly regulated by social or special law (64%) or by mental health law (33%). The latter implies that substance abuse be defined as a mental disorder (Edman & Stenius, 2014).

2.2. Compulsory care in Sweden

Health care and social services in Sweden are provided according to the principles of voluntariness and patient/client involvement. An individual may, however, be placed in care without his/her consent if an administrative court finds it necessary in order to protect the individual and/or others from physical, mental or social harm. Basically, compulsory care can be provided through the Care of Young Persons (Special Provisions) Act,[1] the Care of Substance Abusers (Special Provisions) Act,[2] or the Compulsory Psychiatric Care Act.[3] The two first laws are administered by the municipal social welfare system, and as such, an appendage to the general Social Services Act.[4] In this way Sweden belongs to the above mentioned group of countries with special (social) legislation on compulsory care for substance abusers. The latter act is administered by the health care system and is a supplement to the Health and Medical Services Act.[5] In all three cases applications must be sanctioned by an administrative court. According to court statistics for 2013 there were approximately 3700 cases filed for measures according to the Care for Young Persons (Special Provisions) Act, approximately 1250 applications for compulsory care of substance abusers, and just short of 13,000 cases filed for compulsory psychiatric care (National Courts Administration, 2014). Although substance abuse may be an issue in placements according to the Care of Young Persons (Special Provisions) Act, it will not be discussed any further in this article. Instead, this article focuses on compulsory care for substance abusers and compulsory psychiatric care — more specifically provisions within these acts whereby a person can be committed to compulsory care, but not physically placed in a designated closed

[1] Lag (1990:52) med särskilda bestämmelser om vård av unga (LVU). The law is directed towards persons under the age of 20 if he/she needs protection from a destructive home environment, or exposes him- or herself to substantial risk of harm through socially destructive behavior.

[2] *Lag (1988:870) om vård av missbrukare i vissa fall* (LVM). The first law was introduced in 1982, and revised in 1988. The previous Alcoholics Act and Temperance Care Act also allowed for the involuntary admission of alcoholics, but the new law focused on the need for care and also included drugs and volatile solvents (Edman, 2004; SOU, 2004:3). The legislation targets persons over the age of 18 and applications from the municipal social welfare board are tried in administrative courts. The preconditions for care under LVM are that a person who, due to abuse of alcohol, drugs or volatile solvents, is in need of care in order to break free from her/his abuse and that this care cannot be provided voluntarily. Moreover, the individual is, due to the abuse of substances either a) exposing his/her physical or mental health to serious harm, b) at obvious risk of destroying his/her life, or c) it can be feared that he/she may seriously harm him-/herself or significant others. The maximum period of commitment is six months.

[3] *Lag* (*1991:1128*) *om psykiatrisk tvångsvård* (LPT). Targets persons of all ages who are suffering from a severe mental disorder, where there is an acute risk to the person's own life or health, or for the safety, physical or mental health of other persons. Applications are made by a chief physician and are tried in administrative courts. There is no maximum time of care, but applications must be reassessed and renewed at certain intervals.

[4] *Socialtjänstlag* (2001:453).

[5] *Hälso- och sjukvårdslag* (1982:763).

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