This is the published version of a paper published in *International Journal of Law and Psychiatry*.

Citation for the original published paper (version of record):

Reitan, T. (2016)
Commitment without confinement: Outpatient compulsory care for substance abuse, and severe mental disorder in Sweden..
*International Journal of Law and Psychiatry*, 45(March/April): 60-69
https://doi.org/10.1016/j.ijlp.2016.02.011

Access to the published version may require subscription.

N.B. When citing this work, cite the original published paper.

This is an open access article under the CC BY-NC-ND license

Permanent link to this version:
http://urn.kb.se/resolve?urn=urn:nbn:se:sh:diva-32130
Commitment without confinement. Outpatient compulsory care for substance abuse, and severe mental disorder in Sweden

Therese Reitan *

National Board of Institutional Care, Statens institutionsstyrelse, Box 30224, S-104 25, Stockholm, Sweden
Centre for Social Research on Alcohol and Drugs (SoRAD), Stockholm University, S-106 91, Stockholm, Sweden

A R T I C L E   I N F O

Available online 21 February 2016

Keywords:
Mental health law
Substance abuse law
Involuntary treatment
Compulsory treatment orders
Comparative legislative analysis

A B S T R A C T

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.

© 2016 The Author. Published by Elsevier Ltd. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).

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 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; Rugkäsa & 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

* Tel.: +46 10 453 4019; fax: +46 10 453 4050.
E-mail addresses: therese.reitan@stat-inst.se, therese.reitan@sorad.su.se.

http://dx.doi.org/10.1016/j.ijlp.2016.02.011
0160-2527/© 2016 The Author. Published by Elsevier Ltd. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).
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 determinants 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, overcrowded 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 (LUV). 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 himself/her physically 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.


facility. According to Section 27 of the Care of Substance Abusers (Special Provisions) Act, a client committed to regular compulsory care is to be offered care outside the premises of the institution as soon as this is feasible — so called Care in Other Forms (COF). COF will typically be provided in an open facility or a family home, alternatively in outpatient programs while the client resides at home. According to Section 7 of the Compulsory Psychiatric Care Act, a patient can be committed to either traditional inpatient care or to Compulsory Community Care (CCC) following initial hospitalization.

The Swedish system, whereby substance use disorders without the presence of psychoses or other severe mental disorders, may be grounds for compulsory commitment to care, is often seen to be unique — even in a Nordic context (Israëllson, 2013; Lehto, 1994). It is, then, the compulsory care of substance abusers under social welfare legislation that has been subject to critical discussions both within the social work profession (Palm, 2009; Runquist, 2012), among policy makers, and in social science research (Hall et al., 2012). As will be discussed in the following, a recent government inquiry also suggested that the Care of Substance Abusers (Special Provisions) Act be abolished, and that compulsory care of substance abuse be provided through the “regular” compulsory psychiatric care legislation (SOU, 2011:35). However, it is more common than not, that countries have some form of legislation concerning compulsory commitments to care of persons with substance use problems, but these individuals are more commonly found within the criminal justice system or the mental health system in other countries (Israëllson, 2011; Israëllson & Gerdner, 2010, 2012; Lehto, 1994). The target group of these types of legislation will therefore be subject to similar forms of interventions and restrictions although in different contexts. Although the double-track Swedish system is unique in one sense, the question of how outpatient compulsory care may be organized is relevant for other systems and legislative structures as well.

3. The legislative history of COF and CCC

3.1. Compulsory care for substance abuse and care in other forms (COF)

From the onset, the avowed aim of the Care for Substance Abusers (Special Provisions) Act has been to disrupt life-threatening misuse of substances and to motivate the client to enter treatment voluntarily. The need for cooperation between compulsory care and voluntary care in order to reach these goals was emphasized at the time. Therefore, the client was to be offered an opportunity to initiate or maintain contact with outpatient programs or other caregivers during the period of commitment. This was one of the main reasons why the maximum period of commitment was increased from 2 to 6 months when a revised law was introduced in 1988 (Proposition, 1979/80:1; SOU, 1988/88:25).

Since its introduction the legislation on compulsory care for substance abuse has, then, included an explicit objective to offer clients care outside the institution. This provision is presently regulated in Section 27 and commonly referred to as “Section 27 care”, “Care in other forms”, or “Care in open forms”.

When the maximum length of stay was extended from 2 to 6 months in 1988, the phrasing of Section 15 (now Section 27) was changed from “should” to “shall”. Expanding the length of stay was controversial, but the “trade-off” was to impose an obligation for the caregiver to facilitate COF and the municipal social welfare board to provide COF. The idea was to enhance transition to the community and hopefully increase motivation for voluntary care after discharge (Proposition, 1987/88:147). In 1985, only one out of five clients received COF and the short duration of stay was often maintained as an important explanation.

The 1988 act made it possible to bring the client back to the institution if preconditions for COF were no longer present — typically due to a relapse or unauthorized absence from the designated care facility or program. Moreover, Section 29 was introduced by which the manager of the institution was to report if, and why, a placement in COF had not come about within three months. The intention was to follow up whether clients actually were being offered COF (Proposition, 1987/88:147). So, in “return” for extended duration of commitments, demands on care providers were tightened. Section 29 was repealed in 2005, but managers are still to report absent COF-placements within 3 months.

Clients who are committed to a regular, as opposed to an acute, placement are eligible for COF. Around 75 of these clients are placed in COF at least once during their period of commitment. A COF placement should ideally come about within three months and approximately half of them do. With an average time of placement of 5.7 months a typical client will be placed at the institution for the first 3 months or so, in COF for approximately the same time, and discharged shortly before the maximum period of commitment expires (National Board of Institutional Care, 2014; Reitan & Isaksson, 2014).

3.2. Compulsory psychiatric care and compulsory community care (CCC)

The Swedish legislation on compulsory psychiatric care from 1991 mirrors the growing concerns about the oppressive character of psychiatric services and greater emphasis on patient empowerment seen internationally. Provisional discharges were abolished but the new law included similar provisions for temporary leaves in order to facilitate transfers from hospital to community care. In 1998, a parliamentary committee expressed concern about temporary leaves appearing to have replaced provisional discharges. The committee suggested that a new form of care — community care with special provisions — be introduced. The time was not ripe, though. Instead additional restrictions on the use of temporary leaves were imposed, but to no avail — the number of long-term temporary leaves doubled over the next decade (Sjöström, Zetterberg, & Markström, 2011).\(^\text{10}\)

Within a short period in 2003 several fatal incidents occurred in Sweden involving men with mental problems. They all received extensive media coverage, particularly the murder of foreign minister Anna Lindh, sparking a renewed debate about the security of politicians and about psychiatric services. A national coordinator for psychiatric services was appointed, and in 2006 he proposed the introduction of CCC — community care with special provisions. The proposal was very similar to the one that had been rejected only 7 years earlier, but the arguments were obviously more convincing now. Revisions were passed in March 2008 and came into effect in September the same year (Sjöström et al., 2011). An excerpt of this legislative history is provided in Fig. 2.

CCC was meant to provide care for persons with severe mental disorders who would not accept necessary psychiatric care voluntarily, but who did not need to be hospitalized (Proposition, 2007/08:70). The aspiration was to give the patient an opportunity to prepare for and adapt to life outside the psychiatric facility (p. 74). Moreover, with individualized terms and conditions the level of coercion could be adjusted to avoid greater violation of integrity than absolutely necessary in order to provide required psychiatric care (p. 83).

An application for commitment to compulsory psychiatric care must now specify whether it concerns inpatient care or CCC. CCC can only

---

\(^6\) Vård i annan form.

\(^7\) Oppen psykiatrisk vårdsvård. A similar provision is also available for forensic patients under different legislation. This scheme will, however, not be discussed in this paper.

\(^8\) The correct legal term is, however, “care in other forms” — not to be confused with care in open forms when a client is e.g. moved to an open ward within the compulsory care facility.

\(^9\) Sections 2.5.2 and 2.6.2 in the National Board of Institutional Care (SIS) work delegation instruction, valid from June 1st, 2013.

\(^10\) Trial leaves were commonly used after being introduced in New Zealand in 1911 (O’Brien & Kydd, 2013) and leave of absence was used extensively in England and Wales before community treatment orders were introduced in 2008 (Rugkåsa & Burns, 2009).
come about after initial hospitalization and both forms of care are therefore based on the same basic prerequisite (see Fig. 2).

3.3. Proposed changes to COF and CCC in recent government inquiries

Two recent government inquiries have proposed changes to legislation which would directly or indirectly affect COF and CCC. In 2011 a government inquiry on care and treatment of risk use, substance abuse and dependency suggested that all somatic and psychosocial treatment be transferred to the county health care system, while the municipal social services should continue to provide psychosocial support. Therefore, the inquiry proposed that the Care of Substance Abusers (Special Provisions) Act be abolished and that compulsory care for substance abuse be provided within the framework of compulsory psychiatric care (SUO, 2011:35). In a brief paragraph on COF it was argued that a substantially larger part of compulsory care should be in more open forms and that COF was not a sufficient instrument in that regard. The proposals were not followed through by the government or the parliament, so no significant changes were made to the legislation on compulsory care for substance abuse in general or COF in particular (Proposition, 2012/13:77; Storbjörk, 2014a).

Only 2 months after CCC was introduced in 2008, yet another government inquiry was appointed to draft new legislation within compulsory psychiatric and forensic care. It was specifically asked to assess whether outpatient compulsory care should be made more available (Ministry of Social Affairs, 2008). The inquiry proposed two important changes concerning CCC: First, to avoid unnecessary hospitalization for required medical treatment compulsory measures should be allowed even in CCC. Second, commitment to CCC should be made possible without prior hospitalization (SOU, 2012:17). If so, Sweden would join Norway and New Zealand in an exclusive group of countries with such legislation (Norwegian Board of Health Supervision, 2006; O’Brien et al., 2009).

So far, the inquiry has resulted in two government bills on security, surveillance, and electronic communication at compulsory (forensic) psychiatric care facilities. A new government took office in September 2014 and at the time of writing it is not clear if, and when, a bill relating to CCC will be presented.

4. COF and CCC: same, same — but different?

Despite the obvious differences between COF and CCC – such as the legal frameworks they are part of, the professions and sectors they are administered by, and their histories – they also share sufficient similarities along these and other dimensions to warrant a systematic analysis of resemblances as well as disparities. This may be done in a number of ways, for example in terms of outcome and efficiency, stakeholders’ attitudes and variation in use of time and across jurisdictions, whether these legislations differ in their ability to protect human rights and ensure availability of necessary treatment, or how these schemes deal with social control/risk, and whether decisions are clinician or court-ordered. This study will not be dealing with questions concerning effectiveness or outcomes and only to a certain degree with the implementation and actual practices of COF and CCC. The focus is rather on the legislative design of COF and CCC. Based on a typology presented by Churchill et al. (2007), the question is whether COF or CCC can be characterized as “least restrictive”, alternatively “preventative” schemes — and ultimately whether they serve different purposes.

4.1. Compulsory treatment in the community: least restrictive or preventative?

Using the generic term “compulsory treatment orders” (CTO), Churchill et al. (2007) describe three general conceptual dimensions underpinning the design of CTOs: First, whether the criteria for CTO are the same as for traditional compulsory hospitalization. Criteria for outpatient commitments may e.g. specify that a certain number of recent hospital admissions are required (Dawson, 2006). Second, whether the objective of the CTO is to treat deterioration that has already occurred or to prevent deterioration from occurring. Third, whether the aim is to offer a least restrictive alternative to hospital for all patients or whether the aim is aimed at a specific group of patients, such as patients with “a classic revolving-door pattern of admissions” (Gray & O’Reilly, 2001, p. 319), to be used according to clinical and legal criteria and not, primarily, as a least restrictive alternative. Based on these three dimensions, the authors distinguish between “least restrictive” and “preventative” CTOs. The first category CTOs are seen to emanate from civil libertarian aims of offering community treatment as a less restrictive alternative to hospitalization, while preventative CTOs encompass a desire to implement measures intended to avoid predictable deterioration in a patient’s mental state resulting in dangerousness (p. 28).

A “least restrictive” CTO would, then, have the same criteria for outpatient and inpatient commitment, enable treatment for severe mental or substance abuse problems which have already deteriorated, and it would be aimed at any involuntary patient if appropriate. In contrast, a “preventative” CTO would have different criteria for outpatient and inpatient commitments, enable treatment to prevent deterioration of mental health or substance abuse, and provide “a tool in the therapeutic armamentarium” (p. 29) for specific indications.

A schematic comparison of the legal and administrative structures of COF and CCC is presented in Fig. 3. The characteristics of a “least restrictive” type of community treatment order, adapted from the Churchill et al. (2007) typology, are presented in the first three rows.

4.1.1. Shared eligibility criteria for inpatient and outpatient commitments

For substance abusers in compulsory care the criteria are shared for inpatient and outpatient commitments. The aim of COF is universal, in the sense that all eligible clients are to be offered care outside the institution as soon as this is feasible. The legislation therefore does not provide any particular criteria for COF. Likewise, as shown in Fig. 2, the eligibility criteria for CCC compared to inpatient commitment are formally the same and initial hospitalization is presently a prerequisite for CCC. Both COF and CCC are, then, in this sense “least restrictive”.

4.1.2. Response to deterioration or prevention of deterioration

This distinction may also be described as one between primary and secondary (tertiary) prevention (Chiriac, 2011). A client with an imminent risk of a relapse would not be legally disqualified from a placement in COF – but it would in practice not be compatible with the condition “as soon as it is possible with regards to the planned care and treatment” (see Fig. 1a). A COF placement is, then, not primarily a way of managing an imminent danger of a relapse. COF is in this context primarily a scheme used for clients whose condition is sufficiently improved after a serious downturn. For CCC, the situation is somewhat the opposite. Initially, CCC patients are committed to hospital care according to the same criteria as other patients and, hence, present a severe mental condition. The purpose of CCC itself, however, is more distinctly preventive. CCC was introduced as an alternative for e.g. persons with co-occurring mental disorders and substance abuse who need to “prevent relapses” or persons who need continued medication or other treatment in order to avoid falling back into self-destructive or threatening behavior (Proposition, 2007/08:70, p. 88). This is also reflected in the types of terms and conditions that may be specified when applying for CCC (see Fig. 2).

11 Despite the name — CCC is not associated with any literal coercion (judgment 1552–09 of the Supreme Administrative Court, announced July 5, 2010). The inquiry suggested allowing for forced medication, bringing the patient (back) to a psychiatric ward, testing of urine, breath, saliva, sweat, blood or hair, and bodily searches.

12 Placements in COF without prior hospitalization did occur until the early 1990s when the practice was deemed unlawful by Swedish Parliamentary Ombudsmen (SUO, 2004:3).
4.1.3. An alternative to hospitalization for any committed person?

The third essential feature in the Churchill et al. (2007) typology is the question of whether the CTO is a specific instrument formally or informally targeting specific groups, such as “revolving door patients”, rather than being a less restrictive alternative for any or most involuntary patients. As mentioned, COF targets all clients admitted according to Section 4 of the Care of Substance Abusers (Special Provisions) Act and failures to place a client in COF within a certain time period are to be reported and monitored. The legislative history of CCC suggests a more selective approach. The “revolving door patient” was mentioned as one potential target group for CCC, i.e. persons with serious and long-term mental disorders who have repeatedly been committed to compulsory psychiatric care because they have not been able to voluntarily manage their treatment in a satisfactory manner and therefore only able to reside in their own home provided they observe certain provisions (Proposition, 2007:08:70, p. 88).

4.2. Other restrictive and preventative features of COF and CCC

According to the three dimensions on which CTOs are categorized by Churchill et al. (2007), CCC is the more “preventative” and COF the “least restrictive”. In practice mixed features are not uncommon, and the differences between COF and CCC are not unanimously striking. In their overview of CTOs in different jurisdictions, the authors also include information about the year of introduction, possible duration, enforcement, and reciprocity arrangements, but these factors are not incorporated in the typology of “least restrictive” and “preventative”. In order to develop the typology further these and/or other features could therefore also be considered (see Fig. 3).

4.2.1. Heritage

The year of introduction may for example be quite relevant in this context; the fact that CCC was introduced to legislation at a later stage indicates its selective (“preventative”) character as an attempt to target a group of patients that were not previously being reached or cared for adequately. The fact that COF was part of the legislation from the beginning is indicative of a more universal (“least restrictive”) character.13

4.2.2. Decisions on placements and re-hospitalization

How or rather by who, decisions about placements and the terms and conditions of placements are made, is also relevant for the character

---

13 Thereby also recognizing that even the previous Temperance Care Act from 1955 included provisions for trial leaves of absence and parole from institutions (Runquist, 2012), and that provisions for hospital leave under civil commitment due to mental disorder has been a longstanding practice in many jurisdictions (Churchill et al., 2007; O’Brien & Kydd, 2013; O’Brien, et al., 2009; Winsick, 2003).

---

First Care of Substance Abusers (Special Provisions) Act, 1981 (number 1243)

Section 15 - A person who is in care under this law should, as soon as it is possible with consideration for the planned treatment, be given the opportunity to leave the institution where he has been admitted in order to be cared for in other forms or stay in his own home. (Repealed through Act 1988:870)

New Care of Substance Abusers (Special Provisions) Act, 1988 (number 870)

Section 27 - The manager of a compulsory care institution shall, as soon as it is possible with regards to the planned care and treatment, decide that the client shall be given the opportunity to reside outside the compulsory care institution for care in other forms.

The municipal board of social affairs shall ensure that such care is provided.

Section 28 - Before care in other forms commences the municipal social welfare board shall, after consultation with the client and the caregiver at the compulsory care institution, draw up a plan for the continued care and treatment.

Section 29 - If a client has been residing in a compulsory care institution for three months without being offered care in other forms, the manager shall report this to the institution’s board and state the reason for this. (Repealed through Act 2005:467)

Revised Act, 2005 (number 467)

Section 27 - The National Board of Institutional Care shall, as soon as this is possible considering the planned care and treatment, decide that the client be given the opportunity to reside outside the compulsory care institution for care in other forms.

The municipal board of social affairs shall ensure that such care is provided.

If the prerequisites for care in other forms no longer are present, the National Board of Institutional Care may decide that the substance abuser shall be brought back to the institution.

Section 28 - Before care in other forms commences, the municipal social welfare board shall, after consultation with the client and the National Board of Institutional Care, draw up a plan for the continued care and treatment.

---

Fig. 1. Legal regulation of COF in Care of Substance Abusers (Special Provisions) Act.
Compulsory Psychiatric Care Act 1991 (no 1128), revised 2008 (no 415)

Section 2[excerpt] Compulsory care according to this act is provided as compulsory inpatient psychiatric care or, after such care, as compulsory outpatient (“open”) psychiatric care. […] Compulsory care aims at enabling the patient to voluntarily participate in necessary care and receive the support he/she needs.

Section 3 Compulsory care can only be provided if the patient is suffering of a serious mental disorder and because of his/her mental condition and other personal circumstances
1. has an imperative need for psychiatric care, which cannot be catered for in any other way than by the patient being admitted to a health care facility with qualified psychiatric round-the-clock services (inpatient psychiatric compulsory care),
2. needs to observe special provisions to be able to receive necessary psychiatric care (open compulsory psychiatric care).

Care according to this act can only be provided if the patient refuses such care as mentioned in paragraph 1 or as a result of his/her mental state is substantial reason to believe that care cannot be provided with his or her consent.

Compulsory care cannot be provided if the patient’s mental disorder according to the first paragraph is solely associated with a mental disability.

Assessments of need for care according to paragraph 1 shall also consider whether the patient, as a consequence of his/her mental disorder, is dangerous to the personal security or physical or mental health of others.

Section 26 A person who is provided with open psychiatric compulsory care may reside outside the health care facility. When deciding on a commitment to open psychiatric compulsory care the court must prescribe the specific terms and conditions mentioned in Section 3, paragraph 1 that are to apply. The court may delegate to the chief physician to decide on these terms and conditions. If needed, the court may revoke this delegation. The specific terms and conditions may concern
- an obligation to comply with medication schemes or other care or treatment
- an obligation to keep in touch with a certain person
- an obligation to reside in a home or another institution for care or treatment, or to visit a health center or engage social services
- place of residence, dwelling, education, or employment
- ban on use of intoxicants
- restrictions on being in certain places or contacting certain persons,
- or other necessary terms which follow from the coordinated care plan.

Fig. 2. Legal regulation of CCC in Compulsory Psychiatric Care Act.

of a scheme. Are commitments, for example, clinician or court-ordered (Gray & O’Reilly, 2001)? The circumstance that CCC placements and eventual re-hospitalizations must pass through the administrative courts also points to the “preventative” or selective character of CCC compared to COF, even though the courts seldom oppose applications or clinical assessments (Sjöström et al., 2011; Zetterberg, Sjöström, & Markström, 2014). The proposal to allow placements in CCC without prior hospitalization (SOU, 2012:17) would be a further move in this direction, loosening the connection between CCC and inpatient compulsory care and potentially targeting a different group of patients.

4.2.3. Possibility for client/patient to refrain from placements in COF/CCC
Measuring the degree of “voluntariness” may seem misplaced in this context, but even in compulsory care there is room for client/patient participation or input. Tribunals or hearings where the individual may express his/her views on the commitment itself are explicitly described in most comparable legislations as are regulations concerning appeals, legal assistance, etc. (European Union Agency for Fundamental Rights, 2012; Rugkåsa & Burns, 2009). A psychiatric patient may not only oppose the commitment itself, but also the form of involuntary care. In practice the responsible clinician might also confer with the patient before suggesting a transfer to CCC. Clients in compulsory care for substance abusers may, however, fully reject a COF placement. Runquist (2012) has shown what power resources clients actually possess vis-à-vis the institution by challenging the caregiver’s goal attainment. The universal (“least restrictive”) character of COF is, then, accompanied by a formal and real opportunity for the client to turn down the offer. Although psychiatric patients are consulted about their wishes and preferences, they formally lack the opportunity to refrain from CCC.

4.2.4. Treatment and care plans, terms and conditions
Deinstitutionalization actually consists of two processes; moving patients out of hospitals, but also transferring hospital functions to

14 When introduced in France in 2011, judicial review was not needed if the patient was transferred to CCC within 15 days of hospitalization (Gourevitch, Brichant-Petitjean, Crocq & Petitjean, 2013). In New Zealand, commitments to community care were decided by a judge before gradually becoming the prerogative of medical practitioners (O’Brien & Kydd, 2013).

15 An evaluation of CCC showed that around a third of the patients were positive to, or had accepted, being placed in such care (SOU, 2012:17, p. 426).

16 Around 25% of eligible clients are not placed in COF. The main reasons are lack of adequate placement options, severe mental or somatic problems, or simply that the client objects (National Board of Institutional Care, 2014).
community settings. Many functions are easily transferred, but not the essential function of social control on which institutions were based (Geller, Fisher, Grudzinkas, Clayfield, & Lawlor, 2006). The expansion of community-based compulsory care has, then, entailed a formalization and explication of social control through written terms and conditions.

Section 28 of the Substance Abusers (Special Provisions) Act states that the municipal social welfare board is to set up a treatment and care plan in cooperation with the client and the National Board of Institutional Care before COF is initiated. The plan is not subject to a court trial and, albeit customary, there is no obligation to specify terms and conditions. An application for transfer of a patient to CCC/COF is by this measure also less restrictive than CCC, given the fact that no terms or conditions need to be stated, and the treatment plan does not have to be drawn up by municipal social welfare board, in consultation with SIS and the client, before COF is initiated. No obligation to specify terms and conditions.

Institutional Care before COF is initiated. The plan is not subject to a court trial and, albeit customary, there is no obligation to specify terms and conditions. The types of terms and conditions are specified in Section 26 of the Compulsory Psychiatric Care Act (see Fig. 2), and the court will decide on the terms and conditions or delegate the decision to the chief physician.

Table 1. A comparison between COF and CCC by level of restrictiveness.

<table>
<thead>
<tr>
<th></th>
<th>COF (Substance abuse)</th>
<th>CCC (Psychiatric care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same criteria as for inpatient commitment?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Response to deterioration (least restrictive) or prevention of deterioration?</td>
<td>Least restrictive</td>
<td>Prevention</td>
</tr>
<tr>
<td>Alternative to hospitalization for any committed person if appropriate?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Heritage</td>
<td>Included since first law was introduced in 1982</td>
<td>Introduced to Compulsory Psychiatric Care Act in 2008</td>
</tr>
<tr>
<td>Decision to place into COF/CCC or re-hospitalize</td>
<td>Manager at institution</td>
<td>Administrative court</td>
</tr>
<tr>
<td>Possible for client/patient to refrain from COF/CCC</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Treatment and care plan</td>
<td>Is to be drawn up by municipal social welfare board, in consultation with SIS and the client, before COF is initiated. No obligation to specify terms and conditions.</td>
<td>Coordinated plan for health care and social welfare is a prerequisite, including specification of terms and conditions by court or chief physician.</td>
</tr>
<tr>
<td>Terms and conditions</td>
<td>Abstaining from substance abuse/drug testing, compliance with treatment and care plan/rules and routines at treatment home or program.</td>
<td>Medication adherence, seeing doctor, keeping in touch with staff, allowing home visits, refraining from substance abuse, compliance with rules at certain home or program.</td>
</tr>
<tr>
<td>Coercive measures</td>
<td>Re-admission to institution if prerequisites for COF are no longer present</td>
<td>Re-hospitalization may take place if patient does not comply with terms and conditions, but not solely for this reason</td>
</tr>
<tr>
<td>Stated aim</td>
<td>To reduce time spent in secure facility, ease transition to community</td>
<td>To reduce time spent in secure facility, ease transition to community</td>
</tr>
</tbody>
</table>

By default CTOs are physically less obtrusive and “forceful”, and the use of coercive measures such as seclusion, restraints, coerced medication, body checks have, in the words of Dawson (2006), generally been “the Rubicon that should not be crossed” (p. 489). At present neither COF nor CCC allow for the use of such measures. Although the terms and conditions may include obtrusive measures such as drug

4.2.5. Coercive measures

By default CTOs are physically less obtrusive and “forceful”, and the use of coercive measures such as seclusion, restraints, coerced medication, body checks have, in the words of Dawson (2006), generally been “the Rubicon that should not be crossed” (p. 489). At present neither COF nor CCC allow for the use of such measures. Although the terms and conditions may include obtrusive measures such as drug

Table 1. A comparison between COF and CCC by level of restrictiveness.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>COF (Substance abuse)</th>
<th>CCC (Psychiatric care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same criteria as for inpatient commitment?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Response to deterioration (least restrictive) or prevention of deterioration?</td>
<td>Least restrictive</td>
<td>Prevention</td>
</tr>
<tr>
<td>Alternative to hospitalization for any committed person if appropriate?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Heritage</td>
<td>Included since first law was introduced in 1982</td>
<td>Introduced to Compulsory Psychiatric Care Act in 2008</td>
</tr>
<tr>
<td>Decision to place into COF/CCC or re-hospitalize</td>
<td>Manager at institution</td>
<td>Administrative court</td>
</tr>
<tr>
<td>Possible for client/patient to refrain from COF/CCC</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Treatment and care plan</td>
<td>Is to be drawn up by municipal social welfare board, in consultation with SIS and the client, before COF is initiated. No obligation to specify terms and conditions.</td>
<td>Coordinated plan for health care and social welfare is a prerequisite, including specification of terms and conditions by court or chief physician.</td>
</tr>
<tr>
<td>Terms and conditions</td>
<td>Abstaining from substance abuse/drug testing, compliance with treatment and care plan/rules and routines at treatment home or program.</td>
<td>Medication adherence, seeing doctor, keeping in touch with staff, allowing home visits, refraining from substance abuse, compliance with rules at certain home or program.</td>
</tr>
<tr>
<td>Coercive measures</td>
<td>Re-admission to institution if prerequisites for COF are no longer present</td>
<td>Re-hospitalization may take place if patient does not comply with terms and conditions, but not solely for this reason</td>
</tr>
<tr>
<td>Stated aim</td>
<td>To reduce time spent in secure facility, ease transition to community</td>
<td>To reduce time spent in secure facility, ease transition to community</td>
</tr>
</tbody>
</table>
tests, the only directly related sanction in COF is re-hospitalization. This is also associated with the universal aim of COF and the less formalized decision-making process. A client may have a number of COF placements within the same period of commitment and may in principle be replaced in COF the day after re-hospitalization. In CCC, sanctions cannot be imposed on patients who fail to comply with the specific provisions. Re-hospitalizations must go through the courts and cannot only be based on lack of compliance (Zetterberg et al., 2014). CCC may, then, be described as “less restrictive” than COF. The recent proposal would increase its “preventative” character; by enforcing certain measures the aim is to avert deterioration and consequent hospitalization.

4.2.6. Stated aim

COF and CCC share the same stated aim of reducing the time in confinement and ease transition to voluntary care and treatment in the community. These aims are both “less restrictive” and “preventative”: On the one hand, the aim is to reduce infringement on personal integrity by imposing fewer (physical) restrictions. On the other hand, the schemes are meant to prevent future deterioration of mental health or substance abuse by enabling participation in care and the community. The recent government inquiries have not challenged the basis aims of these two CTOs — namely “[to reduce number of days of confinement, and facilitate transition to subsequent voluntary care]” for substance abusers (SOU, 2011:35, p. 304) and making CCC more, not less, accessible for persons with severe mental disorders (SOU, 2012:17). Although limitations on liberty can be just as restrictive in a community setting (O’Brien et al., 2009), the underlying notion in both seem to be that outpatient provisions are less restrictive and therefore more appealing.

5. Summary and discussion

Sweden belongs to a group of countries with special (social) legislation on civil compulsory rehabilitative care for persons with severe substance abuse — in addition to civil compulsory psychiatric legislation (Israëlsson, 2013). Individuals with co-occurring mental health and substance use disorders may, then, experience commitments according to both the Substance Abuse (Special Provisions) Act and according to the Compulsory Psychiatric Care Act. Both pieces of legislation include an option of providing compulsory care outside a hospital facility: Care in Other Forms (COF) for substance abuser and Compulsory Community Care (CCC) for severe mental disorders.

Both schemes mirror international trends towards deinstitutionalization in past decades — even within compulsory care — known as “community treatment orders”, “compulsory community care”, etc. They often have historical links to previous provisions for temporary leaves and provisional discharges, but are formalized arrangements often based on an avowed aim of reducing time spent in confinement and facilitating transition to the community. Moreover, both schemes are heavily infused with both clinic and law, so to speak, and decisions profoundly rely on clinical assessments. Placements in CCC are formally decided by an administrative court, consisting of judges and laymen, but are based on assessments and investigations made by the social services. The application must also include a medical report by a doctor as well, thereby ensuring both social and medical assessments. Although there was a 25% increase in the number of applications for involuntary care compared to the previous year (perhaps indicating a lower threshold for applications), the approval rate was 84% in 2013 (National Board of Health and Welfare, 2014). Whether this indicates that courts are “rubber stamping” clinical judgments (Lipsky, 1980), or whether clinicians are able to present their cases in a sufficiently “legal” manner is of course not easily determined. It should also be pointed out that these cases are not solely decided by clinicians or professionals; laymen are represented in both the courts and in the social welfare boards that formally apply for involuntary care of substance abusers.

Although a recent government inquiry suggested that the separate legislation on compulsory care for substance abusers be abolished, the idea of compulsory care in the community was not challenged. Rather, it was argued that COF could not compare to CCC. This article has shown they are in fact comparable, but serve different purposes:

Based on a typology developed by Churchill et al. (2007) COF and CCC have been described and compared in terms of “least restrictive” or “preventative”. A “least restrictive” community treatment order targets in principle all committed persons and therefore shares the same criteria as for inpatient commitments. Logically, the more preventative schemes are, the more selective they are — with distinct criteria and greater room for professional discretion. Although these two schemes have mixed features, COF can be characterized as “least restrictive” in comparison with the more “preventative” CCC. The differences are essentially related to the universal scope of COF and the selective structure of CCC.

CCC was introduced to compulsory psychiatric care legislation almost two decades on. It provides a supplementary option for patients deemed to be in need of intensive social control, but not necessarily in need of hospitalization. The recent proposal to allow CCC without foregoing hospitalization would also accentuate CCC’s role as selective, or “preventative”, form of care potentially catering to a different target group. In 2013, some 13,000 applications were filed for compulsory psychiatric care in Swedish administrative courts (National Courts Administration, 2014). During a 2.5 year period in 2008–2011 approximately 1600 patients were transferred to CCC (National Board of Health and Welfare, 2011). Obviously, not all of the court applications were granted, but the proportion of CCCs is clearly insignificant in comparison. COF, on the other hand, has been a part of the compulsory care legislation since its introduction and is to be offered to all eligible clients. COF placements are consequently less formalized, and transfers between inpatient and outpatient care are commonplace.

Like most CTOs, both COF and CCC are associated with certain terms and conditions, usually instructing the individual to refrain from substances or to take psychotropic drugs, as well as general compliance with treatment programs or medical appointments. Breach of terms in COF will usually bring the client back to the institution. The client does have the right to reject a COF placement and thereby challenge the care provider’s goal attainment. In CCC, sanctions cannot be imposed on patients who fail to comply with the specific provisions. Re-hospitalization must be tried in court and cannot solely be based on lack of compliance. Apart from that, neither COF nor CCC allows for

---

17 Disruptions of placements in COF are reported annually (National Board of Institution-al Care, 2014). Most clients are brought back to the institution, but are often replaced in COF. This is similar to CTOs in England and Wales where a patient may be recalled to hospital for up to 72 h, after which the CTO must be continued or revoked (Rugkåsa & Burns, 2009).

18 Case studies of re-hospitalization after CCC showed that the main reasons were that the patient was not taking medication as prescribed or was misusing (other) drugs. Patients could be readmitted for a few hours or days, primarily for pharmaceutical treatment.

19 The number of patients in inpatient compulsory psychiatric care on a single day in 2008 was 904 (National Board of Health and Welfare, 2009). When it comes to the use of CCC there is a clear need to develop basic statistics. This would allow for an improved monitoring of this form of care and both regional and international comparisons of varying use of CTOs such as that provided by Dawson (2006).
use of coercive measures such as forced medication, restrictions, or body checks. The proposed introduction of certain coercive measures in CCC would increase its “preventative” (and selective) character.

The distinction between “less restrictive” and “preventative” proved to be useful in the context of Swedish compulsory care for psychiatric problems as well as substance abuse. Heritage, relative ease of transfers between inpatient and outpatient care, and the stated aims of the schemes (prevent deterioration or act upon deterioration) are other features of CTOs which could easily be added to the typology. COF and CCC are interesting from many perspectives. They represent attempts to alleviate the pressures of involuntary commitment. But, describing care and services in terms of “inpatient” or “outpatient” is partly dubious. Firstly, it does say much about the actual content of care. Secondly, care facilities also have become more “porous” as clients move between different degrees of openness during incarceration. Thirdly, community care may reproduce many of the less visible structures which were the initial object of reform (Perrings, 1994). The reality of that risk is basically an empirical question; which formal or informal terms apply and how, or if, are sanctions enforced? This is also a reminder of the importance of looking beyond the captions and headlines. Even core concepts as “voluntary” and “involuntary” are not clear-cut; the subjective experience of or objective level coercion and voluntariness may vary substantially (Larsson-Kronberg, Öjehagen, & Berglund, 2005; O’Donoghue et al., 2014; Runquist, 2012).

A judicially, clinically, and ethically challenging issue is related to timing. CCC’s preventive character is about imposing restrictions in the hope of avoiding future deterioration of mental health. But, it requires initial hospitalization which means CCC patients must present an imperative need for care in a facility. If a patient is soon transferred to CCC, it may be questionable whether this imperative need existed or if shortcuts are made when a patient is about to be placed in CCC. Allowing CCC without prior hospitalization could alleviate that problem, but possibly lower the threshold for commitments overall (Chiriac, 2011). There is a similar inherent problem with COF as placements can come about more or less directly after admission to compulsory care. How urgent was the need for care in closed facility to begin with if “outpatients are considered well enough to live outside the hospital” (Dawson, 2006, p. 485). COF and CCC tread on the thin line between fulfilling requirements concerning the manifest, while dealing with future risks. Closely related to this is the competency or capacity issue, which Dawson (2006) suggests is the major question of principle facing mental health law — particularly concerning involuntary outpatient care: Outpatients are considered well enough to live outside the hospital and although some may lack the competence to consent to psychiatric treatment, not all of them will. The right of patients to refuse further psychiatric treatment when their competence returns, is the principal fault-line dividing the CTO statutes in North America from those in Australasia and the UK (Dawson, 2006).

The most urgent and unanswered question is, nonetheless, whether different institutional arrangements for compulsory care tend to generate better quality of care and better outcomes. Although such studies are often hampered by e.g. small populations and wanting generalizability, partly due to strict research inclusion criteria (Storbjörk, 2014), a cross-sector approach could offer ways of increasing the potential study populations. The methodological difficulties of establishing the effects various schemes may have on outcomes are vast, at least if we think in terms of randomized controlled studies, but much more could definitely be done in terms of documentation and attempts to assess the clinical significance of various schemes (Gray & O’Reilly, 2001). There are but few studies that directly or indirectly discuss the clinical significance of CTOs in Sweden (e.g. Ekendahl, 2007; Hajighasemi, 2008; Hajighasemi & Bilsten, 2009; Lindahl, Berglund, & Tännö, 2013; National Board of Health and Welfare, 2010; Reitan & Isakszon, 2014; Runquist, 2012; Sjöström et al., 2011; Zetterberg et al., 2014). The access to elementary statistics on CCC is still very rudimentary, and the contents of COF are still largely unspecified. Filling these gaps are simple, but vital, preconditions for understanding the different worlds of care an individual with complex psychosocial and somatic problems may encounter and a precondition for knowledge based practice.

Acknowledgments

I wish to thank colleagues at the National Board of Institutional Care (Statens institutionssyfte) for helpful comments in an early stage of this work.

References
