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Modes and Impact of Coercive Inpatient Treatment for Drug-Related Conditions in Switzerland

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\textbf{Key Words}

Inpatient treatment · Illicit drugs · Court referral · Civil commitment · Treatment outcomes

\textbf{Abstract}

\textbf{Background:} Two forms of institutionalized pressure to treatment can be distinguished in Switzerland: civil commitment and court referral. In court referral, the referred patient has the right to refuse treatment. \textbf{Objectives:} To compare court referrals for inpatient treatment to voluntary therapy. \textbf{Methods:} Comparison of interviews at treatment entry and discharge records. \textbf{Results:} There were few systematic differences at entry except for voluntary subjects having had less contact with the legal system before treatment, independently of the specific court referral. At discharge, voluntary patients had a better social integration and fewer legal problems. \textbf{Discussion:} Legal problems waiting for court referrals at discharge may be a significant handicap for reintegration. Otherwise, voluntary patients and court referrals showed few systematic differences in inpatient treatment.

\textbf{Introduction}

Compulsory care and treatment for drug abuse and dependence include a range of legal, motivational and therapeutic interventions. Weisner [1] has called this the ‘coercive continuum’, with different types of drug treatment and degrees of pressure on drug users to enter and stay in treatment. In Switzerland, the ‘severest’ type of compulsory treatment for drug dependence is civil commitment, followed by referrals from the criminal justice system, workplace referrals and pressure from families and friends. Pressure for drug users to enter treatment may also stem from health problems or other drug-related problems without interference from others. In fact, some kind of motivational push is usually involved in any process of entering a treatment program. However, it makes sense to distinguish institutional forms of coercive treatment (based on legislation and defined procedures) from noninstitutional pressure by relatives or employers.
Types of Institutional Coercion

Swiss legislation provides two main types of institutional coercion for the care and treatment of individuals with drug problems.

The first type is civil commitment, based on the Swiss Civil Law (Schweizerisches Zivilgesetzbuch, Art. 397 ff.), called ‘Fürsorgerische Freiheitsentziehung’ (deprivation of liberty to provide care that otherwise cannot be provided). Such coercive care has to be provided in an ‘appropriate institution’ that has the necessary therapeutic infrastructure and competence. De facto, this type of civil commitment often means forced hospitalization for drug dependence in a psychiatric hospital.

The commitment can be ordered by a special authority that functions as a court in relation to matters of guardianship (Vormundschaftsgericht) or by physicians authorized by cantonal (canton = Swiss state) regulations or laws. Both special authority and physicians may also just refer the patients to treatment, and only if they refuse is civil commitment enacted.

Physicians must, in all cases of commitment, describe the problems and risks, based on a personal assessment of the patient. The main reasons for ordering civil commitment for drug-related problems are psychiatric conditions (delusional states, psychosis, amnesic syndromes, risk of suicide). The patient has the right to appeal to another court against the commitment [2].

The second type is a referral from the criminal justice system, referred to as court referral. Treatment by court referral is based on the Swiss Penal Code (Schweizerisches Strafgesetzbuch, Art. 44). The same provision is made for convictions on the basis of the Swiss Narcotic Law (Betäubungsmittelgesetz). A sentence of imprisonment can be suspended by the court in favor of admitting the convicted person to undergo treatment. However, physicians constitute less than 2% of the cases in 1998 [5]. Similar numbers were found for outpatient treatment of alcohol dependence. In terms of inpatient treatments for drug abuse, prevalence rates were in the same range including formal civil commitments. Treatment statistics between 1997 and 2000 reported prevalence rates from 0.8 to 3.6% [6–9].

A temporary utilization of civil commitment as an instrument to enforce detoxification of drug-dependent persons, who were arrested in an open drug scene, was started in early 1991 and evaluated in comparison to voluntary residential detoxifications in the same psychiatric hospital. This practice was discontinued after a few months on the basis of high relapse rates after discharge. Patients reappeared in the drug scene, so this application of civil commitment was found to be highly ineffective [10].

In sum, civil commitments have been rather rarely used for drug-dependent individuals in Switzerland, and additionally patients committed to treatment by civil commitment constitute a small minority among the patients in drug therapy.

Referrals from the criminal justice system (i.e. court referrals as defined above) to treatment programs are more prevalent, even though they only concern a small fraction of all convictions based on the Swiss Narcotic

Utilization of Coercive Treatment

There are no comprehensive national figures on the utilization of civil commitment for drug-related problems. The Canton of Zurich has released routine statistics that include such figures. According to the Research Report 2000, the proportion of civil commitments in contrast to voluntary (psychiatric) hospitalizations was 33% in general; for persons with drug dependence or other drug-related problems, no exact figure is available but is estimated to be lower [4].

In terms of outpatient treatment for opiate dependence (either heroin or methadone), referrals from the special authority that functions as a court in relation to matters of guardianship (Vormundschaftsgericht) or from entitled physicians constituted less than 2% of the cases in 1998 [5]. Similar numbers were found for outpatient treatment of alcohol dependence. In terms of inpatient treatments for drug abuse, prevalence rates were in the same range including formal civil commitments. Treatment statistics between 1997 and 2000 reported prevalence rates from 0.8 to 3.6% [6–9].

The second type of coercive treatment is therefore always an option that is not practicable without the (silent or expressed) consent of the convicted person or inmate. For this reason, some authors have not subsumed this form of treatment under coercive treatment. However, the alternative is a prison term, so the pressure on the individual to undergo treatment is quite high.

Compulsory Inpatient Treatment in Switzerland

Eur Addict Res 2002;8:78–83
Law. In 1986, 4.3% of all evaluated convictions from 6 major cantons were court referred [11]. In 1989, 3.7% of all offenders were referred to treatment [12]. In 1991, criminal justice system referrals consisted of 2.9% of all convictions (for consumption, trafficking and/or other offences), and in 1994, such referrals accounted for 2.8% of all convictions. The proportion of referrals varies considerably from canton to canton and varied between 0 and 18.5% in 1991, and between 1 and 12.5% in 1994 [13].

The early success of inpatient abstinence-oriented treatment in Switzerland [14, 15] has encouraged judges to make court referrals to treatment an alternative to prison. These referrals are partly against the ideology of abstinence-oriented institutions which have traditionally been based on autonomy and free will. In addition, court referrals have been directed towards methadone maintenance treatment, but up to the year 2000, more referrals went to inpatient institutions [16]. In terms of patient proportions, court referrals amounted to 4–6.5% in outpatient treatment for substance abuse in 1998 [5]. In inpatient drug therapy, court referrals constituted about one third of the clients in the years 1995–1998, compared to 7–8% of the alcohol inpatients and 4–5% of the inpatients in mixed settings. Withdrawal and transfer patients included less than 5% of referred patients (all figures in this paragraph from Herrmann et al. [16]).

This situation has led us to question the role of coerced treatment in inpatient treatment. Specifically two questions will be answered in this paper. Firstly, do court referrals differ systematically from voluntary inpatient treatment? Secondly, do court referral and voluntary patients differ with regard to the length of treatment and discharge characteristics?

**Methods**

**Sample**

All patients in the FOS treatment network who entered treatment between 1995 and 1999 were included in the analysis if they fulfilled the criteria listed below. The FOS treatment network has been described in detail elsewhere [8, 17].

**Criteria for Inclusion in this Analysis.** (a) Existence of treatment entry and discharge data: patients who had not yet finished treatment were excluded from the analysis. (b) Respondents who had indicated that the reason for treatment was a voluntary decision or court referral in the entry questionnaire were included. (c) Individuals with a record of civil commitment were excluded due to small numbers which would not have allowed meaningful statistical tests (see above), and because this group is markedly different from the court referral group.

Using these criteria 2,793 patients were included into the analysis (table 1). This sample covers 66.6% of all the treatment entries in Switzerland registered within the FOS treatment network.

**Operationalization**

Treatment entry and discharge data were collected within the treatment units, by trained staff as part of a routine assessment. At treatment entry, patients were interviewed by means of a standardized questionnaire; at discharge, a member of the staff reported data. The following variables were included into the analysis: sociodemographic characteristics, education, housing situation before treatment entry, social relationships, drug career, self-reported health status, treatment experiences, legal experiences, length of stay in current treatment, legal situation at discharge, housing situation at discharge, kind of discharge (regular vs. early).

**Statistical Analysis**

Three groups were separated: voluntary patients, who started therapy without either a court referral or being committed to treatment by civil commitment (VP for voluntary patients; n = 1,882 or 67.4% of the entire sample), patients who expected a court referral and thus started inpatient treatment (CRE for court referral expected; n = 427 or 15.3% of the sample) and patients with court referrals (CR for court referral; n = 484 or 17.3%). Differences between these groups were identified either with table analysis or in case of interval scaled variables with analysis of variance or covariance. As the sample size was large for these statistical tests and almost all of the differences were statistically significant without necessarily being meaningful, we selected an effect size of 20% difference or 1 SD for inclusion in the substantive results of this report. Sociodemographic differences are reported without this criterion.

**Results**

All details of the analysis can be found in a research report in German [18]. This contribution will only summarize the most important characteristics.
Compulsory Inpatient Treatment in Switzerland

Situation at Treatment Entry
In terms of sociodemographics, males were more prevalent than females in all three groups. The CR group had the highest proportion of males versus females compared to the other groups (VP 74.4%; CRE 85.9%; CR 86.0%). VP were also slightly older (less than a year difference) and comprised a higher proportion of Swiss citizens. All of these relations were statistically significant, which is not surprising given the high number of patients in each group.

In terms of the housing situation in the last year before treatment entry, VP were more likely to be living in or renting an apartment or their own house, to have never been institutionalized or to have undergone their last drug withdrawal in remand or in prison (fig. 1).

As expected, with regard to employment and financial situation in the year before treatment, self-referrals were more likely to have had salaried work to finance their living (fig. 2) on a short-term and long-term basis than the other groups.

Prior Treatment Experiences
In terms of prior treatment experiences, CR had fewer voluntary prior inpatient treatment experiences but more coerced ones (fig. 3).

In addition, VP had lower prevalence rates on all measured indicators with regard to legal experiences (fig. 4 for an overview).

Situation at Discharge
Contrary to expectations, there was no difference between the proportions of regular versus irregular dropouts between CR and VP. However, CR stayed in treatment significantly longer than VP (320 days with SD 224 vs.
277 days with SD 200). This finding may be explained by CR considering the prospect of having to go to prison in case of dropping out of treatment early. Also, VP more often had a place to live after discharge (VP 55.6%; CRE 35.6%; CR 39.5%). Another important difference concerned the legal situation at discharge, where VP had markedly fewer legal charges against them at discharge than CR (VP 23.7%; CRE 93.2%; CR 95%). In fact, almost all CR were facing a charge at discharge. No other criterion at discharge showed differences using the effect size criterion specified above. Patients relapsing during treatment were included in the analysis; there were however no significant differences between the groups with regard to overall consumption of addictive drugs (alcohol and tobacco included).

**Discussion**

VP showed some important differences from CR at treatment entry. In general and not surprisingly, VP seemed to have had less contact with the legal system before treatment independently of the specific treatment court referral. At treatment discharge, not many differences between the groups could be detected. VP seemed to be somewhat better integrated socially in terms of their living situation than the other groups. Otherwise, dropout rates did not differ significantly between the groups, and thus we do not expect drastic differences in treatment success. However, it depends on how treatment success is defined. One of the major concerns is the patients’ legal situation after discharge. At discharge from treatment,
CR (including CRE) are often subject to conditional release, patrol supervision, extended correctional measures, persisting charges or pending criminal charges. This may also be the case for VP, however to a much smaller degree (see above). One could speculate that persistent charges and suspended criminal sanctions against discharge patients could easily create situations to trigger relapse to drug use. However, only a follow-up study several months after treatment could possibly give conclusive evidence for this speculation.

Overall, the results indicate that the current situation in Switzerland with court referrals to inpatient treatment seems to work. Patients referred by the court do not seem to have marked differences in the course of treatment or in the situation at discharge. The only exception is legal charges, which seem to be independent of treatment and its course. Maybe a situation could be created whereby such patients come off treatment with a ‘clean slate’, e.g. where charges related to their prior life are dropped and where they can begin a new life.

References


Compulsory Inpatient Treatment in Switzerland

Eur Addict Res 2002;8:78–83

83