

Rethinking hospitalisations for substance use disorders

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The results of the paper of Habermayer et al. [1], now published in *Swiss Medical Weekly*, may at first sight appear trivial: involuntarily admitted patients show poorer health and functioning. Moreover, the proportion of those who leave against recommendation is twice as high as in voluntarily admitted patients. One could simply conclude that this is the effect of negative selection. In a vicious circle, the less affable subjects would be committed as involuntary patients, would also leave the hospital prematurely because of their grumpiness, and would therefore be less well treated and consequently show poorer health and functioning. The authors, however, question this conclusion as premature, showing that both voluntarily and involuntarily admitted patients shared most clinical and social characteristics.

The paper is, even so, noteworthy for several other reasons that may solicit some comment. As the authors point out, Swiss law establishes that an involuntary admission is only legitimate when its main goal can be achieved with this measure and a suitable setting exists. The authors, in their conclusions, state that *at least* involuntary admissions do not lead to sustained inpatient treatment (my italics). The expression *at least* may be the most thought-provoking part of the sentence. It implies that possibly voluntary admissions also would not be as judicious as habitually assumed. This formulation raises a question, which has only seldom been discussed, about the utility of hospitalisation itself when treating patients with substance use disorders. In the Habermayer et al. sample, 50% of the patients were admitted for the treatment of substance use disorder itself, thus one can infer that referring physicians expected the hospital to play a specific role of in the treatment of their patients.

There may be no doubt concerning the utility of a hospital infrastructure for such conditions as unstable coronary heart disease or brain surgery, because of the necessity of continuous monitoring and time-intensive therapeutic measures. Why, however, should the 24-hour presence of healthcare givers, i.e., also during the sleep-time of the patients, be useful for the treatment of such a chronic and recurrent problem as substance use disorder. Although “temporary distancing”, the temporary changing of the social context, is often given as a reason for hospitalisations (often also asked for by patients), the efficacy of such an environmental time-out has never been corroborated.

Ten percent of the patients in the sample of the Habermayer et al. study were admitted because of intoxication, even 46% among the involuntarily admitted. One could thus argue, as the authors note, that hospitalisation for the management of intoxication may help to avoid harm from intoxication. But in this case, the question arises – why not hospitalise in a somatic hospital unit? After all, the intoxication-related harms are almost exclusively prevented and treated with somatic interventions.

One finding especially highlighted by the authors was that both voluntarily and involuntarily admitted patients shared most clinical and social characteristics, that mostly behavioural problems determined the mode of admission, and that in more the 50% of the patients the coercion was already removed on the first day of treatment. One may therefore infer that involuntary hospitalisation is in most cases due to social disturbances rather than based on a therapeutic strategy. Even if one were to admit seclusion in a medical facility to be an acceptable means to counter social nuisances, several problems remain. A commonly accepted principle used to justify legally sanctioned restrictions of individual liberties is the so-called *harm principle*, which holds that the liberty of individuals can be limited to prevent harm to other individuals. Physical injuries can indisputably be considered harm, but the question is trickier in the case of public nuisances and offenses. For example, what degree of harassment, alarm or distress of others should be considered a justification to impose a legally sanctioned limitation of freedom on the author of the nuisance? Even if one accepts the so-called *offense principle*, which allows limitations of liberty in order to prevent offenses to others, the problems of the criteria *utility* and *necessity* remain. The limitation of liberty has to be an effective means to prevent harm/nuisances (utility) and there has to be no alternative means (necessity). Thus, article 426 of the Swiss Civil Code in fact states that a patient *may be committed to an appropriate institution if the required treatment or care cannot be provided otherwise*. Thereby, even if the coercive hospitalisation were efficacious (which is contradicted by the results of the Habermayer et al. study), this wouldn't a priori justify the patient's limitation of freedom.

In order to better regulate the practice of involuntary admissions and coercive treatments, great efforts have been made in Switzerland in recent years to protocolise proce-

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dures. Most of these protocols, however, focus on the justification for and correct application of the coercion. Such procedures and their correlated indicators naturally have as a consequence a focusing effect, encouraging decisions on the basis of the most pronounced and distinct available information. Currently, the burden of proof on decision-makers concerns the presence of a risk of harm/nuisance and the burden of proof on clinicians relates to the strict application of the protocols. Neither of them has to prove by protocol that all alternative means have been considered and are all inapplicable.

In conclusion, the paper published by Habermayer et al. underlines the clinical inefficacy of coercive measures in addiction psychiatry and reanimates more generally the question about the utility of hospitalisation for the treatment of substance use disorders.

Reference

- 1 Habermayer B, Wyder L, Roser P, Vogel M. Coercion in substance use disorders: clinical course of compulsory admissions in a Swiss psychiatric hospital. *Swiss Med Wkly.* 2018;148:w14644. doi: <http://dx.doi.org/10.4414/smw.2018.14644>.