Compulsory Mental Health Care in Norway:

A Study of the Interface between the Law and Psychiatry

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1. Preface

1.1 Acknowledgments

First and foremost I would like to thank the formerly committed patients and their relatives, lawyers, psychiatrists, physicians and members of the supervisory commissions who have kindly participated and shared with me their expertise for my research. Their contribution was most important.

When I became the administrative leader of the Department of Psychiatry at the Faculty of Medicine at the University of Oslo, I was met with encouragement by the psychiatrists with whom I worked. I would especially like to mention the late professor Nils Retterstøl and the manager professor Alv A. Dahl, who gave me confidence from the very first day. I would like to thank professor Svein Friis, with whom I collaborated with for several years, for the friendship we had in our work with the administration of the Department. He gave me the necessary security and confidence to do my work. Professor Astrid Nøklebye Heiberg has always supported me with enthusiasm. She has read my papers and given me helpful comments, and I have benefitted much from her professional knowledge in this field. She has encouraged me in my scholarship "downs", and I have learned much from her. Thanks for giving me so much of your time.

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I would also like to show my gratitude to Gro Hillestad Thune's network on human rights in mental health care. They have inspired me, and we have also had a lot of fun together.

I wish my parents had lived to see this; they would have been proud. They supported me throughout my younger years.

My son, Trond, has always supported his mother and given me good advice on my research. He has never complained about not having an "ordinary" mother. Thanks go also to my daughter Trude, who has been a good discussion partner.

And last, and most importantly, thanks to John, my husband and best friend for 55 years. Without his support, interest, curiosity and respect this work could never have been carried through. I hope I can deserve his never-failing loyalty. Thanks for giving me this opportunity during our retirement.

I dedicate this work to my dear husband John.

1.2 Summary

The Norwegian Mental Health Care Act allows the use of coercion under certain conditions. Even though the current practice has been criticized, little empirical data exists about the attitudes towards compulsory mental health care. Only a few studies have been conducted on the effects of compulsory mental health care, and they show contradictory results. The use of coercion is also a potential threat to patients' human rights. The aim of my study is, therefore, to elucidate these questions with different approaches:

- Attitudes among stakeholders (Paper 1)
- Potential legal protection (Paper II)
- Treatment criterion (Paper III)
- Decisions of the Supreme Court of Norway: have they influenced mental health legislation or clinical practice? (Paper IV)

In the four papers we have also attempted to bring Human Rights into debate.

Our first paper explored the following question: is it possible to empirically construct the generally accepted attitudes regarding the use of coercion in mental health care? After using Q-methodology we found that the most widely shared attitude stated that a trusting relationship between the patient and the therapist is of great importance. This attitude gives partial support to the present Mental Health Care Act. But compulsory commitment in mental health care represents a dramatic infringement on an individual's life. This deprivation of liberty is based on a professional medical assessment that does not require a court verdict. The Norwegian mental health legislation is based on society's confidence in psychiatry as a profession. This confidence allows professionals to treat patients against their will. We will present possible changes that may increase the legal protection for the mentally ill; among other things, that an initial court action should be conducted before compulsory mental health care can be implemented, with the exception of life-threatening situations.

Our aim was also to explore whether there are benefits or harmfulness of involuntary treatment after a coerced admission. Few studies have been conducted on the effect of compulsory mental health care, and the results have been contradictory. The conclusion is that more randomized studies are needed.

It was also interesting to know if the decisions of the Supreme Court of Norway have influenced mental health legislation and psychiatric practice. We found that the court has in many cases followed psychiatric experts' opinion. In this connection we have made the following suggestion: A special master's degree in law could be established called forensic psychiatry. The program could deal with all aspects of compulsion in mental health care, both the forensic and administrative decisions. This could make lawyers and judges more prepared for their task in the courts, and make them more independent of the psychiatric experts' decisions.

1.3 List of papers

I Diseth R., Bøgwald K-P., Høglend P. Attitudes among stakeholders towards compulsory mental health care in Norway. International Journal of Law and Psychiatry 2011; 34:1-6.

II Diseth R., Høglend P. Potential legal protection problems in the use of compulsory commitment in mental health care in Norway. International Journal of Law and Psychiatry 2011; 34: 393-399.

III Diseth R., Høglend P. Compulsory mental health care in Norway: The treatment criterion. Accepted for publication in International Journal of Law and Psychiatry.

IV Diseth R., Høglend P. Decisions in the Supreme Court of Norway: Have they influenced Mental Health Legislation or Clinical Practice? Submitted.

1.4 List of abbreviations

CPT	The European Committee for the Prevention of Torture and Inhumane or Degrading Treatment or Punishment
CRPD	The UN Convention on the Rights of Persons with Disabilities
ECHR	The European Convention on Human Rights
EMK	Den europeiske menneskerettighetskonvensjonen
ØSK	The UN International Convent on Economic, Social and Cultural Rights

De lege ferenda = the way the law ought to be

2. Introduction

A legal system is not an abstract collection of bloodless categories but a living fabric in a constant state of movement.

(Lord Lloyd of Hampstead, 1972)

It is a basic tenet of health legislation that a person is autonomous and dignified. This is confirmed in human rights documents and has been reflected in the Patients' Rights Act (1999) and the Mental Health Care Act (1999). The right to refuse medical treatment is universally recognized as a fundamental principle of liberty. A careful consideration of competence in the medical care setting leads to a conclusion that it can best be assessed by determining the patient's ability to understand the information necessary to provide informed consent to treatment. If a patient has this capacity, both his consent and refusal must be honored (Annas and Densberger, 1984).

Section 4-1 in the Patients' Rights Act says that health care may only be provided with the patient's consent, unless legal authority exists, such as in chapter 3 of the Mental Health Care Act. But competence is the crucial issue, since a lack of competence, or even the questioning of an individual's competence, deprives that individual of the liberty to make decisions about their treatment. Competent individuals are at liberty to make their own medical treatment decisions; incompetent individuals are not. Although the patient has a right to refuse treatment, it remains the physician's legal responsibility to ensure that the patient understands the consequences of that refusal. According to the Patients' Rights Act, Section 4-9, the

patient has the right to refuse health care even if such a refusal will be life threatening: "The patient is entitled, due to serious conviction, to refuse to receive blood or blood products, and to refuse to break off an ongoing hunger strike."

Deprivation of freedom on an administrative basis in mental health care is one of the most radical infringements upon a person's civil rights. According to the Mental Health Care Act, section 3-3, compulsory mental health care may be applied, after an overall assessment, if this clearly appears to be the best solution for the person concerned, or he or she constitutes an obvious and serious risk to the life or health of himself/herself or the life or health of others. Each year approximately 11, 000 compulsory commitments, or 253 per 100, 000 inhabitants, take place in Norway. The statistics show that Norway uses compulsory commitment more than other Nordic countries. Furthermore, the use of coercion and compulsory commitments is increasing in Norway (Bjørngaard and Hatling, 2005; Høyer et al., 2002). In Norway there are more individuals deprived of their freedom in psychiatric institutions than in prison, i.e., administrative decisions without court decisions, but with medical expert assessment (Lund, 1980). I have not included criminal law and rules of criminal procedure in this thesis, but have concentrated my study on the administrative decisions and the civil law procedure.

The use of coercion in mental health care touches on several different topics such as legal and human rights, autonomy and paternalism, and the right to the most efficacious treatment. Even though the person concerned has the right to be informed about his case, and the legal principle that all parties and interests shall be heard before a decision is made, these must often be put aside for a rapid and efficient treatment. In a study from Norway (Høyer, 1986), it was revealed that patients admitted compulsorily are not sufficiently aware of their legal position and legal rights. Thirty-eight percent of the patients interviewed were found unable

to make use of their legal rights. More than half of these were unable to exercise these rights due to a lack of adequate knowledge.

The encroachment on our personal freedom must have statutory authority. Act No. 62 of 2 July 1999 (The Mental Health Care Act, 1999) relating to the provision and implementation of mental health care, with later amendments section 1-4, gives the mental health professional responsibility for the administrative decisions in mental health care. Our mental health care legislation is based on our confidence in psychiatry as a profession. This confidence allows professionals to treat patients against their will. In some countries, initial court action is necessary before compulsory mental health care can be implemented.
In 1994 the European Council recommended (CPT, 1997) that compulsory commitment should only be implemented after a court verdict. Norway has chosen not to follow this recommendation because the Norwegian government recognizes the Supervisory Commissions as a court due to the fact that the leaders of the commissions are judges. In a resolution (ØSK, 2005), the European Council requested that member state governments formalize this rule through national legislation as soon as possible: The Committee recommends the state party to ensure that every decision to detain a person with mental illness for compulsory psychiatric treatment will be reviewed promptly by an independent judicial body. In Norway, the patient can appeal a decision on compulsory commitment to the supervisory commissions. However, the appeal process may often be based on an incomplete record, since the supervisory commission has access to the records on which the commitment is based from only one source, namely the senior physician.

In the Human Rights Act of May 21, 1999[1], Norwegian lawmakers decided that some of the international conventions would take precedence over Norwegian law. Among these conventions is The European Convention on Human Rights (ECHR, 1950), ratified by Norway in 1952. The purpose of the Human Rights Act is to strengthen the status of human rights under Norwegian law. There is also an ongoing debate focusing on whether the European Convention on Human Rights should be directly incorporated into the Norwegian Constitution.

The ECHR presents the following definition of legal protection in Art. 5: "Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law…..The lawful detention of persons for the prevention of spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants."

Norway's code of laws with commentaries (EMK, 1996) contains the following comment on Art. 5: "The deprivation of freedom must be 'legal', i.e., in accordance with international law and the principles that the convention are based upon." The deprivation of freedom must also be in accordance with national law. Accordingly, an individual of unsound mind can be deprived of his or her liberty based on an administrative decision, but the article gives the individual the right to have prompt access to judicial proceedings.

This article 5 causes legal protection problems in the Norwegian mental health care system.

[1] The Human Rights Act of May 21, 1999 No. 30.

3. Background

The right to use coercion in mental health care in Norway is regulated by the Mental Health Care Act of July 2nd 1999 No. 62. This act, as well as earlier mental health care acts, was predicated on the needs of the patient for adequate medical treatment, and the respect for their human dignity. However, criticism has been raised against the use of coercion on persons with mental disorders. Compared with other Nordic countries, Norway leads the statistic for compulsory commitment. To be able to reduce the use of compulsory commitment, we need to know more about the factors and processes that lead to one of the most radical infringements of personal freedom that we have. The use of coercion in mental health care touches on several different topics, such as legal and human rights, autonomy and paternalism, and the right to the most efficient treatment. This thesis discusses these questions.

As the administrative leader of the Department of Psychiatry at The University of Oslo, my curiosity and interest in the judicial circumstances for patients committed to psychiatric hospitals, were awakened. With my master's degree in law and general jurisprudence it was quite natural for me when I became a pensioner to study the legal protection and attitudes towards compulsory admission in the mental health care in depth, resulting in this thesis. But the interface between law and psychiatry is complex, and has the potential for gross misunderstanding (Zemishlany, 2006). Each discipline has its own concerns with regard to the psychiatric patient, and there is a significant language gap between the two disciplines. According to Zemishlany, the two systems can be complementary only if both sides make a serious effort to communicate and respect each other's principles and language. The courts of law are concerned with the freedom and the rights of the individual much more than with the mental health of the patient. The physician is concerned with the need for medical treatment

to improve the health of the patients, while the court rules by the letter of the law to assure the protection of the rights of the individual and the public. The concern for patients' rights may cause the pendulum to swing too far, at the expense of the patients' welfare. At the same time we must ensure that the paternalistic attitude does not influence the legal system.

The media has focused a lot on patients' experiences with the use of coercion in the mental health care system. Many mental health patients do not feel that they have any influence on their own treatment and are not regarded as equal participants. They lose their dignity (Kogstad, 2009; Thune, 2008). The recent government grant of 2.7 million Norwegian kroner for the purpose of reducing compulsion in psychiatric institutions has been unsuccessful. Since the mental health care act in 1999, the amount of compulsory admissions has not been reduced (Storvik, 2008; Bremnes & al., 2011). At the same time, we are witnessing in the news a frustration over the lack of help and resources for people who need psychiatric treatment. There is a lack of outpatient departments, which could be open at nights and on week-ends. There is also a shortage of beds in the acute wards.

There are two opposite poles in Norwegian psychiatry concerning compulsory commitment. A great deal of former patients and their organizations want to remove the treatment criterion in the Mental Health Care Act[2] because it is not documented that coercion gives positive outcomes, but they will keep the compulsory commitment of patients who are a danger to their own and others' health. Coercion has led to life-long trauma for some people and the treatment criterion is supporting and maintaining a paternalistic culture regarding treatment. Psychiatry has only been able to prove the effectiveness of the treatment under these conditions to a limited extent (Høyer, 2000).

[2] Act No. 62 of 2 July 1999 Section 3-3: 3.a: having the prospect of his or her health being restored or significantly improved considerably reduced, or it is highly probable that the condition of the person concerned will significantly deteriorate in the very near future

On the other hand, the Norwegian Psychiatric Association has, in its program for 2009, concluded that removing the treatment criterion is unethical. The criterion ensures solidarity with those who, because of severe mental illness, can not take care of themselves. Many would deteriorate if the mental health care had no legal authority to interfere. The medical professionals have the capacity to define the necessary treatment and have the power to set aside the patients' human rights by using compulsion, on the grounds that the patients lack insight into their own illnesses. But the users' organisations do not share this point of view. The Norwegian Ministry of Health and Care Services[3] argues that if the law solely allowed for the compulsory commitment of patients who are a danger to their own or others' health, this would mean a serious limitation of the conditions that must be satisfied for compulsory mental healthcare to be applied. The Ministry also argues that an increased focus on the degree of danger would risk increasing the stigma associated with being mentally ill.

3.1 Patient perceptions of coercion in mental hospital admission

Several studies (Iversen & al., 2002; Hiday & al., 1997) have shown that the patients' perceptions of coercion do not always agree with their legal status. Legal status is therefore not a good measurement of coercion. The patients might also perceive coercion during the decision making process when their viewpoints are not being taken into consideration. One study (Iversen & al., 2002) investigated the perceived coercion among patients admitted to acute wards in Norway, both voluntarily and involuntarily. Both a visual analogue scale (the Coercion Ladder, CL) and the MacArthur Perceived Coercion Scale (MPCS), which is a five-item questionnaire, were used to measure perceived coercion. Two hundred and twenty-three consecutively admitted patients to four acute wards were included in the study and

[3] The Ministry of Health and Care Services: Proposition to the Odelsting No. 65 (2005-2006). Concerning an Act amending the Mental HealthCare Act and the Patients' Rights Act.

interviewed within 5 days of admission. Many patients reported high levels of perceived coercion during the admission process, with the involuntary group experiencing significantly higher levels than the voluntary group. However, the difference was not large: 32% of the voluntarily admitted patients perceived high levels, and 41% of the involuntarily admitted patients perceived low levels of coercion. Legal status did not significantly predict perceived coercion on either the MPCS or the CL after taking negative pressures and process exclusion into account. Another study (Lidz & al., 1995) reported that the patients' feelings of being coerced in the admission process appeared to be closely associated with feeling pressured and/or a perceived lack of procedural justice. This has been replicated in several American studies (Hoge & al., 1997; Poulsen, 1999; Monahan & al., 1995) and in New Zealand (McKenna & al., 1999).

Feeling coerced in the admission process means perceiving that one does not have influence, control, freedom or choice, or does not make the decision to enter the hospital. How patients were treated in the process involves at least two concepts closely related to coercion, but theoretically distinct: process exclusion and negative pressures. The study (Iversen & al., 2002) has interesting implications. They emphasize the importance of the interpersonal process during admission. If it were possible to reduce the level of "threat" and "force" and increase the extent to which patients' feel their views are taken into consideration during the admission process, the level of perceived coercion might be reduced. I refer here to my Paper III.

3.2 Coercion and outcome of psychiatric hospitalization

Psychiatric treatment is to a large degree based on clinical assessments, and measurable biological parameters do not exist (Andersen & al., 2004). There is little empirical knowledge available about the quality of Norwegian mental health care (Øiesvold, 2005).

The main focus in a Swedish study (Kjellin & al., 1997), based on 84 compulsorily and 84 voluntarily committed patients in two Swedish counties, was to determine the balance between the ethical benefits and costs between these two groups. The great majority of all the patients reported improvement as a result of the psychiatric care. Avoiding integrity violations and coercive measures seem to be important conditions for a positive outcome of care. For both the committed as well as the voluntary patients, an association was found between the perceived respect for autonomy and self-reported improvement in mental health.

An article from 2005 (Salize and Dressing) highlights the fact that "research activities are remarkably few in number, especially considering the frequency of involuntary measures and the controversial perception or discussion of these measures among the individuals concerned, professionals, or a wider public. Many basic research questions still remain to be adequately addressed, such as the long-term effects of involuntary treatment". Furthermore, the EUNOMIA project (Mayoral and Torres, 2005), which is a European study in twelve countries that evaluates the use of coercive treatment measures, such as seclusion and physical and chemical restraint, concludes that "there is a remarkable lack of experimental studies concerning the use of these measures. [---] Controlled and randomized studies are necessary on populations that are representative of those seen in the usual clinical practice, to be able to obtain results that serve to give good practice recommendations on their application".

A Nordic study (Høyer & al., 2002) underscores that "little is known about the effects of coercing patients. […] The justification for the use of coercion is basically a belief that

coercion works, meaning that compulsory treatment improves the outcome compared to the outcome with no (coercive) intervention." The study refers to Hiday (1996), who has stated that "given the controversy that coercive treatment has generated in psychiatry and law, it is surprising that there is not a wealth of data on the extent and outcomes of coercion".

4. Aims of the study

The overall aim of this study is to elucidate compulsory commitment in mental health care with following research questions:

- Testing differences of attitudes between groups of stakeholders
- Changes that may increase the legal protection
- Are there benefits or harmfulness of involuntary treatment after a coerced admission? Secondly we want here to evaluate studies that try to compare involuntary treatment with voluntary treatment.
- Have decisions of the Supreme Court of Norway influenced mental health legislation or clinical practice?

In connection with these research questions I will also discuss whether our mental health care system is in accordance with human rights.

5. Methodology

5.1 Procedure and methods

5.1.1 Recruitment of participants

In Paper I the aim was to study the multitude of attitudes regarding coercion in mental health care. We wanted to use subjects who, based on their various experiences with mental health care, or their occupational positions, might represent different viewpoints towards these issues. We chose to incorporate at least 10 subjects (respondents) in each group: psychiatrists, non-psychiatric physicians, lawyers and members of supervisory hospital commissions, relatives of psychiatric patients and formerly committed patients. The relatives of patients and the former patients were recruited for the study with the assistance of the Norwegian Association of Families of Persons with Mental Disorders, the organization Mental Health, and the association "We Shall Overcome". The supervisory commissions were contacted in writing. Lawyers, physicians and psychiatrists were randomly contacted from membership lists.

5.1.2 Sampling of statements

The statements in this study were sampled by a group of clinicians and researchers after reviewing relevant texts and conducting extensive discussions about the subject. They were revised several times by the authors and other researchers until a consensus was reached. The statements intended to cover the most important principles relating to coercion in mental health care, including aspects of paternalism, autonomy, legal rights and justice. The 30 statements are shown in Appendix 1.

5.1.3 Methods

A research method is a procedure to solve problems in order to obtain new knowledge. Any procedure which serves this purpose belongs to the arsenal of methods (Aubert, 1982). A method helps us to make appropriate choices (Hellevik, 1999). It gives us a survey among alternative procedures and the consistency of taking some alternatives into consideration. We can benefit from the experiences of scientists before us.

A partial aim of this thesis was to identify attitudes from different groups of stakeholders to the mental health care system in order to find out whether or not the Mental Health Care Act corresponded with the stakeholders' view on compulsory commitment.

The juridical method, which I know best, is not useful when it comes to surveys about attitudes. The purpose with the juridical method is to make it possible for the users of jurisprudence to find solutions to the concrete questions of the law. We can look at the jurisprudence as a problem- or conflict solution technique. The lawyers' argumentation is built on a descriptive, an analytical, and a normative solution of the problems. The aim is to give a description of what is happening, an explanation of why it is happening and a recommendation on what should be done (Graver, 1986). The ability to find the right substantive rule of law is fundamental in the legal system (Hydén, 1977).

In order to find methods for the studies of attitudes, we can choose to go to the nearest alternative: sociology. According to Max Weber (1978), sociology is a science which deals with the interpretation of understandable social actions in order to find a causal relation between those actions and their consequences. In the field of sociology, the word ”meaning” does not refers to an objectively ”correct” meaning or one which is ”true” in some metaphysical sense. This is what distinguishes the empirical sciences of action, such as sociology and history, from the dogmatic disciplines in that area, such as jurisprudence, logic,

ethics and aesthetics, which seek to ascertain the "true" and "valid" meanings associated with the objects of their investigation.

Q-sort method

The study (Paper I) used Q-methodology to identify prototypical attitudes and to test possible differences in the attitudes between groups of stakeholders towards the use of coercion in psychiatry. Q-sort method is an established method, combining both qualitative and quantitative research, and is often used to analyse complex subjective structures such as opinions, attitudes or values. It is based on the assumption that several statements about what one wants to examine can be collected. These statements are often of a contradictory nature, and are supposed to cover a broad spectrum of possible understandings. The respondents give weight to the statements in their answers from their own point of view – the subject therefore applies his/her own "meanings" and understandings to the statements. This method forces the respondents to consider each statement in relation to all the other statements, and thus provides a nuanced expression of the respondents' attitude, reducing "response bias" (Håland and Synnevaag, 1992).

Computerized inventory

In Paper III an on-line computerized inventory was carried out in the PubMed and Cochrane databases under the combined search terms *mental health care* and *compulsory treatment*. A total of 197 references were found. Limiting the time span considered to July 2000 - June 2010 cut the number of references in PubMed to 118 (67%). A combined search terms *mental health care, compulsory treatment* and *involuntary admission* brought 11 references. Papers that described children and adolescents, patients with anorexia nervosa or criminals were

excluded. All abstracts were read. Studies associated with the key words *treatment criterion* and *coercion in mental health* was critically studied in detail.

A secondary manual search of the references cited in the identified publications was also carried out.

In Paper IV an online computerized inventory was carried out in Lovdata.no database under the search terms *Høyesteretts avgjørelser (decisions of the Supreme Court)* and *Psykiatri (Psychiatry)* and *Menneskerettigheter (Human Rights).*

The search revealed that the Supreme Court has been involved in 28 psychiatric cases after 1904. Five cases (1904, 1922, 1925, 1926 and 2004) dealt with the declaration of incapacity where the Court established the fact that having a mental disease is not the same as being incapable of managing one's own affairs. In four cases (1981, 1988, 2000 and 2001), the court's judgment was in favor of the complaints of the patients, who were then discharged from the mental hospital. In eight cases (1971, 1993, 1998, 1999, 2000, 2001, 2002, 2004), the patients were denied a discharge. In five cases (one in 79, 97 and 99 and two in 82) the patients had already been discharged from the hospital, and the issue of discharge could no longer be decided by The Civil Disputes Act. Two cases (1979 and 1994) concerned complaints pertaining to diagnosis. Three cases (1984, 1986 and 1987) dealt with the question of compensation. One case in 1984 was about access to the patient's own journal.

5.1.4 Problems in the study of the legal system

My study is mostly connected to the sociology of law, because the study is about the attitudes towards compulsory treatment in psychiatry and mental health care law. And the sociology of law's method of dealing with the legal system does not require an interpretation of the system's content and implications, but has its own methods to describe and develop theories in order to analyse the social reality in which we live. The sociology of law describes and

analyses the law as it applies to society (Mathiesen, 1984). Does law have an unintended impact on society? Mathiesen argues that it is often said that the law has a veiling effect on the power structure in society. The court with its rituals and procedures diverts the people's attention from the real problems in the society. The problems are defined as legal, but in reality they are socially and economically determined. Paper II in my study deals with responses to the following: "The users don't believe that the extensive use of coercion is only about lack of resources and effective treatment, but just as much about the culture we often find among professionals that have power in the mental health care system."

Our mental health legislation is based on our confidence in psychiatry as a profession.

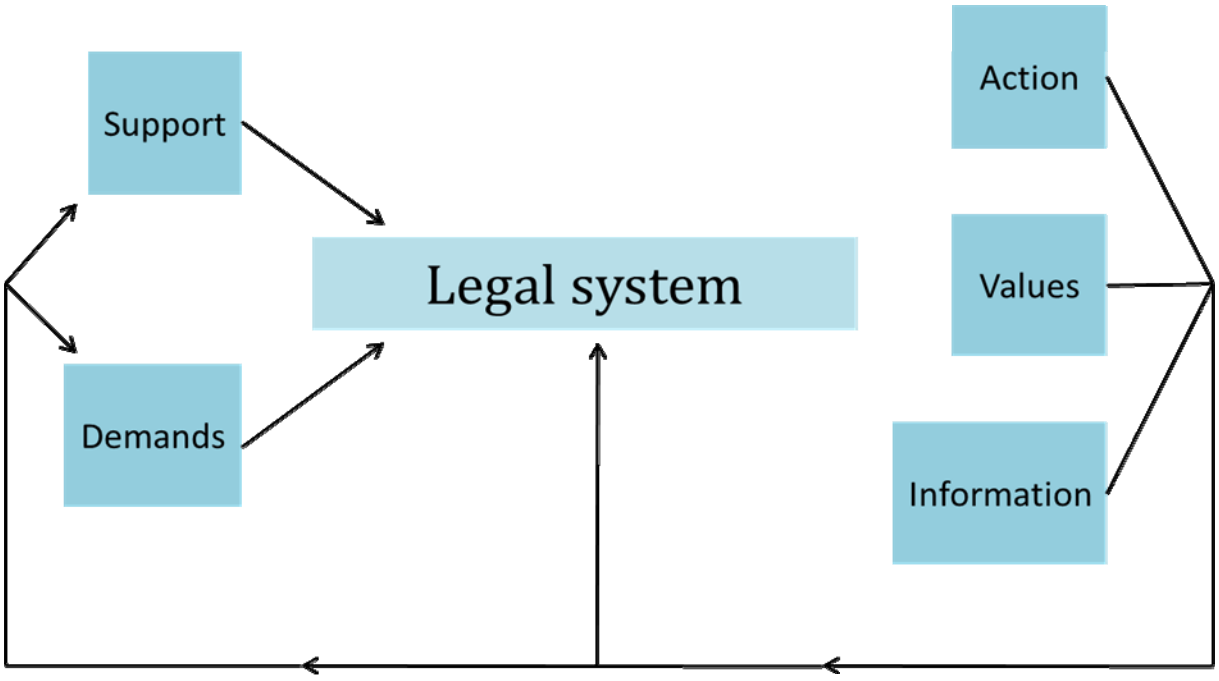
In the report from Statens Helsetilsyn[4] (Bruk av tvang, 2006), SINTEF Helse has uncovered social problems in connection with compulsory commitment in mental health care. According to the report, the use of compulsory assessment in mental health care is associated with the problems of poverty and lack of permanent lodging (more than 40 %). The majority of patients in psychiatric institutions also belong to the lower social hierarchy. Many patients have minimal networks and few resources outside the hospital. Paper IV deals with these questions.

While the science of law is mostly useful for those who employ the substantive laws and procedures, the sociology of law will be of practical use to the legislators. Pressure groups that want changes in currently applicable laws could be interested in the results coming from the research done within legal sociology (Aubert, 1982). As an example, I can cite pressure groups like Mental Health Norway, The Norwegian Association of Families of Persons with Mental Disorders and the association "We shall overcome" which would be very interested in research about the evaluation of compulsory treatment in psychiatry, which may eventually change the law of mental health care. Paper III deals with these questions.

[4] Norwegian Board of Health Supervision

Why is it so difficult to change the system? The tendency is for the system to be kept in equipoise (homeostase). Sociologists and criminologists have been concerned with social control, which can be regarded as an example of regulation by means of negative feed-back to the society. The system tries to stabilize the society by addressing the discrepancies with countermeasures. In society there are many examples that explain social institutions' ongoing existence by noting that their decisions help to maintain their power and position. A positive feed-back is characterized by the fact that any change creates a tendency to extend the institutions.

Within the philosophy of law there are a great deal of discussions about how legal systems are built and how they are functioning. As a starting point, these discussions have posed the question "What is law?" But Eckhoff and Sundby (1976) place greater emphasis on analyzing the relationship between the elements, and seek to explain the system's dynamic aspects and its interaction with the outside world. The legal system is an open and dynamic system. The inputs to the system are called supplies, and the outputs are called products. Among other things, an individual's norms and beliefs will come into the picture: partly as a reservoir that law-makers can draw from and use as raw material for its own norm production, partly as factors that can support the juridical claims and positions, and partly as factors that counteract legal objectives and therefore ought to be opposed. The products will influence the future additions to the system, and thus also the future production.



[5]

The surrounding society

In our paper about the treatment criterion (Paper III) we discuss this question. The users' perception of the treatment criterion could influence future legislation.

Among mankind's norms and values, moral issues have the greatest impact on the law. Many moral and legal norms either partially or fully coincide. The system shall be an effective instrument to implement policy objectives and requirements, and they shall reflect peoples' moral attitudes. These requirements are sometimes in conflict with each other. Many people have exaggerated ideas about the possibility of changing social conditions with legal means. The demand "a law must be created which can change the condition" is a common response to all sorts of defects and distortions in the society. It is easy to forget that the financial situation is often more important than the legal one.

[5] Eckhoff T., Sundby NK. Rettssystemer, Oslo: Tanum-Norli, 1976

On the other hand, the legal system's ability to change direction quickly is not impressive. All living organisms have a tendency towards self-preservation. That which is regulated is not absolutely constant, but variations are kept to acceptable limits by the opposing forces triggered whenever the state approaches one of the boundaries. Even if the legal system is relatively resistant to external influences, it is far from immune to "climate change" in the surrounding society. An example here is that the user-perspective has been taken seriously in the new act of mental health care (Paper III). We now have influential user organisations which, together with the media, exercise a strong pressure on the government in order to remove the treatment criterion in the Mental Health Care Act. The opposing forces are triggered because the contents of the law have approached one of those boundaries. Despite pressure from the user organisations, the law committee, called Lovutvalg 2010, which was appointed by the Norwegian government in May 2010, concluded in May 2011 (NOU, 2011) that the existing treatment criterion should be maintained. The Mental Health Care Act has obviously approached one of its boundaries.

The sociology of law's most important function is to make it possible to do research *de lege ferenda* with approximate scientific methods. The sociology of law will therefore make it possible not only to work for the existing legal order, but also for ideas which modify or are in conflict with the legal order (Aubert, 1982).

An interesting inquiry was made in Sweden (Hetzler, 1978). The inquiry was made a long time ago, but I believe the question is also of relevance today. The question was how "Lag om beredande av sluten psykiatrisk vård av 1966" was functioning in practice. The law's intention was to give objective reasons for compulsory commitment. In this way the patients' protection, accorded by the law, could be taken care of. The law, however, was too general or abstract. It gave no precise description of the cases where compulsory commitment has

authority in the law. The wide scope for discretion indicated that the psychiatrists were strongly under the influence of different factors in making their decisions about compulsory commitment. The concrete working situation has an influence on how they use the law. Because there is a shortage of treatment-beds, it would be an advantage to choose compulsory commitment. Such patients receive priority over voluntary patients. The responsible mental health professional can solve his professional and administrative problems with compulsory commitment. The law becomes an elastic instrument in solving those problems. The main conclusion in this inquiry was that this type of law will become an instrument in the hands of those who use it (Aubert, 1982). It is difficult to know whether in practice the Norwegian act of mental health care sets a limit, and if such a limitation would be respected in an eventual conflict with practical and professional considerations. This would be an interesting question for further research.

The law is part of a complex social totality. The effect of the law can not be studied in isolation (Mathiesen, 1984). The concept of effect in the sociology of law is not similar to the concept of effect in natural science. The law can only work through the process of thinking, while a stone falling to the ground we can see without any process of thinking.

In their book about legal systems, Eckhoff and Sundby (1976) have tried to build a bridge between natural science and social science, by applying the ideas from cybernetics. Cybernetics is the interdisciplinary study of the structure of regulatory systems. Cybernetics is closely related to Control Theory and System Theory. Cybernetics is pre-eminent when the system under scrutiny is involved in a closed signal loop, where action by the system in an environment causes some change in the environment, and that change is manifested in the system via information, or feed-back, causing the system to adapt to new conditions: the

system changes its behaviour. The mathematician Norbert Wiener (1961) was one of the front-figures in a co-operation between mathematicians, engineers, physiologists, psychologists, sociologists and social-anthropologists in the 1940s when cybernetics was developed. Everyone who participated in the co-operation was astonished by how similar the problems were which they had worked on separately. They learned from each other how they could better manage the problems within their own professional work. This view has therefore inspired my work, which is a study of the interface between law and psychiatry. The attempt to create a unified science by reducing everything to physics has been a failure according to Eckhoff and Sundby (1976). Physics can not explain what is happening in open dynamic systems such as legal systems. There is seldom conformation between such theories and practice. One reason for this is that human beings are not as predictable as machines. Such theories are therefore of little value in modern sociology.

As we know can see, there are several weaknesses and errors in studying methods for the legal system. But it is interesting to try to combine sociology of law together with theories of Eckhoff and Sundby in their book of 1976.

5.2 Statistics

The name "Q" in Q-sort analysis comes from the form of factor analysis that is used to analyze data. Normal factor analysis, called "R method" (Rank Order Correlation) involves finding correlations among the variables within a sample. The R-method was developed by Charles Spearman (1904). Q factor analyses reduce the many individual viewpoints of the subjects down to a few "factors", which represent shared ways of thinking[6]. The method has been used in different sciences, including psychology. The interest in Q-method can be seen

[6] http://en.wikipedia.org/wiki/Q_methodology

in the founding of a specialized journal for Q-studies (Operant Subjectivity), and a society with annual scientific meetings (Bøgwald, 2002). Several specialized software programs have recently been tailored to the requirements of Q studies. One of these, PQMethod version 2.09 (Schmolck, 2000) for principal components analyses (PCA) was used in Paper I.

The Q sort is usually a self-directed process. To carry out a study there needs to be something for the participants to rank. This usually consists of between 10 and 100 items (in our study in Paper I we have 30 items). As identical items are given to different groups, a researcher can look at the patterns of responses to uncover and name distinct ”points of view”, even with small groups (Donner, 2001). Q-sort is rarely used on more than100 respondents, and excellent results can be achieved with only a dozen participants. Our study had sixty-two respondents who represented six groups with different roles in mental health care: former patients, relatives of psychiatric patients, members of supervisory commissions, psychiatrists, and other physicians and lawyers (Paper I).

The result of the Q-sort analysis reveals the respondents' subjective assessment. The data are easy to collect, to analyze and to explain. The Q-sort method is not only an excellent tool for the researcher, but also a good exercise for the respondents. The respondents' assessments are their own; the respondents must consider the same statements, and equal numbers of statements shall be placed in each of the categories. The researcher can therefore compare these subjective assessments better than when using an ordinary qualitative method. The most challenging task in designing a Q-sort, is selecting the statements for inclusion. But the researcher must realize that no list with such elements is perfect, and it is a comfort to know that no list ought to be. The Q-sort method is, however, a very powerful tool (Donner, 2001).

Every respondent has a high degree of freedom in expressing his or her subjective assessments about the statements, sorting them on a scale from, for example – 4 (“strongly disagree”) through zero (“neutral”) to + 4 (“strongly agree”). The statements will be given on cards which the respondents sort according to the abovementioned scale. As usual for Q-sorting, forced distribution is applied: in our paper the 30 statements should end up in a quasi-normal distribution, with 6 statements in the neutral category (“0”) and only 1 statement in each of the most extreme categories (Appendix 2). William Stephenson formulated the principles of the Q-sort method as early as 1935 (Stephenson, 1935). A letter in 1935, from Stephenson to Nature, is known as the ”birth” of this statistical method. He suggested an inverted factor analysis where persons were correlated instead of items. In the following years he developed the Q-method with his colleagues.

The data calculated from these forms is affected by Q-factor analysis, which is the same as the traditional R-factor analysis, only reversed. The data from the calculation is reversed in such a way that the persons (cases) become variances and the statements are treated as cases. The principles in the statistical calculation are the same for the two types of analysis. The real difference is that in the Q-method you can analyze the commonalities in the response patterns, not how the statements are distributed in the answers (Kobbernagel, 2006). The factor analysis counts clusters of answers which are similar to each other in the data material. Some of the respondents’ answers are so similar to each other that they will create a pattern, and such a pattern is called a factor. On the basis of the calculations, a number of factors are presented that make it possible to describe commonalities in the responders’ views regarding the statements. There is thus a form of agreement among some of the responders, and disagreement with others.

Q-method can be used to establish the factorial composition of a group on a set of issues, and has been widely used in the social sciences.

5.3 Ethical aspects of the study

The project ”Attitudes Among Stakeholders Towards Compulsory Mental Health Care in Norway” has been approved by the Regional Ethics Committee for Medical Research, and has been carried out in accordance with the Declaration of Helsinki. All subjects have given their written consent to participate after being informed about the project’s aim and procedures.

6. Results

6.1 Synopsis of Paper I

ATTITUDES AMONG STAKEHOLDERS TOWARDS COMPULSORY MENTAL HEALTH CARE IN NORWAY

Objectives: The Norwegian Mental Health Care Act allows the use of coercion under certain conditions. Even though the current practice has been criticized, little empirical data exists about the attitudes towards compulsory mental health care.

Method: This study used Q-methodology to identify prototypical attitudes, and to test the possible differences of attitudes between groups of stakeholders towards the use of coercion in mental health care. Sixty-two respondents who represented six groups with different roles in mental health care participated: former patients, relatives of psychiatric patients, members of supervisory commissions, psychiatrists, other physicians, and lawyers.

The participants were asked to assess the degree to which they agreed on 30 statements concerning the use of coercion for the mentally ill.

Results: Three factors were found that express different attitudes towards the question in a meaningful way. The most widely shared attitude stated that a trusting relationship between the patient and the therapist is more important than the right to have an attorney. This attitude gives partial support to the present Mental Health Care Act. However, the second most common attitude argues that involuntary hospitalization, if necessary, should be decided in a court and not by the hospital doctor.

Conclusions: Differences in attitude could be partly explained by the respondents' role in mental health care. Both psychiatrists and "somatic" physicians expressed more agreement with the present legislation than the other stakeholders. The findings may have implications for the legal protection of mental health care patients.

The six groups of respondents were compared regarding their level of agreement with the three empirically generated attitudes. A MANCOVA-model was used.

Table 2 ANOVA for the three main attitudes

	Dependent variable	F	*P*	Partial Eta Squared
Corrected model				
	Attitude 1	0 .77	0.68	0.16
	Attitude 2	3.15	0.002	0.44
	Attitude 3	1.23	0.28	0.22
Respondent group				
	Attitude 1	0.85	0.52	0.08
	Attitude 2	6.75	0.001	0.41
	Attitude 3	2.41	0.05	0.20
Respondent gender				
	Attitude 1	0.005	0.94	0.001
	Attitude 2	0.053	0.82	0.001
	Attitude 3	0.075	0.79	0.002
Respondent age				
	Attitude 1	1.45	0.23	0.03
	Attitude 2	0.18	0.67	0.04
	Attitude 3	0.48	0.49	0.01

Attitude1: Mild paternalism.

Attitude 2: Autonomy, legal rights.

Attitude 3: Medical paternalism

The main result of this analysis was the strong association between group membership and Attitude 2, as is evident from Table 3:

Table 3 The average correlations between groups/gender and the 3 Attitudes

Group	n	Attitude 1	Attitude 2	Attitude 3
Psychiatrists	10	0.48	-0.03	0.39
Other physicians	10	0.43	-0.04	0.37
Relatives	12	0.47	0.07	0.23
Patients	10	0.26	0.51	0.04
Supervisory*	10	0.41	0.10	0.15
Lawyers	10	0.38	0.36	0.18
Gender				
Female	31	0.40	0.16	0.20
Male	31	0.41	0.15	0.26

* Members of supervisory commissions

The level of agreement with Attitude 2 was especially high among former patients, but it was also generally shared by the lawyers. Psychiatrists and other physicians, members of the Supervisory Commissions, and relatives tended to be neutral or disagree with that attitude. As for Attitude 3, only one group comparison was statistically significant: psychiatrists on average agreed more with this attitude than the former patients.

Comments and limitations

Attitude 1 was generally accepted by most of the 62 respondents regardless of gender, age and their role in relation to involuntary hospitalization. This attitude emphasizes a balance between protecting the patient-therapist relationship, with the patient's autonomy and civil rights on the one hand, and the necessity of using involuntary commitment for some patients with severe mental disorders on the other. This view seems to be close to the intentions of

The Norwegian Mental Health Care Act. As most of the respondents tended to agree with this law, the respondents give a certain degree of support to the current Norwegian legislation in this area. Attitude 2 might be seen as critical to the current mental health care in Norway. Former patients and lawyers agreed to the statements regarding autonomy and legal protection. The members of the Supervisory commissions and the relatives of patients were more in favour of Attitude 1. Perhaps this could be explained by the fact they are in more contact with the practical aspects of mental health care. Could this also be an indication that the commissions are not sufficiently independent from the psychiatrists in charge? Psychiatrists and other physicians tended to agree with what might be called paternalistic attitudes (Attitude 1 and 3). This is also in accordance with the empirical findings of Roe (Roe & al., 2002) and the hypotheses of Chodoff (1984) and Levenson (1987).

The present study has some limitations, especially regarding the selection of the respondents from the former patient group. These participants were recruited from the interest-organizations of former patients. It is possible that some of these respondents are patients who are more unsatisfied with their experience in the mental health care system than the average patient.

In the planning of this study the aim was to include a group of individuals from the general population. Thirteen members of the general population were selected. They were not statistically representative of the general population, but were chosen because of their interest in the project. This group mostly endorsed Attitude 1, and from this we can conclude that they supported the current Norwegian legislation in the mental health care area. We excluded this group from our analyses because we could not be sure that this group was representative of the general population.

All groups were connected first by letter, and if they agreed to take part in the project, they received a manual (Appendix 2). The average response rate was 52. The lower response rate was from the members of the Supervisory commissions (25).

6.2 Synopsis of Paper II

POTENTIAL LEGAL PROTECTION PROBLEMS IN THE USE OF COMPULSORY COMMITMENT IN MENTAL HEALTH CARE IN NORWAY

Compulsory commitment in mental health care represents a dramatic infringement on an individual's life. In Norway, this deprivation of liberty is based on a professional medical assessment that does not require a court verdict. This article presents possible changes that may increase the legal protection for the mentally ill.

The concept of legal protection has at least two definitions: The state's protection of the individual's legal rights (including the right to health care) and the protection afforded to citizens from abuse and arbitrary actions by the state. Infringements on personal liberty without consent require such legal authority as is found in the Human Rights Conventions. These Conventions have precedence over national laws.

Norwegian legislation is based on our confidence in psychiatry as a profession. This confidence allows professionals to treat patients against their will. In some countries, initial court action is necessary before compulsory mental health care can be implemented. This should also be possible in Norway in most cases, with the exception of life-threatening situations.

After our first article about stakeholders' attitudes towards compulsory mental health care, we wanted to call attention to the potential legal protection problems in mental health care. Involuntary hospitalization for mental health care is not subject to the same strong regulations that characterize criminal law. This article presents current legislation, and discusses possible changes that could increase the legal protection for the mentally ill patients who are subject to compulsory commitment. The article also addresses the following important question: Is the intervention proportionate to the situation that it seeks to address?

The protection afforded to citizens from abuse and arbitrary actions by the state has special resonance in legal theory and practice. A basic requirement is that citizens should be given broad access to an independent court when having their rights tried, including situations where the state is the opponent. The basic legal principle is that an infringement on personal liberty which occurs without the individual's consent requires legal authority under what is called the principle of legality (Eckhoff, 1984). This is rooted in the Norwegian law, and in the Human Rights Conventions. Individuals with mental illnesses can be deprived of their liberty without having committed any criminal offences. Our Mental Health Care Act states that compulsory mental health care can be used if a person is suffering from a "serious mental disorder" and constitutes an obvious and serious risk to his or her own life and health, or those of others. The lawmakers have full confidence and belief in the psychiatrists' ability to make the right decisions concerning involuntary commitment.

Legal protection against compulsory commitment by the mental health care services is based on a number of human rights conventions and on Norwegian national legislation. Norway is bound by these conventions according to international law, and in the Human Rights Act of May 21, 1999, lawmakers decided that some of these international conventions would take

precedence over the Norwegian law. The purpose of this act is to strengthen the status of human rights under the Norwegian law.

Decisions about the compulsory commitment of patients who resist treatment should be made only after an adjudicatory process, where legal professionals who are used to balancing conflicting values are part of the decision-making process. An important guarantee of legal protection is the right to a lawyer. When the decision to require compulsory care is made, the patient does not have the right to a lawyer or legal adviser. This is a weak legal protection guarantee. On the other hand, allowing a patient access to a lawyer before commitment could, at least in some cases, delay an urgent compulsory commitment, and could actually be life-threatening in a worst-case scenario.

Legal protection is somewhat guaranteed through the work of the supervisory commissions. They are intended to be the most important guarantor of legal protection in mental health care. But Høyer (1986) argues that they do not perform their task (as legal protection authorities) in a satisfactory manner. One significant weakness of the commissions is their insufficient expertise when it comes to reviewing the professional judgment of senior psychiatrists.

In the case of an infringement of liberty based on administrative decisions, the European Convention on Human Rights, Article 6, includes the right to a fair trial by an independent tribunal, authorized by law. In Norway, the decisions of the supervisory commissions can be appealed to Tingretten (The District Court) and Lagmannsretten (the Court of Appeal). The courts verdicts can in turn be appealed to the Supreme Court.

The duty to provide information is an important legal protection guarantee. As soon as a patient enters the mental health care system, the duty to provide information takes effect, vis-à-vis the patient, the relatives of the patient and the supervisory commission.

Detailed legislation can never replace ethical awareness and knowledge about human rights among health care personnel. An increase in awareness seems necessary. Otherwise, all of these important protections are just regulations on paper, which will not improve the legal protection of psychiatric patients. But it is always very important to have an open debate about ethics and practice.

Comments and limitations

Compared with other European countries, Norway ranks the highest when it comes to the use of compulsory commitment (Bremnes & al., 2008). There are some doubts about these figures because our Mental Health Care Act can not be compared with similar laws in other countries. As an example we can mention that our act forbid conversion from voluntary admission to involuntary admission.

The work of the supervisory commissions has since the commissions were established in our first Mental Health Act in 1848, been a guarantee for legal protection. This has been an exceptional control mechanism compared to similar systems in other countries. But Høyer's study in 1986 concluded that they do not perform their task in a satisfactory manner. Later on in NOU 2011:9 the existing arrangement of the supervisory commissions is criticized. I will mention some examples: the appointment processes of the members are by chance; 57 supervisory commissions directly beneath the Norwegian Board of Health Supervision provide for a wide span of control; the lack of procedures regarding quality assurance and

follow up of the control authorities' (Norwegian Board of Health Supervision) current administrative and professional work. The members are appointed for four years and can be reappointed for more four years in the same commission. It is, I think, good reasons for a rearrangement of the supervisory commissions as a guarantee for legal protection.

When it comes to the information requirement "all information shall be adapted to the patient's individual prerequisites". Høyer's (1986) analysis has shown that patients were often either lacking information or given inadequate information about the appeal process. The patients are in a vulnerable situation and in most cases need help to adapt all information and make use of their legal rights. Therefore it is so important to have a legal adviser as we have suggested in our paper.

The intervention must be proportional to the situation that it seeks to address: The European Committee for the Prevention of Torture and Inhumane or Degrading Treatment or Punishment (CPT, 2006) has criticized Norway for the use of police and handcuffs when mentally ill persons are brought to the hospital, a practice without ethical or legal justification.

Legal protection should, however, never be more than one of several measures used to realize medical, social and human ideals in the treatment of psychiatric patients (Eskeland, 1983). A conflict can easily arise between a patient's self-determination on one side and the society's responsibility in mental health care service on the other. Human rights and legal protection can be argued for on both sides.

6.3 Synopsis of Paper III

COMPULSORY MENTAL HEALTH CARE IN NORWAY: THE TREATMENT CRITERION

Background: The Norwegian government has chosen to keep a treatment criterion in the Mental Health Care Act even though several user organizations oppose it. From a critical user perspective, the only reason for using coercion to require mental health treatment is that the individuals are in a state where they are an immediate danger to themselves and/or their surroundings. However, mental health professionals state that patients may resist compulsory treatment because they lack psychological insight into their own suffering.

Aims: The aim of this paper is to make an overview of the research studies concerning the benefits or harmfulness of involuntary treatment after a coerced admission. Secondly we aim to evaluate studies that try to compare involuntary treatment with voluntary treatment.

Methods: A systematic overview of the studies, published over the last decade of compulsory mental health care regarding treatment criterion and coercion in mental health care, was investigated in detail, together with a secondary manual search of the references cited in the publications identified.

Results: Few studies have been conducted on the effect of compulsory mental health care, and the results have been contradictory.

Conclusion: Additional, more randomized studies are needed to document the kinds of effects the use of compulsory treatment have on treatment results. One may also suggest that the question regarding the use of coercion should be transferred to legal bodies with an adjudicatory process.

The current legislation is based on the idea that persons with serious mental disorders are without psychological insight and/or the competence to give consent. This is a view that may

have a somewhat weak scientific support. On the contrary, research has shown that even people with a severe psychiatric disorder are capable of a level of psychological insight that is similar to the norm: "the justification for a blanket denial of the right to consent or to refuse treatment for persons hospitalized because of mental illness cannot be based on the assumption that they uniformly lack decision-making capacity" (Grisso & al., 1995; Grisso and Appelbaum, 1995).

The user organizations believe that compulsory mental health treatment based on the treatment criterion has led to life-long trauma for many people. Psychiatry has only been able to prove the effect of treatment under these conditions to a limited extent (Høyer, 2000). Removing the treatment criterion would also be in accordance with the Recommendation of the European Council (2004), which does not allow for compulsory commitment based on a treatment criterion alone.

In this paper we also argued that the decision over the use of coercion should be transferred to legal bodies. It should be based on a psychiatric evaluation, but taken by a juridical representative (or a committee) who have experience in arguing opposing values and views. In other countries the use of an independent body in cases with compulsory commitment has become more common. A judge, for example, may play an important role in such a case. Member States in the European Union, with an obligatory inclusion of a legal representative during the commitment procedures, have significantly lower compulsory admission quotas (Dressing and Salize, 2004).

Comments and limitations

There is little empirical knowledge available regarding the quality of mental health care in Norway. There are some studies, but these are not of a high quality. We do need more and

better studies in order to obtain more knowledge about what effect compulsory treatment has on recovery. We have therefore in this paper made a systematic overview of the studies both in Norway and other countries regarding treatment criterion and the kinds of effects the use of compulsory treatment have on results. We hade hoped to find in the research studies a wealth of data about the benefits or harmfulness of involuntary treatment. But those that have been carried out show contradictory results. Unfortunately, it is difficult to come to any conclusion about the use of the treatment criterion and the use of coercion for mental health treatment in the absence of controlled, randomized studies. There is no clear evidence regarding the effects of coercion on patients and that involuntary treatment works better than voluntary treatment.

In May 2010 the Norwegian government appointed a committee on the revision of the Norwegian Mental Health act. The mandate asked the committee to asses both the necessity of the treatment criterion, and if the legislation for mental and somatic patients could be harmonized by making mental capacity a common criterion for involuntary treatment. The report was delivered in May 2011 (NOU 2011). The committee has concluded that the present treatment criterion should be maintained despite the existence of a broad and reasoned criticism of compulsory treatment, particularly when it comes to the long-term effects of antipsychotics. The committee finds that different types of treatments, even with antipsychotics, have positive effects, and are essential for the improvement of many cases of severe mental disorders. Lack of treatment can be very serious for people with severe mental illness who are without decision-making competence. Avoiding essential health damage should be the primary criterion for establishing compulsory mental health care. The treatment criterion is built on a principle of damage, which include an obvious risk to the patient's own life and health, or those of others. On the other hand, in somatic medicine a patient

(according to the Patients' Rights Act, section 4-9) has a right to refuse health care in special situations, which can threaten the patient's life. These special situations are to refuse to receive blood or blood products, and to break off an ongoing starving strike due to serious conviction.

6.4 Synopsis of Paper IV

DECISIONS IN THE SUPREME COURT OF NORWAY: HAVE THEY INFLUENCED MENTAL HEALTH LEGISLATION OR CLINICAL PRACTICE?

According to the Mental Health Care Act, cases concerning compulsory hospitalization or observation, as well as other cases about civil rights outside this law, can be brought before the Courts with the right of appeal. How does the Supreme Court interpret cases in psychiatry as a court of appeal? Have their rulings influenced mental health legislation and clinical practice?

An online computerized inventory was carried out in the Lovdata.no database under the search terms *Høyesteretts avgjørelser (decisions of the Supreme Court) and Psykiatri (Psychiatry) and Menneskerettigheter (Human Rights).* The search revealed that the Supreme Court has been involved in 28 psychiatric cases since 1904. These cases dealt with compulsory hospitalization or observation, legal invalidity, access to one's own journal, compensations, cancelling the diagnosis and cases where the complainants have already been discharged.

The decisions in the Supreme Court, which are described in Norsk Retstidende (Norwegian Supreme Court Reports), have been analysed. They are then compared with the historical development of the mental health legislation and clinical practice in psychiatry.

Decisions in 1981, 1988, 2000 and 2001 are typical examples of the Supreme Court's consideration of reasonableness, which was expressed in Proposition to the Odelsting no.11 (Innst. O. nr 11) that compulsory mental health care is a drastic action which should not be used against a person functioning well over longer periods of time without allowing him to "try" to see how things go on outside even if he is suffering from a mental disorder and one or both of the additional criteria are fulfilled. The Court is here in accordance with the view of the psychiatric experts. We therefore notice a feedback system from the society to the Court and from the Court to the psychiatric profession and to the lawmakers and vice versa. This strengthens the Court's legitimacy in society.

With regard to patients with no manifest sign of psychosis due to medication, we observe an unwillingness to discharge these patients. The Supreme Court is more "conservative" and has been criticized for this view.

Comments and limitations

Comparatively few complaints in the area of psychiatry have reached the Supreme Court, and there have been none since 2004. One might question whether the Court in "discharge"-cases is suitable to take independent decisions against both the expert assessment of psychiatrists and the Supervisory Commission. The majority of patients in psychiatric institutions also belong to the lower social hierarchy. Compulsory admission for mental health care is associated with problems of poverty and the lack of permanent lodging (Bruk av tvang, 2006). Patients with limited resources would perhaps give up after contact with the Supervisory Commission; their complaints would not be forwarded to the courts.

After Paper IV was written, a new case was brought before the Supreme Court in December 2011 (Norsk Retstidende 2011). The question was if a "helseforetak" had broken the procedural rules in the Mental Health Care Act in connection with a decision about compulsory observation, and if this commitment constitutes a breach on the Human Rights Convention article 5 no. 1. The Court found that the procedural rules had not been complied with, and the case was then rejected by the Court because the "helseforetak" was not the right legal person. The Court concluded that it was the State, represented by the Ministry of Health and Care Services, which was the legal person in cases concerning the Human Rights Convention.

This paper does not include extensive literature on the relationship among courts and mental health practice in other countries and is therefore limited to the Norwegian system. This is perhaps a drawback for this paper. It could have been very interesting in comparing our courts and mental health practice with similar systems in other countries.

7. Discussion

7.1 Discussion of major questions

The study of compulsory mental health care revealed at least four major questions which are discussed in the following:

1. Attitudes among different respondents
2. Legal protection problems
3. Treatment criterion
4. Decisions in the Supreme Court: Have they influenced Mental Health Legislation or Clinical Practice?

I will also discuss the human rights' perspective in connection with the above mentioned topics.

7.1.1 Attitudes among different respondents

The first paper found that among the six groups of respondents the most typical attitude (Attitude 1) explained 23 % of all the variance. The respondents empathize with the legal right to adequate treatment for the mentally ill, and want to protect a trustful relationship between the patient and the therapist. The patients' needs for care and protection from hurting themselves justify the use of involuntary hospitalization. Statement 2 has the highest score:

"According to medical ethics it is right to take care of the patients that are considered seriously ill and not able to take care of themselves. These principles legitimate the compulsory commitment of psychiatric patients."

Psychiatrists, other physicians, relatives and members of the supervisory commissions tended to agree with Attitude 1, which might be called a paternalistic attitude. This view seems to be close to the intentions of the current mental health care act.

Attitude 2 accounted for 14 % of the variance and was the second most important empirical attitude. The attitude states that it is more important to treat the patient with respect than to use treatment that is assumed to be effective. It strongly argues for the patient's right to have a lawyer appointed if she or her is involuntary committed. The agreement with Attitude 2 was especially high among former patients, but it was also generally shared by the lawyers.

Statement 5 had the highest score here:

"It is more important to treat a patient with respect and maintain his/her dignity, than to give treatment that is assumed to be efficient but may weaken his/her integrity".

This attitude is critical to the current mental health care act, and may be called an autonomy and legal rights attitude.

The main result of this analysis was the strong association between group membership and Attitude 2.

Before a firm conclusion can be made this study must be replicated.

To our knowledge, little empirical research has been done to test if the attitudes differ between groups of stakeholders (such as psychiatrists and lawyers) towards the use of coercion and involuntary hospitalization. In a study from Israel (Roe & al., 2002), a difference in attitude was observed between patients and staff members; patients were less likely to justify the use of involuntary hospitalization, and staff members were always more likely to express the view that the patient's rights should be compromised when perceived as conflicting with the patient's clinical needs.

In a Norwegian study (Falkum and Førde, 2001) a representative group of Norwegian physicians were given 16 statements about attitudes of paternalism and patient autonomy. In this study paternalism scored highest among the oldest physicians, and psychiatrists scored significantly lower than other physicians. The doctor-patient relationship has long been of importance in the training of psychiatrists, a fact that might have influenced this difference in attitude.

A Swedish study of psychiatrists' attitudes regarding compulsory treatment revealed that 98 % of them found it ethical to hospitalize against the patients' will if they are a danger to themselves or others (Kullgren & al., 1996). They found some minor differences in attitudes, depending on the respondents' age and gender. In accordance with Roe (Roe & al., 2002), we did not observe any age- or gender-related differences in the measured attitudes. In a study from North Carolina, outcome preferences for persons suffering from schizophrenia were assessed within four stakeholder groups: persons in treatment for schizophrenia, relatives of the patients, clinicians, and members of the general public (Swartz & al., 2003). The findings suggested that all these stakeholders were willing to accept the coerciveness of *outpatient* commitment to gain improved outcomes for certain persons with mental illness. In contrast to our findings, they found that the different stakeholders were equally concerned with avoiding involuntary hospitalization.

Lauber & al (2004) have made a comparison of two representative Swiss samples, one comprising of 90 psychiatrists and the other including 786 individuals of the general population, in order to compare experts' and lay attitudes towards community psychiatry. The de-institutionalisation of people with mental illness aims at improving the living conditions of those affected, and decreasing their social stigmatisation. However, integration in the community caused new difficulties: the general population met the mentally ill with a

considerable amount of rejection and social distance. Despite the plethora of studies about the stigma associated with mental illness, little is known about the attitudes of mental health professionals towards those affected. Besides, it is unclear how the professionals' attitudes differ from those of the general population. This study found that the psychiatrists' attitudes were significantly more positive towards mentally ill people than that of the general population.

According to a French paper (Guedj & al., 2012) 95 % of the participants (123 lay people, 20 nurses, 5 psychologists and 6 physicians) agreed that involuntary hospitalization is acceptable under certain conditions, especially – in accordance with French law – when the patient presents a risk to others.

A questionnaire analysis from 2004 (Lepping & al.) tried to study the attitudes of both the mental health professionals and the lay-people towards involuntary admission and treatment in England and Germany. Psychiatrists and other mental health workers were in tune with society with regards to attitudes towards involuntary admission. People involved with mentally ill patients, but not in the detention process, have negative attitudes towards involuntary admission. The different legal frameworks between Germany and England did not influence attitudes.

The most important finding of Paper I was that the differences in attitude could in part be explained by the respondents' role in mental health care. The difference between medical professionals and lawyers may reflect a professional socialization, with possible implications for the legal protection of mental health care patients, such as future work with mental health care legislation. This new legislation should, in my opinion, include the right for the patient to have a lawyer present when the decision to require compulsory care is made.

In a doctoral dissertation Kogstad (2011) has made an investigation of users' experiences with mental health care. The analyses were built on both qualitative and quantitative data, and contribute to thematic fields such as treatment cultures, infringements seen in relation to human rights, recovery processes, the importance of social networks, the validation of users' knowledge, and power relations. The findings reveal that psychiatric clients experience infringements to a degree that cannot be explained without reference to their status in a system in which the professionals are allowed to ignore the patients' voices when evaluating them. In another doctoral dissertation Husum (2011) has investigated the attitudes of acute psychiatric staff towards the use of coercion. The gap between staff attitudes and the actual use of coercion may indicate that staff consciousness and knowledge about ethics and human rights could be improved in order to further reduce its use, and to improve the quality of care.

All the stakeholders in the mental health care system must bear in mind that their own attitude and ethical arguments might be biased by their social role.

7.1.2 Legal protection problems

In Paper II I have argued for the right to have a lawyer when the decision to require compulsory care is made. Decisions about the compulsory commitment of patients who resist treatment should be made only after an adjudicatory process. According to my earlier suggestions, the Law committee of 2010 (NOU 2011) has recommended 3 hours of free legal advice for information and consultation in establishing a case of compulsory care. The committee could have proposed transferring the decision-making power over the use of coercion to legal bodies. On the other hand, allowing a patient access to a lawyer could, in some cases, delay an urgent compulsory commitment and in a worst-case scenario, be life-

threatening. It will be interesting to see if the Government will follow the committee in this matter in a new mental health care law.

The law-committee of 2010 does not suggest any essential changes in the system of court control. This system has an important protection accorded by the law, and must be continued (Paper II and Paper IV). The claim of court control is also included in many human rights conventions, which Norway is obliged to follow.

7.1.3 Treatment criterion

Despite the broad and reasoned criticism of compulsory treatment, the Committee (NOU 2011) has concluded that the present treatment criterion should be maintained. Lack of treatment can be very serious for people with severe mental illness who don't possess decision-making competence.

However many users in the psychiatric area disagree with the use of the term "mental illness". They prefer the term "psychosocial disability" (Minkowitz, 2006-2007). The term indicates that the problems arise in a person when meeting the society and its established norms. Psychosocial disability is not necessarily a mental illness. Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments. This way of thinking refers to the UN Convention on the Rights of Persons with Disabilities (CRPD, 2006), signed by Norway in July 2008, but not yet ratified by the Norwegian government. The focus is no longer on what is wrong with the person, but what is wrong with the society when people with psychosocial disability are being discriminated against and excluded. The

transfer from a medical model to a social model will involve a re-thinking of psychiatric practice and mental health care laws.

The law-committee of 2011 has discussed this UN Convention in their proposal, and is of the opinion that the aim of this Convention must be realised gradually. The Mental Health Care Act will not be altered because of the Convention, but perhaps it ought to be.

One member of the law-committee has made a dissent: she believes that the loss of liberty and the compulsory treatment in the Mental Health Care Act are discriminating, and go against CRPD. She suggests that the Mental Health Care Law be set aside. People with psychosocial disability have, through the remaining legislation[7], a legal right to the necessary health care and health services.

7.1.4 Decisions in the Supreme Court of Norway: Have they influenced mental health legislation or clinical practice?

The most astonishing in this paper is that comparatively few complaints in the area of psychiatry have reached the Supreme Court, and none after 2004. We had a decision in 2011 about procedural rules and the Human Rights Convention. The Court rejected the case and concluded that it was the State which was the legal person in cases concerning the Human Rights Convention.

I think some of the reasons are that patients were often either lacking information or given inadequate information about the appeal process. Patients admitted compulsory are often not sufficiently aware of their legal position and legal rights. The statistic has also uncovered social problems in connection with compulsory commitment. Many patients belong to the lower social hierarchy and have minimal networks outside the hospital. A solution on these problems would be that a lawyer is appointed when a case of compulsory care is establishing.

[7] The Patient' Rights Act of July 2, 1999 No. 63
The health Personnel Act of July 2, 1999 No. 64
The Speciality Healthservice Act of July 2, 1999 No. 61

This is also recommended by the Law Committee and if the Government will follow the committee, this will influence mental health legislation and clinical practice.

7.1.5 The Human Rights' perspective in connection with Papers I - IV

We presume that our legal system is in accordance with human rights, and that our legal system will be interpreted as far as possible, in such a way that it will not be contrary to international law. In 1994[8], lawmakers added an amendment to the Norwegian Constitution that stated: "It is the responsibility of the authorities of the State to respect and ensure human rights". Later on, in 1999, The European Convention on Human Rights and protocols were adopted by Norwegian legislation, and this adoption gives them precedence over comparable Norwegian laws[9]. There was a certain resistance to adopting The European Convention on Human Rights, and giving them precedence over comparable Norwegian laws, such as the Norwegian Health Care Act. It was argued that such incorporation would, to a large extent, transfer the use of resources to the courts and would delimit the role of the Parliament. This would be especially critical because of the discretionary character of the rules.

The use of coercion is controversially and ethically challenging. Therefore the coercion in psychiatry and ethics cannot be separated. In the papers I-IV I have attempted to bring human rights into the debate. But we have a dilemma which also the Law Committee (NOU 2011:9) has pointed out. Which framework puts the various Human Rights Conventions relating to mental health care? Use of coercion represents a severe encroachment in a person's integrity and autonomy. Both a person's integrity and autonomy are protected by our national laws and human rights. A conflict can arise between a person's legal rights and the society's responsibility to give health care service. How can we balance safety versus autonomy in

[8] The Norwegian Constitution §110 c, amended 15 June 1994
[9] Act of May 21st 1999 No. 30

connection with compulsory admission and coercive treatment? There is a highly sensitive debate going on in the media and among the public about the situation of patients in the mental health care system. We need this debate in order to bring forward the obligations Norway has with regard to the human rights conventions. Many are worried about the use of compulsory commitment in psychiatry, and that this practice has not been placed under such strong limitations as found in the criminal legal system.

A chronicle (Blesvik & al., 2006) illuminates our human rights commitment regarding psychiatric patients. The chronicle brings forward the following statements and ideas, which could inspire a constructive discussion:

1. When patients are sent to involuntary commitment, both the police as well as hand-cuffs are often used. The patients feel this is very offending. The delegation of the European Committee for the Prevention of Torture and Inhumane or Degrading Treatment or Punishment (CPT, 2006) has in their report commented that using hand-cuffs and fetters on patients in bringing them from their homes to the hospital must cease. It stigmatizes and incriminates the patients.
2. The involuntarily committed patients have complaints about enforced medication. They are drugged, and because of this they feel that they are not able to argue their case when their complaints are treated in the Supervisory Committee.
3. It is worrying that neither the government nor the professional psychiatric milieu take into consideration the obvious uncertainty about the effects of compulsory treatment. No sound research has been found supporting the position that compulsory treatment aided the overall treatment (Hatling, 2002; Høyer, 2000; Bjørngaard and Hatling, 2005).
4. The Norwegian law does not permit ECT (electro convulsive therapy) without

informed consent. Yet it is employed using the paragraph of necessity[10] (Helserett, 2001). The method is problematic and controversial (Read & al., 2004; Rose & al., 2005).

5. There is a lack of information. There are examples of insufficient information given to the patients and their relatives about their legal rights, and the possibilities of complaint (Niveau, 2004).

There is a great need for more knowledge about the contents in the human rights conventions among the staff in psychiatric care. The chronicle requests that our government take responsibility so that our international human rights obligations are not only regulations on paper, but that they mean something to the people who need them.

The use of coercive interventions in mental health care is a potential threat to the patients' human rights. That is why a consistent and strong focus on reducing their use is so important (Husum, 2011). Coercion should only be used as an absolute last resort, after everything else has been tried, and only then for protection and security reasons.

In Paper II we have mentioned that CPT (2006) has criticized Norway for the use of police and handcuffs when mentally ill persons are brought to the hospital. The police are aware of this problem. In 2005 the Oslo police department had brought 2550 patients to the hospital. The police task in bringing mentally ill persons had increased with 11.8 % in Oslo from 2004 to 2005 and in Trondheim by nearly 20 %. The police wanted the health care system to take on this task itself, since it taxes so many of the police resources.[11]. In Bergen there was no increase, mostly because of the fact that Bergen has introduced an acute ambulance team after

[10] Act of May 22 1902 No. 10 §48
[11] www. klassekampen.no (01.12.2006)

a model from England, called “Crisis Resolution Team”. The team works with individual clients and their families in situations pertaining to acute psychic disturbances. The emphasis is on helping people in their community. This idea has inspired many psychiatric centres in our country, which administrate their own acute teams. These teams will probably make the task easier for the police, and the patients will not feel themselves stigmatized and incriminated.

In May 17, 2014 The Norwegian Constitution will be 200 years old. In that connection a committee has been appointed to present suggested amendments to our Constitution in order to strengthen human rights in our legal system. After such a revision, the Norwegian Constitution will probably reflect a more modern view on human rights protection. Human rights will function as a shield against the excessive power of the state because ordinary laws can be modified according to the existing political view, while, according to §112 in our Constitution, a part of the Constitution can only be altered after a first, second and third Storting after the following general national election.

The strengthening of human rights principles in our legal system will probably also benefit people with psychiatric disabilities. The two greatest threats against mental patients are involuntary detention and abusive treatment. All forms of compulsory commitment in the mental health care system must be legally justifiable, ethically justifiable and treatment compatible.

7.2 Clinical and research implications

There is little empirical knowledge available about the quality of Norwegian mental health care. Many basic research questions still remain to be adequately addressed, such as the long-term effects of involuntary treatment. Little is known about the effects on patients in the use

of coercion. It is surprising that there is not a wealth of data on the extent and outcomes of coercion (Hiday, 1996). Controlled and randomized studies are necessary on populations that are representative of those seen in usual clinical practice, to be able to obtain results that serve to give good practice recommendations on their application (Mayoral and Torres, 2005). There are few studies about the use of compulsory commitment in mental health care in Norway. International studies are of varying quality, and can only be applied to a certain degree to the Norwegian system.

Perhaps one reason for this is that the figures given to the Norwegian Board of Health Supervision from the mental health care services in the country are deficient. The figures in the reports must be more reliable.

There are also serious problems with the research methods in the area of compulsory treatment in psychiatry.

I would like to make a suggestion: A special master's degree in law, called forensic psychiatry, could be established. The program could deal with all compulsion in the mental health care system, both the forensic and administrative decisions. This could make lawyers and judges better prepared for their task in the courts, and make them more independent of the psychiatric experts' decisions. An institute of forensic psychiatry could also be established.

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9. Appendix

Appendix 1

1	The assessment of what is normal or pathological is related to cultural, moral and political attitudes of the people who make the assessment	
2	According to medical ethics it is right to take care of the patients that are considered seriously ill and not able to take care of themselves. These principles legitimize compulsory commitment of psychiatric patients.	
3	The social background of the patient is decisive for what treatment he/she receives.	
4	Rapid treatment is more important than securing a good collaboration between patient and therapist.	
5	It is more important to treat a patient with respect and maintain his/her dignity, than to give treatment that is assumed to be efficient but may weaken his/her integrity.	
6	It is important that the patient remains in control of his personal and private affairs even if the treatment of the mental disorder suffers as a result of this.	
7	The rule should be that there is always an attorney appointed to a person who is involuntarily committed to psychiatric health care immediately after such a decision is made.	
8	The rule should be that there is always an attorney appointed to a person who is involuntarily committed to psychiatric health care as soon as such a decision is made.	
9	Compulsory treatment will be more efficient and help the patient on a long-term basis.	
10	If the physician deems it necessary, compulsory treatment should start immediately after the patient is committed.	
11	The establishment of compulsory psychiatric health care mostly employs flexible rules, where considerations of fairness and expediency will be a part of the assessment. Compulsory rules would be a better solution.	
12	Compulsory commitment is easier to accept if the reason given is that the patient is a danger to others.	
13	Compulsory commitment is easier to accept if the reason given is that the patient is a danger to himself.	
14	Compulsory commitment is easier to accept if the reason given is that the patient is not capable of assessing his own situation.	
15	Compulsory commitment is easier to accept if the reason given is a danger that the opportunity for treatment may be lost.	
16	A larger part of the community's resources should go to treatment of psychiatric patients rather than other welfare benefits.	
17	When a patient does not wish to remain in a psychiatric institution, it is better that the case is decided in court than by the administrative senior physician's assessment.	
18	To prevent further unnecessary compulsory measures, it is important to have a more precise legal assessment of the patient's rights and what he/she must accept.	
19	The professional assessment of what is best for the patient often stands in opposition to the patient's legal security.	
20	In psychiatry there are opposing interests between treatment considerations and considerations regarding legal security.	
21	When choosing between several courses of action the purpose of the treatment is put above the law.	
22	Legal protection would improve if it is the court that makes decisions about compulsory commitment.	
23	The trusting relationship between patient and therapist is more important than the right to an attorney.	
24	The trusting relationship between patient and therapist is more important than court treatment.	
25	Patients with a serious mental illness should have the legal right to relevant treatment.	
26	Treatment in psychiatry is an adaptation to the norms of the society.	
27	Psychiatry is a part of the government's power.	
28	The use of involuntary measures in psychiatry is the uttermost consequence of solidarity between humans.	
29	Efficient treatment considerations weigh heavier than considerations regarding the patient's right to decide for himself.	
30	As long as the treatment perspective is the basis for decision making, anything is allowed.	

Appendix 2

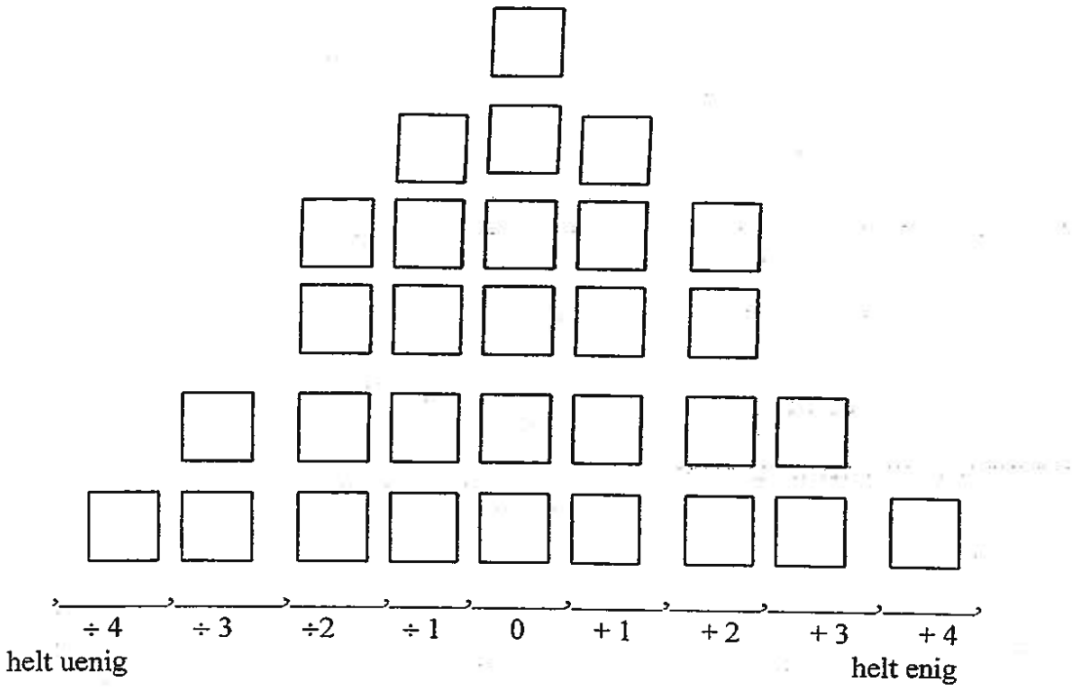
Til deltakerne i forskningsprosjektet "Tvang i norsk psykiatri"

Takk for at du vil stille opp og bruke ca ½ time av din tid på ovennevnte prosjekt.

Svarene du gir behandles anonymisert, og du trenger bare å oppgi alder (år), kjønn (M eller K) og hvilken gruppe av personer du befinner deg i (fra A til G, se under).

A psykiater
B lege (ikke psykiater)
C pårørende til psykiatriske pasienter
D tidligere pasient
E medlemmer av Kontrollkommisjon
F andre
G jurist

Du har nå fått 30 kort med ulike påstander. Disse skal sorteres ved at de legges i 9 hauger som uttrykker hvor enig eller uenig du er i disse påstandene. Enigheten beskrives ved at haugene har tallverdier fra + 4 ("helt enig") til-4 ("helt uenig/minst enig"). Du må prioritere så godt du kan slik at du ender opp med 9 hauger der et kort legges i haugene merket henholdsvis + 4 og – 4, to kort i hver av haugene +3 og - 3, osv. som illustrert nedenunder. Når du har bestemt deg for hvilken haug hvert kort passer best, skal kortnummer skrives i skjemaet nedenfor. Husk også å fylle ut alder, kjønn og gruppetilhørighet før skjemaet returneres sammen med kortene til prosjektleder Rigmor Diseth, Universitetet i Oslo, i den vedlagte konvolutten.



Alder: **Kjønn:** **Gruppe:**

Article I

Article II

Article III

Article IV

Errata

Art. III, side 17, 4.linje: Szemishlany rettes til Zemishlany

Art. III under References side 24: Norsk Retstidende 1998 rettes til 1988