Understanding and interpreting the process behind compulsory admissions:

A QUALITATIVE STUDY

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Abstract

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Research question I will investigate how healthcare professionals that make decisions regarding compulsory admissions to mental institutions understand and interpret the criterions listed in the "act of mental healthcare", their attitudes and believes regarding the use of force upon patients and lastly their thoughts on the reasons behind the differences in the practicing of compulsory admissions.

Background The "act of mental healthcare" which defines the criterions that have to be present before a person can be committed to treatment is the subject of individual interpretation. There are huge regional differences in the use of compulsory admissions to psychiatric hospitals in Norway ranging from 8 for every 10 000 inhabitants in Førde to 34 for the University Hospital of Northern-Norway. This indicates that the practices differ.

Analytical framework I have used paternalism as my theory for explaining the process behind compulsory admissions. Paternalism revolves around a situation where someone makes decisions for someone else, against that persons wish, but in the person's interest. The person in question is in this connection considered as being irrational, not able to make informed choices.

Method and sample 10 relevant healthcare professionals that have responsibilities for taking decisions regarding compulsory admissions where interviewed. The interviews were qualitative and semi-structured and lasted between 60 and 90 minutes.

Findings My informants knew the contents of the law well, but their interpretations of the criterions and when too apply them varied. Their attitude towards the benefits and consequences regarding the use of compulsory mental healthcare influences their decisions in the matter. This is related to paternalism, different opinions regarding what is in the best interest of a patient will give different practices. A variety of possible reasons for the differences was presented. Unreliable numbers, distance to hospital, different routines, socio-economic factors, differences is the interpretation of the law, not knowing the law, conflicting signals from the government and county doctors, consciously breaking the law in cases with suicidal patients, professional environment etc.

Conclusion My informants were all well informed regarding the «act of mental healthcare», but found it challenging to interpret. The interviews gave me the clear impression that the attitudes and believes of the individual healthcare professional regarding the use of compulsory admissions influences their practices. A variety of factors seems to influence the differences in the use of compulsory admissions, the most striking to me is that forced observation after §3-2 in the "act of mental healthcare" are often used, even if the main criterion of "serious mental disorder" is not present. This is a situation where paternalism goes before the law.

Acknowledgements

I would like to thank all those who have supported me during my work with my master thesis. First of all I would like to thank my girlfriend Monica for supporting me and taking care of me during a stressful period. I would also like to thank my family for their support. In addition, a big thanks to every informant that participated in my study, you gave me important insights into a very interesting field. Also thanks to Mona who helped me in practical matters.

Conducting the interviews, examining the results, and presenting and analyzing the findings proved too be the hardest and most time-consuming part of the work connected with the thesis. Conducting the interviews and writing the thesis has been very interesting, but the work load has been great. The last three weeks before submitting the paper has been very tiresome and stressful, with frequent meetings between my supervisor and me, the workload appeared at times to be overwhelming. However, I feel I have learned a lot from the process. Not only about the mental healthcare services and the process behind compulsory admissions, but also about the research process, and how challenging and extensive this process can be. I have had the opportunity to experience how it is to do hard mental and theoretical work under time pressure. It gave me some new insights.

Lastly, I would like to thank my supervisor, Eli Feiring. She has been a great help for me, providing me with excellent guidance on how to do qualitative research and perform elite interviews.

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1 Introduction

The main focus of my thesis will be on the process behind the use of compulsory admissions to psychiatric hospitals inside Norway. The background for the practices of compulsory admissions and other uses of force in the psychiatric sector is the "act of mental healthcare" which describes the criterions and conditions that have to be present if somebody is to be subjected to compulsory mental treatment. Whether or not a person's condition corresponds with the criterions described in the law is the subject of individual interpretation. (This interpretation is done by two independent healthcare professionals, where one of them has no connection to the institution where treatment is to take place, the other one is working at the treating institution). It therefore follows that the way the independent healthcare professional understands and interprets the criterions in the law will influence his or her decisions. Furthermore one would assume that the decision maker's beliefs and attitudes regarding the effects and consequences of compulsory admissions will define their practices. An indication of this could be that the regional differences in the use of compulsory admissions are huge, ranging from 8 for every 10 000 inhabitants in Førde to 34 for the University Hospital of Northern-Norway (SSB, 2009). The "act of mental healthcare" could be considered to be paternalistic. Paternalism is a situation where somebody makes decisions for another person, but against the person's wishes. The decisions, however, is made in the best interest of the person concerned. The justification for paternalism is that the person in question is not considered to be in a condition to know what is in his or her best interest. The person are in other words neither rational nor autonomous, unable to make informed choices. "The act of mental healthcare" when it comes to compulsory admissions involves the process where someone makes choices for others. The choices is made against the wishes of the person in question, but is justified as being in the best interest of the person concerned, unless the person represents a present treat to the life and health of others (Then the interest of society will be taken into consideration) . On that background I have chosen paternalism as my theory.

I am going to interview healthcare professionals working in the Hospital of Innlandet, which has few compulsory admissions and healthcare professionals working at the Hospital of Vestfold and at the hospital of Sørlandet which have many. These regions are in many ways similar, they all include cities, but none of the biggest, and they all include rural areas. To

answer the research question regarding the decision process behind compulsory admissions I will investigate the following:

How do the informants understand and interpret the "act of mental healthcare" and its criterions?

- Do they believe that the law could be interpreted differently by other healthcare professionals?

Their attitudes regarding the use of force

- Do pressure/signals from the Government influence the attitudes and decisions of the responsible healthcare professional?

-Does the professional environment in an institution influence the attitudes and behaviours of the healthcare professionals?

Their thoughts and opinions regarding the reasons for the differences in the use of compulsory admissions

1.1 Background

In many countries of the world, this includes Norway, debates surfaces from time to time regarding the use of compulsory admissions in the mental healthcare services. People and groups are asking questions of whether or not it is justifiable to commit people that have not committed any crime, to be subjected to hospitalization in a mental institution against their will. The healthcare services in Norway is known for committing more patients, both in numbers and in percentage of the population to treatment in mental hospitals than most other comparable countries (tidsskriftet.no). This is also a concern of the Norwegian government

that has it as a stated goal that the use of force in the psychiatric sector should be reduced (NOU 2011:9). On the other hand some people are complaining that it is difficult to get someone committed to a mental hospital (usually the families of the patients), and it is not rare that the newspapers reports on psychiatric patients committing murder or other acts of violence, we also see a relatively large number of the same category of patients committing suicide.

”The act of mental healthcare” is the law which determines the criterions that has to be present if a patient is to be committed to psychiatric care against his or her will. First of all the patient must be suffering from a “serious mental disorder”. In addition to be suffering from a serious mental disorder the patient has to fulfill at least one of the two secondary criterions. These are the so called “treatment criteria” (a), and the so called “danger criteria” (b). The treatment criteria (a) points at situations where the patient without receiving treatment will get his or her possibilities to get cured or to have their health improved significantly reduced, or that it is a big possibility that the patient, in the near future, will see their mental health considerably worsening, or (b) that the patient represents a danger (in the near future) to their own or others life and health. The law also states that no one shall be committed to a mental hospital unless a total evaluation says that this would be in the best interest of the patient, unless that person represents an immediate threat to the life and health of others. In addition, voluntary solutions shall be tried first, unless this is obviously pointless (lovdata). (I will present the contents of the law “the act of mental healthcare”, in chapter three with comments and explanations) This is the legal background for compulsory admissions in Norway. However, if a patient fulfills the criteria’s or not is up to individual interpretation, this interpretation is done by a physician(s)/psychiatrist(s)/special psychologist(s) (hereafter called healthcare professionals). Maybe this fact could be some of the reason for the considerable regional differences in the use of compulsory admissions to psychiatric hospitals that we see inside Norway. Ranging from 8 patients committed to hospitalization in Førde, to 34 for the University Hospital in Northern-Norway, we can clearly see that the regional differences are huge (SSB, 2009).

Why is this important? Being committed to treatment in a psychiatric hospital against a persons will, with locked doors, with the potential use of straps, forced medication, room searches and strip searches and other coercive measures (lovdata), naturally represents the risk of traumatization, in varying degrees, of the patient. We are here talking about “strong or hard

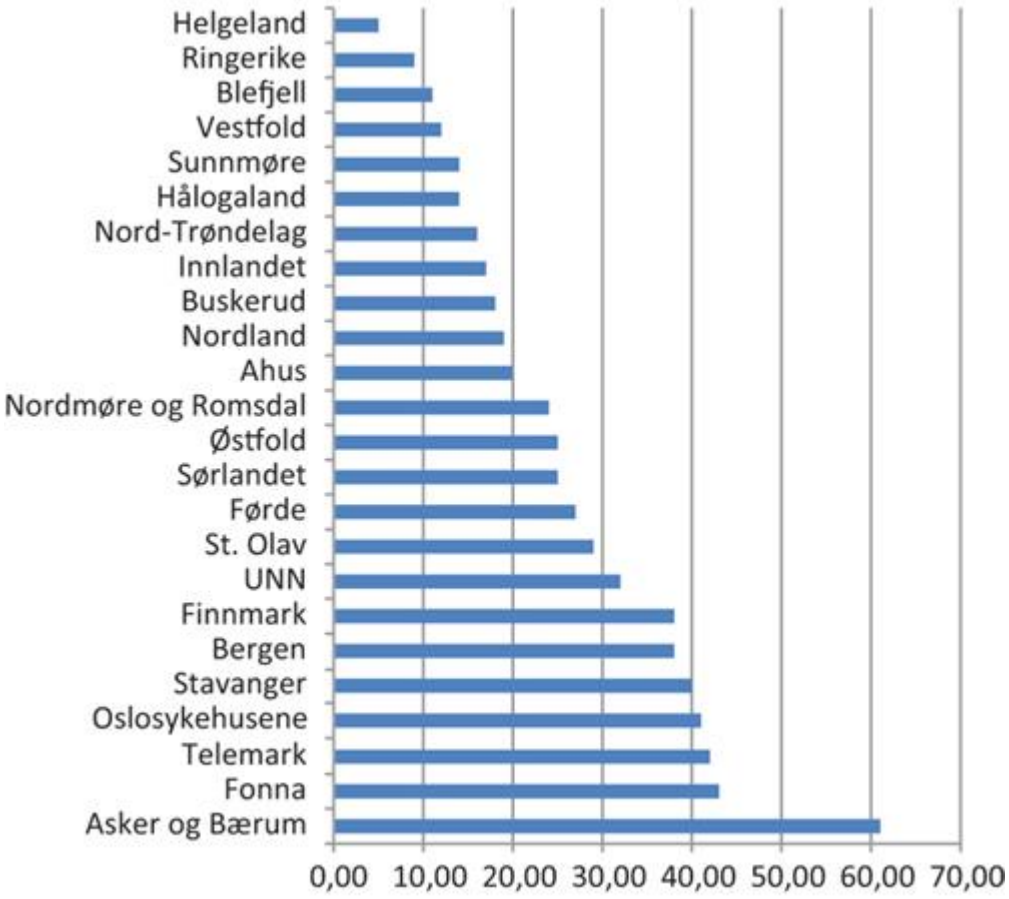
paternalism". Because this is such a considerable intrusion into a person`s life it is obvious that patients, relatives and society needs to be certain that everybody is treated equal, and that no one will have their rights violated. On the other hand, it is also important that society is protected against potentially dangerous and violent patients. Looking at the national statistics, we can see the following numbers:

[1] Inkluderer tvungent psykisk helsevern og tvungen observasjon.
Kilde: Spesialisthelsetjenestestatistikk, Statistisk sentralbyrå.

These are the number of patients that have been committed in the different regions during one year. These numbers do not say how much time the patients has spent in the hospital, or if a person have been committed more than once during the year. In other words these numbers can be somewhat misleading regarding the extent of compulsory admissions. It is obviously a considerably smaller burden for a patient to spend three weeks in a mental hospital against his or her will than it is to spend a year.

Another way to present the numbers is by using so called "point counting's". "Point counting's means that you count the number of patients committed to psychiatric healthcare at

specific dates. For instance a specific date every third month. The numbers you get will tell you how many people that is committed at the given dates. That will remove the possibility that someone will be counted more than once (the same person may by compulsory admitted, discharged and readmitted again etc.), while at the same time give a picture about whether patients are committed for a long time or not. The numbers below were presented by SAMDATA 2007:



Looking at the two graphs we see that the results differ from each other. For instance in the first graph where they count the number of compulsory admissions during a year The hospital of Asker and Bærum scores about average. In the other graph however, the ones showing "point counting's" they score very high. The reason for this is probably that the hospital keeps their committed patients longer than others. Both graphs however, indicate that there are different practices (looking away from external factors like socio-demographic factors).

Investigating the way the responsible healthcare professionals understands and interprets the law, their attitudes towards the use of force and also their beliefs regarding the reasons for the differences may help illuminate the situation.

2 Previous research – what have been done before?

The main writing`s regarding the topic has taken the form of statistics from the SSB (the statistical agency of the Norwegian government) and Samdata, both of them trying to analyze their numbers. In 2011 a descriptive report was issued on behalf of the Norwegian Government called NOU 2011:9 "The extent of the use of enforcement". The report looks into the use of force in the Norwegian healthcare sector. They look into the use of compulsory admissions to psychiatric hospitals, on top of this they look into the use of different enforcement agents, and also other forms of coercion; like the use of strip searches, isolation, forced medication etc.

To my knowledge there has not been done any qualitative study in this field. Conducting semi-structured, in-depth interviews with healthcare professionals that has the responsibility for taking decisions regarding compulsory admissions to find out their knowledge of the law, their attitudes towards the use of force and their opinions on the differences in the use of compulsory admissions represents something new.

2.1 Subjective interpretation of the law

SSB is the statistical agency of the Norwegian government that collects statistics regarding public affairs in Norway, this obviously includes healthcare data, and others are doing the same; Sintef, Samdata etc. which is where I have the statistics that was presented earlier. In an article from 2011, published by SSB, they try to explain the reasons for the regional differences. The main reasons for the differences they believe are differences in the interpretation of the law and socioeconomic conditions; they also claim that it could be a variety of other causes. They admit however that to which degree the interpretation of the law in the different Health-enterprises in Norway varies are difficult to measure. Another aspect is that it is not only the health-enterprises that interpret the law leading to forced hospitalization it is also the GPs and healthcare professionals working in the municipalities. These

physician`s examines the patients before anyone can be committed to compulsory treatment. If the physician at this point considers the patient not to fulfill the criteria`s in the law then the process of compulsory admission will not be started, in the opposite case, and if the patient refuses voluntary treatment, the patient will be sent to a mental hospital. At the mental hospital the patient will be examined again by a healthcare professional employed by the institution. It is obvious that the way the first physician understands and interpret the law effects the number of people being referred to mental treatment (Samfunnsspeilet, 2011). This is confirmed by a survey done at the psychiatric emergency services in Oslo. The investigation showed that the probability of being referred to a compulsory admission was largely dependent on the psychiatrists who received the patients. One psychiatrist referred 60 percent of the patients for compulsory observation, while another referred only 15 percent (Mental Health No. 2, 2009). In other words; the problem can be both, different practices and interpretations of the law in the different health-enterprises, and different interpretations between different healthcare professionals working in the municipalities.

2.2 Socio-demographic factors

The best known reasons for demographic differences in the incidence of serious mental diseases are connected to urbanization, drug abuse, traumatization and migration (NOU 2011:9). In the article from SSB referred to earlier one points at the fact that people from populations or areas with low income, high alcohol consumption, much drug abuse and little education etc. are more often than other groups of people living in other areas, submitted to compulsory mental treatment. A large portion of the persons, about 40 percent, that is committed are homeless. These fact`s shows that poverty could play a considerate part when it comes to handling psychiatric problems (Samfunnsspeilet, 2011). However, mental diseases obviously influence a person`s ability to take education, work and make money and also diminishes a person`s ability to build and keep social relations. This is a problem that is widely discussed in the literature regarding health ethics; it is called the social gradients of health. It says that a person`s social status, housing situation, level of education, income etc.

greatly influences that persons health (Daniels, 2008). Mental health is obviously a part of health.

More than half of Norway`s heavy drug addicts live in Oslo. Drug addicts, alcoholics and homeless people are more likely to get mental problems than other groups of people. So obviously this fact will influence Oslo`s statistics. Non-Western immigrants is also a group that is more likely to have mental problems than the general population, this is largely due to lower education, lower income, language problems and traumatic experiences. Oslo has a large number of non-Western immigrants compared to the rest of the country (Rognerud and Holte 2004). On this basis one would assume that Oslo would have the highest number of compulsory admissions compared to the population than any other region in Norway. However, this is not the case. Statistic`s from 2007 shows that Oslo in total had about 21 admissions per 10 000 inhabitants, which put the region far down on the list. By comparison the University Hospital of Northern-Norway had about 34. Northern-Norway is perhaps the least urbanized region in Norway (NOU 2011:9). Given the fact that socio-demographic factor`s influence the incidence of mental disorders one would assume that demographically similar areas should have about the same level of compulsory admissions to psychiatric care. The geographic variations in enforcement figures from 2003, however, do not fit particularly well with such a description. Three hospitals had more involuntary admissions per 10 000 population than for example Oslo (Ullevaal, Aker, Lovisenberg, Diakonhjemmet), Bergen (Haukeland) and Trondheim (St. Olav's hospital). Among hospitals without major cities, there are significant differences in the number of compulsory admitted patients. In Samdata resolution figures for 2009, Oslo University Hospital and Akershus University Hospital had respectively 21 and 29 percent fewer decisions on compulsory admissions than the national average (NOU 2011:9).

As we can see from this information; demographic factors does not seem to be the main reason explaining the regional differences. However, it does seem to play a part. The following situational description from 2005 shows that it has an impact: The range of the catchment area of Oslo and Akershus changed in 2005. The districts, Grorud and Stovner (Which both is a part of Oslo), was transferred to Akershus University Hospital. These areas score poorly on socio-demographic variables such as income, education and housing, it is also areas with a large population of immigrants. Meanwhile, the municipalities; Nesodden, Frogn, Oppegård, Ski and Vestby, was transferred from Asker and Bærum Hospital to Aker

University Hospital. These municipalities score high on socio-demographic variables. These changes in the catchment areas had a major impact on the enforcement rates for the three health-enterprises concerned. The enforcement rates for Aker University Hospital decreased considerably from 2004-2005, while it went up in the two other hospitals of Akershus and Asker and Bærum. Speculating on the numbers, one could claim that Akers decline was due to the loss of two districts (Grorud and Stovner) who scores low on socio-demographic variables, and in return got the before mentioned municipalities of Follo which score high on the socio-economic scale. The fact that Akershus University hospital, after taking over the areas of Stovner and Grorud experienced an increase in the number of persons committed to mental care strengthens the notion that socio-demographics factors influence the statistics. What was more surprising, however, was that the enforcement rates went up in Asker and Bærum hospital after losing the municipalities of Follo. There is no obvious reason why Asker and Bærum should have a higher enforcement rate than the municipalities of Follo. These municipalities score high on the variables; income, education and housing. In other words it must be other factors that play a part. After looking at this statistics one must conclude that socio-demographic factors influence the enforcement numbers, but that this is just part of the explanation, it must be other factors that have a bigger impact (NOU 2011:9).

2.3 Traditional Asylum

One element that makes you wonder is the fact that among one fourth of the health enterprises with the lowest enforcement figures there where none that had a traditional asylum or mental hospital within the catchment area (NOU 2011:9).

2.4 Requests for compulsory admissions

The number of requests for compulsory admissions that the health enterprises receive varies considerably. Numbers from Samdata 2007 show that the national average was 270 requests for every 100 000 inhabitants. Østfold and Sørlandet was the regions that received the most requests with 490 and 350 per 100 000 inhabitants. While Førde, Innlandet and Buskerud where the ones that received the fewest, ranging between 110 and 130. This shows that the area that receives the most requests, receives almost five times as many as the area with the lowest number. On an average 30 per cent of the requests are declined, the numbers vary from 15 to 50 per cent. Østfold which is the area that receives the most requests declines 45 per cent of them (NOU 2011:9). This is a clear indication that different healthcare professionals working in the municipalities differs in their understanding and interpretation of the law, and also that their attitudes regarding the use of force differs. This again will influence their practices, which again may contribute to the regional differences we see in the use of compulsory admissions.

2.5 Recently

During April 2013 the Norwegian newspaper Dagbladet issued a series of articles criticizing the use of force and the use of compulsory admissions in the Norwegian healthcare sector. The numbers from 2009 and 2011 shows that the use of compulsory admissions is increasing, this contradicts the governmental goal that they should decrease. According to the Norwegian Health Directorate the numbers increased from 7200 in 2009 to 8300 in 2011. The President of the organization "Mental health" Bjørn Lydersen states in the Newspaper issued the 10. Of April 2013."It is unacceptable that the number of compulsory admissions is increasing while the government simultaneously has decided that the use of coercion within the mental healthcare sector shall decrease". He continues by saying that there is considerable cultural challenge`s in this part of the healthcare sector that you do not find in other parts, and that it is forces at play that is in opposition to the governmental goals. The Minister of Health comments in the same newspaper the 24. Of April saying that the Ministry of Health will implement additional measures if the use of force is not decreased (www.dagbladet.no).

3 Legal background - The act of mental healthcare

The “act of mental healthcare” chapter three defines the rules that have to be followed and the criterions that has to be present before anyone can be committed to psychiatric treatment against their own wishes. The third chapter is called: “Application and termination of compulsory mental health care”. Let`s take a look at the contents, starting with § 3-1:

3.1 § 3-1 Medical examination

“Compulsory mental health care may not be applied unless a physician, that does not have any connection to the institution where treatment will take place, has personally examined the person concerned in order to ascertain whether the legal conditions for such care are satisfied. The physician who carries out the examination shall give a written opinion. If there is a need for a medical examination as mentioned in the first paragraph, but the person concerned avoids and refuses such an examination, the chief municipal medical officer may on his or her own initiative or at the request of another public authority or of the next-of-kin of the person concerned decide that such medical examination shall be carried out. If necessary the person concerned may be fetched and examined by force. The administrative decision of the chief municipal medical officer regarding compulsory examination shall immediately be recorded in writing. The decision may be appealed to the county governor without suspense effect. The King issues regulations governing the delegation of the chief municipal medical officer’s authority” (Lovdata).

Comment: This is the first step that must be taken before a patient can be committed to hospitalization in a mental institution. If the healthcare professional (that do not have any connection to the institution where treatment will take place) at this point considers the patient not to fulfill the criteria`s in the law then the process will not be started, in the opposite case, and if the patient refuses voluntary treatment, the patient will be sent to a mental hospital. At this point the physician acts as a gatekeeper. Given the fact, like highlighted in the former

chapter, that the requests for compulsory admissions varies in a degree from one to five between the regions it is likely that the evaluation of whether compulsory mental treatment is needed or not differs. At the mental hospital the patient will be examined again by a healthcare professional employed by the institution. That 30 percent of the requests on an average are declined supports the notion that the evaluations differs between the healthcare professionals working in the municipalities.

3.2 § 3-2 Administrative decisions regarding compulsory observation

"*On the basis of the information from the medical examination according to section 3-1, the responsible mental health professional will consider whether the following conditions for compulsory observation are satisfied*" (Lovdata)

1. Voluntary mental health care has been tried, to no avail, or it is obviously pointless to try this.

2. The patient has been examined by two physicians, one of whom shall be independent of the responsible institution, cf. section 3-1.

3. It is highly probable that the patient fulfills the criteria`s for compulsory mental health care as laid down in § 3-3.

4. The institution is professionally and materially capable of offering the patient satisfactory treatment and care and is approved in accordance with section 3-5.

5. The patient has been given the opportunity to state his or her opinion, cf. section 3-9.

6. Even though the conditions of the Act are otherwise satisfied, compulsory observation may only take place when this, after a complete evaluation, clearly appears to be the best solution for the person concerned, unless he or she constitutes an obvious and serious risk to the life

and health of others. When making the assessment, special emphasis shall be placed on how great a strain the compulsory observation will entail for the person concerned.

The responsible mental health professional will make a decision on the basis of the available information and his or her personal examination of the patient. The decision of the responsible mental health professional and the basis for it shall immediately be recorded. Compulsory observation may not be carried out for more than 10 days from the start of the observation without the patient's consent. If the patient's condition indicates that it is absolutely necessary, the time limit may be extended for up to 10 days with the consent of the head of the supervisory commission. Transfer to compulsory mental healthcare pursuant to section 3-1 may be affected before or upon expiry of this time limit, if the conditions for such care are present. The patient, and his or her next-of-kin and as the case may be, the authority which has made the request pursuant to section 3-6, may appeal a decision pursuant to the second paragraph to the supervisory commission" (Lovdata).

3.3 § 3-3 Administrative decisions regarding compulsory mental health care

On the basis of the information from the medical examination that must have been done according to § 3-1 and compulsory observation, if any, pursuant to section 3-2, the responsible mental health professional will evaluate whether the following conditions for compulsory mental health care are satisfied:

1. Voluntary mental health care has been tried, to no avail, or it is obviously pointless to try this.

2. The patient has been examined by two physicians, one of whom shall be independent of the responsible institution, cf. section 3-1.

3. The patient is suffering from a serious mental disorder and application of compulsory mental health care is necessary to prevent the person concerned from either a. having the prospects 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, or b. Constituting an obvious and serious risk to his or her own life and health or those of others on account of his or her mental disorder.

4. The institution is professionally and materially capable of offering the patient satisfactory treatment and care and is approved in accordance with section 3-5.

5. The patient has been given the opportunity to state his or her opinion, cf, section 3-9.

6. Even though the conditions of the Act are otherwise satisfied, compulsory mental health care may only be applied when, after an overall assessment, this clearly appears to be the best solution for the person concerned, unless he or she constitutes an obvious and serious risk to the life or health of others. When making the assessment, special emphasis shall be placed on how great a strain the compulsory intervention will entail for the person concerned.

The responsible mental health professional will make a decision on the basis of the available information and his or her personal examination of the patient. The decision of the responsible mental health professional and the basis for it shall immediately be recorded. The patient, and his or her next-of-kin and, as the case may be, the authority which has made the request pursuant to section 3-6, may appeal a decision pursuant to this provision to the supervisory commission. The patient may appeal a decision to apply compulsory mental health care for up to three months after the care has been terminated. (Lovdata)

Comment: The rules regarding compulsory observation and compulsory admission is almost identical. What differs however, is that regarding compulsory admissions the law states that it should be “highly probable” that the criterions of the law is met. In the case of compulsory admission, the criterions are to be met.

3.4 The supervisory commission

Today's central control authority, the supervisory commission, is headed by a lawyer that shall be eligible to serve as a judge. The commission also consists of a doctor and two other members, each with a personal deputy. Of these, shall be a person who has been under

psychiatric care, or who is, or has been related to a patient, or who have represented the interests of a patient (Act of Mental Healthcare § 6-2). The commission has the power to overrule the decisions regarding compulsory admissions and other decisions regarding the use of force upon a patient. The patient may complaint to the commission in these matters (NOU 2011:9).

3.5 Explanation of the terms in "the act of mental healthcare"

As we can see the law is extensive and it is obviously the product of individual interpretation by the different healthcare professionals that makes decisions in matters regarding compulsory admissions.

"Serious mental disorder"

According to NOU 2011:9 issued by the government, the expression: "serious mental disorder" is a legal term and is not connected to any specific diagnosis. The term is the same that was used in the earlier law: "law of psychiatric healthcare" of 1961 (Lovdata). The main criterion, "serious mental disorder", was kept in the new and revised "act of mental healthcare" of 1999. Based on earlier court rulings the department stated in connection with the law proposal (1998-99) that:

"The term serious mental disorder is a legal term that does not describe any clear psychiatric diagnosis. As the situation is today, the term serious mental disorder is closely linked to psychosis. A serious mental disorder is however not limited to only encompass psychosis, but can also include certain other conditions. Regarding which border conditions, in addition to psychosis which can be placed under the term "serious mental disorder", one would face a complete evaluation, not only of the sickness itself, but also of the external effects it has. Persons with major loss of function and that is unable to interpret reality can be placed under the term serious mental disorder" (NOU 2011:9, 14.1 Serious mental disorder).

One can say that the core area of the main condition "serious mental disorder" is clear and active psychotic states. But also special borderline cases may fall under the term, including certain manifest deviation states of non-psychotic character where the malfunction is as great as that seen in psychosis. Whether the state can be equated with psychosis depends on a rigorous and complete assessment, where not only the disease state, but also the impact it claims, must be given considerable weight. In addition the individuals with chronic psychotic illness, even in symptom-free periods, when symptom freedom is due to antipsychotic medication is to be considered to be suffering from a "serious mental disorder" according to rulings by the Norwegian Supreme court. Severe mental illness in the legal sense is thus understood both from a phenomenological and functional description (NOU 2011:9, 14.1 "serious mental disorder").

The treatment criteria

The treatment criterion is justified as being in the best interest of the patient, and consists of a recovery option and a worsening option. A key issue to be assessed according to the treatment condition (both options) is how the serious mental condition will develop without compulsory mental healthcare (NOU 2011:9, 14.2 Treatment criteria).

Recovery option

The recovery option is most appropriate as reason for admission and means that patients without compulsory mental health care will "get their views to cure or improvement significantly reduced," § 3-3, first paragraph, first alternative. This is both a demand forecast (probability) and efficiency. It is not a requirement for compulsory intervention that the possibility of improvement is lost, but that it may be significantly reduced. This indicates that any reduction in improving the outlook is insufficient. Furthermore, the effect of the requirement is "healing or significant improvement", in other words expecting a small improvement or some improvement is not sufficient. The degree of improvement must at least be "significant". It does not appear from the law a timing at which the improvement must be expected to occur (NOU 2011:9, 14.2.2 regarding the recovery option)

Worsening option

The worsening option is most appropriate as the basis for maintaining compulsory mental health care. Worsening option means that it is "highly probable that he (the patient) in the very near future will get his condition deteriorated significantly" if the mandatory protection ceases. This part of the treatment condition was enshrined in the Mental Health Act 1999 in light of the Supreme Court's practice. Both the ruling and the legislative history are emphasizing that the requirements for maintenance on this basis must be strict. This is because the application of worsening option may be appropriate for patients who are brought up on treatment-related optimal level, but where there is a risk of recurrence if the mandatory protection ceases. It is therefore required that the possibility of deterioration must have a high probability. According to the legislative history, this means more than average probability (NOU 2011:9, 14.2.3 regarding the worsening option).

The danger criteria

The danger criteria becomes relevant when compulsory admission is necessary because the patient, due to his or her “serious mental disorder”, “represents a present and serious danger to their own or others life and health” (NOU 2011:9).

Danger to oneself

The danger criterion is connected with considerable insecurity because of the difficulties in predicting it. The danger criterion regarding danger to oneself encompass danger to the patient`s life and health. With life and health both physical and psychological health is included, most relevant is suicidal tendencies, inflicting physical harm to self and other kind of behavior that is seriously unhealthy. The law states that the danger must be” serious”, in other words the potential danger must be great, in addition the potential danger must be present at the moment of decision. The time aspect is very relevant (NOU2011:9).

Danger to others

This criterion involves that a person through his actions and due to his “serious mental disorder” represents a “present and serious danger” for other peoples “life and health”. The demands are the same as with danger to yourself. The danger must be real at the moment of decision. The danger must be related to murder and serious violent crimes (NOU2011:9).

“Complete evaluation”

"Even if the legal conditions are otherwise met, compulsory psychiatric care can only take place after a complete evaluation has been taken, and that compulsory psychiatric care appears by far to be the best solution for the patient, unless he or she constitutes an obvious and serious risk to the life and health of others. The assessment requires particular attention on the strain the intervention have on the person in question."

It follows from the first sentence that compulsory mental health care can only be adopted when it is clearly the best solution for those who are subject to the coercion, which express a threshold for what the reasonable and proportionate intervention should be. The second sentence states that the burden of the individual by being subjected to coercion is to be given "special attention" in the assessment to be made. The patient's interests and beliefs should therefore be given proportionately greater weight than the health care and social considerations in favor of compulsory mental health care.

The emphasis on the patient’s interests is less if forced intervention is justified because of danger for others. This can be seen directly from the wording of the Act of mental healthcare § 3-3 first paragraph, and the expression of the general perception that the individual has a lower level of protection if they represent a danger to others life and health. The wording can give the impression that it should not be made an overall assessment in cases where the patient represents a present treat to the life and health of others. This, however, is not a correct understanding of the law. Also in these cases there will be done an assessment, but the threshold of "clearly the best solution" does not apply here NOU 2011:9).

Comments

As we can see, even when the criterions are operationalized, their meaning and when to apply them is the subject of individual interpretation. How will a person's condition develop without treatment? What is a considerable improvement? When will it be highly probable that a patient, in the very near future get his condition deteriorated significantly? And how do one proceed when evaluation the degree of resistance against a compulsory admission? What other factors would be included in a "complete evaluation"? This is relevant to the research question. Is the interpretation of the criterions influenced by the attitudes of the healthcare professionals, and could those interpretations again explain the differences in the practicing of compulsory admissions?

4 Theory

4.1 Justifying paternalism

How can a society defend giving people medical treatment against their will? This question is especially relevant in cases where the persons treated do not represent any treat to others. Regarding compulsory admissions we are talking about very intrusive measures. A mental institution has many similarities with a jail. The patient is not allowed to leave, the doors are locked, the patient must stay in his or her room at night, visitors may be searched as may be the patient if he or she has been on a permission, the patient may lose the right to use a telephone, watch TV, read newspapers and books, listen to music etc. In addition to this mental patients may be/often are medicated against their will, in case of a patient becoming violent, the patient may be strapped to a bed or in other ways have their physical movement restricted (NOU 2011:9). We are here dealing with "hard paternalism".

Paternalism can be defined as an action which restricts a person`s liberty justified exclusively by consideration of that persons best interest and carried out either against his present will or of his prior commitment (Garriston and Davis 1983). As the term implies, it can be described as an attempt to asses and address the needs of an individual or group of individuals in the same way as parents do for their children (Beauchamp and Childress 1989).

According to John Stuart Mill no person is warranted in telling another person what he or she should do with his or her own life or for his or her own benefit. "The person who is most interested in the wellbeing of a person is the person himself, maybe with the exception of persons with a strong attachment to the person in question. The interest of other persons and society in a person`s wellbeing is trifling compared to that of himself. It is only the person himself that know his own preferences, his own thoughts and his own feelings. All errors which he is likely to commit against advice and warning, are far outweighed by the evil of allowing others to constrain him or her to what they may deem to be in the best interest of the person. But the strongest of all the arguments against the interference of the public with purely personal conduct is, that when it does interfere, the odds are that it interferes wrongly,

and in the wrong place» (Mill, 1859). Mill believes however, that paternalism can be defended in cases where a person lacks autonomy. In other words, circumstances are present that inhibits the person from making rational decisions.

One could argue about what is a rational decision. A rational decision can be described as a decision that maximizes benefit. What is a benefit for a person is however, like Mill points out, up to subjective evaluation. Eating too much and becoming obese could be considered irrational because it is unhealthy, but it could also be considered rational by the person doing the overeating, because of the pleasure the person receives from eating. The variety of interests, labor choices, political stances and so on shows how the opinions of people regarding what is rational or not varies, and that it is in its entirety up to personal and subjective evaluation. But a person that do not know what he is doing, like a mental patient suffering from psychosis, are obviously not autonomous. Autonomy can be defined as the ability of the person to make his or her own decisions, implicit here is that the person is the ruler of his or her own body and mind. In other words; if a person is considered to have the capacity to make an informed, rational decision then he or she is considered to be autonomous. (Wikipedia, 2013). In a medical context, respect for a patient's personal autonomy is today considered too be one of the many fundamental ethical principles in medicine. In cases where a patient are compulsory admitted the patient are not considered to be autonomous. It follows that a healthcare professionals have examined the patient considering him or her to be suffering from a “serious mental disorder”, in other words the patient is not rational, unable to make informed choices. This justifies paternalism, in other words making choices on behalf of, and in the best interest of the patient. The responsible healthcare professional have then reached the conclusion, based on his or her believes and attitudes regarding the effects and consequences of the use of force, that the use of compulsory admission is the best option for the patient.

4.2 Paternalism as a reason for compulsory admission

As we have seen, the answer to the opening question of this part may be found in paternalism. Historically the medical profession is based on paternalism. Even the Hippocratic Oath

includes a line that encourages physicians to perpetuate the imbalance of power between doctor and patient: “I will prescribe regimen for the good of my patients according to my ability and my judgment”. In this sentence, there is no reference to the will or opinions of the patient. Some decades ago the doctor was a powerful, authoritarian figure in society, often writing parts of the patient`s files in Latin, masking the condition of the patient to him or her. This, however, is history. At least it is in Norway and in most, if not all of the West. The trend during the last few decades has been in the direction of increased autonomy and informed consent. The patient shall be informed about his or her condition, the patient shall be informed about possible treatment and in unison with the physician choose which treatment he or she wants. The patient also has the right to refuse treatment. The Norwegian law regarding patient-rights § 4-1 says in the first paragraph that "health care can only be given with the patient's consent, unless there is a legal basis for providing healthcare without consent (Lovdata)." This paragraph states that the patient is autonomous, unless there exists specific reasons that make`s the patient incapable of making rational decisions. This appears to reflect an anti-paternalistic stance. However, as the law says, there are exceptions. These regard`s people suffering from dementia, mental disorders, or physical conditions that makes them unable to make rational decisions.

So the law states that there are the exceptions of § 4-1 in the law regarding patient-rights, these exceptions obviously include mental patients that meets the criterions in the act of mental healthcare. The “act of mental healthcare” states that only people that are suffering from a “serious mental disorder” and that meets certain additional criterions can be treated against their will. If you meet the criterions outlined in the “act of mental healthcare”, and you refuse medical treatment, you are no longer considered to be autonomous. You are not rational and someone else must make choices on your behalf. As we have seen, this is also supported by the writings of Mill, which states that only persons without the ability to make rational choices should be subjected to paternalism. But Mill also states that: “the strongest argument against the interference of the government into someone`s life is that when they interfere, the chances are great that the government interferes wrongly and in the wrong place” (Mill, 1859). There are historically endless examples of “wrong interference” in the treatment of psychiatric patients. During the 1800s one believed that mental-disorders where caused by some sort of physical imbalance. Examples of treatment of the imbalance were blood-draining, because one believed that mental disorders were due to too much blood in the brain. Other inhumane method`s that was used was purging, blistering, whipping and the

inhalation of mercury. Almost drowning patients and extracting teeth has also been used as "treatment" for insanity. More recently lobotomy was used as "treatment". During a lobotomy, parts of the frontal lobe in the brain is destroyed, resulting in the patient getting more or less permanently apathetic (Student pulse, 2010). If these methods of "treatment" were intended to be in the best interest of the patients or if they were experiments on persons without the ability to resist, I do not know. The justification however, was paternalism.

Today, methods like these are history, however closed buildings, locked doors, restraining access to information and to the outside world, isolation, stimuli deprivation, straps and medication is used. Even with the improved and much more human methods chances are, like Mill emphasizes, that society will interfere wrongly on behalf of the patient. Understanding the implications of paternalism is therefore, in my opinion, very relevant in relation to my three research questions. Obviously the healthcare professional cant now what is the optimal solution for the patient, he can only try to "address and assess" the needs of the patient. This assessment is subjective and will differ from healthcare professional to healthcare professional. The assessment will be influenced by the attitudes of the healthcare professional, which again will influence the decisions taken on behalf of the patient, which once again, most likely, will lead to differences in the practicing of compulsory admissions. Given the fact that we are here dealing with hard paternalism it is very important, in my opinion, that the practices are unison and that nobody will have their rights violated. I therefore consider my research to be important.

5 Method

As we have seen, the act of mental healthcare is the subject of individual interpretation. By conducting semi-structured, qualitative interviews with healthcare professionals responsible for making decisions regarding compulsory admissions I wanted to investigate their understanding and interpretations of the criterions in the law, their attitudes towards the use of coercion and lastly their believes and thoughts regarding the reasons for the regional differences in the use of compulsory admissions.

5.1 Research design

During my investigation into the matter I have not found any research where healthcare professionals responsible for making decisions regarding committing patients to treatment in mental hospitals have been interviewed. I could try to answer the research question using quantitative research like a questionnaire, but this would probably not be sufficient to get the answer to the questions that I am asking. Silverman (2010) emphasize that you should pick the research design that is most suitable to bring answers to your question (Silverman 2010). Quantitative research is possibly better to tell you how a present situation are, what opinions people have about a specific question and what they want done about it. For instance you could pick out a randomly selected group of the population, giving them a questioner, asking them if they know about the use of compulsory admissions in the healthcare sector in Norway, the extent of it, and whether it should be reduced or not. You would then find out their feelings regarding compulsory admissions, if they think it is too much or too little of it, and what should be done about it (reduce the use, increase the use or doing nothing), it does not tell you why the use is too high or too low, or what specifically to do about it, nor the reasons for it. Qualitative methods drill deeper, where you can use much time on a small group of specifically chosen people getting detailed information. I have chosen to use a qualitative design, not because it is superior to quantitative design, but because it is most suitable for my research. Given the fact that if a patient meets the criteria`s in the law or not is

up to individual interpretation and judgment I am actually studying the evaluation processes of the responsible healthcare professionals and the different variables that influence that evaluation process. Conducting qualitative, semi-structured, in-depth interviews would be highly relevant in an attempt to answer my questions. In this way I will be able to get an answer to how the people that are responsible understands and interprets the "act of mental healthcare", their attitudes regarding the use of force, and what they believe is the reasons for the regional differences in the use of compulsory admissions. These are questions that would be hard, if not impossible to answer using quantitative methods. Qualitative methods also have the strength that they allow for follow-up questions to clarify what may be unclear (Silverman 2010). They could also provide important information on relevant elements that the researcher has not considered up-front. Another strength using a qualitative method is that it opens for a change of view along the way, this is especially important when studying something that has not been looked at in a similar way before. Elements may emerge that needs to be elaborated on. Using semi-structured interviews will allow me to "dig deep" into the case.

My object of research has been on the understanding and interpretation of the act of mental healthcare, the attitudes of the informants regarding the use of force and on the differences in the practicing of compulsory admissions in Norway, which I believe is related to the two other questions.

The decisions whether someone is to be compulsory admitted to mental treatment against their will are taken by two independent healthcare professionals, one which is not working at the treating institution and one that is working at the treating institution (Lovdata). I have chosen to interview the healthcare professionals working in the treating institution. The reason for that is that these are the ones that you could describe as belonging to a "professional environment" that makes such decisions on a continually basis. They are also the ones that have the final decision; the healthcare professional outside the treating institution sends patients to the institution with a request that the person in question will be committed. The healthcare professional at the treating institution has the power to decline that request. This is a decision that the responsible healthcare professional at the treating institution takes alone. I therefore have found it most relevant to interview healthcare professionals in charge at the treating institutions. By the term "responsible healthcare professional" I am referring to persons with the authority to decide if somebody should be

committed to treatment in an institution. The healthcare professionals that have this authority are physicians, psychiatrists and specialized psychologists in the appropriate position.

5.2 The sample

My sample has been chosen on the background of the process that I am studying. The process is very specific and involves a few key players. My informants are therefore selected on the background of position and authority and are not representative for physicians or other healthcare professionals in general. This is a case of non-probability sampling. Only persons who have had firsthand involvement with the processes have been chosen, others would be irrelevant for the study. I have used what Tansey call "purposive sampling", this method of selection is based on the purpose of the study. "If the study entails interviewing a pre-defined and visible set of actors the researcher may identify the particular respondents of interest and sample those deemed most appropriate for the study (Tansey, 2007)". In other words my selection is strategic. To some degree I have also used so called "snowball sampling". This involves asking informants if they know of others in similar positions that may be suitable for the study (Tansey, 2007). I got two of my informants in this way.

All my informants are healthcare professionals with the responsibilities of taking decisions regarding compulsory admissions to mental treatment in an institution. The informants included physicians, psychiatrics and specialized psychologists. The persons I have been interviewing are highly educated and they have extensive knowledge on the subject. They would be the kind of informants that you could characterize as elite or expert informants.

I have interviewed 10 healthcare professionals. Where eight is physicians, one is a psychiatrist and one is specialised psychologist. Two of these worked at an institution for severe psychosis, two are working at a DPS, and the rest are working at psychiatric emergency receptions. My informants are working in the regions of Vestfold, Kristiansand and Innlandet. This is a selection of informants that I believe will help me gain answers to my questions.

All of my informants have been recruited by written and oral requests for participation in the project. The interviews have been conducted at the informants working place during their working hours. The interviews were recorded by a Dictaphone, I also made notes.

5.3 Elite interviews

According to Tansey elite interviews may serve a variety of purposes. First of all; elite interviews is rarely considered in isolation, this is neither the case in my study. I have used time and effort to get an overview of the existing literature regarding compulsory admissions to mental hospitals. If I can confirm the information established by other sources this strengthens their notions, if my research rejects the information it weakens their notions. Any findings are strengthened if they are confirmed by multiple sources. Elite interviews can also make you establish what a set of people think, what their attitudes, beliefs and values are. Using semi-structured interviews and asking open-ended questions allows the informant to talk freely and may provide rich details regarding the thoughts and attitudes of the informant regarding the key questions of the research (Tansey, 2007). This is highly relevant for my study since it is exactly the thoughts and attitudes of the informants in relation to the act of mental healthcare and the use of coercion that I am studying, in addition I am trying to establish what the group believes is the reasons behind the regional differences in the use of compulsory admissions.

Compulsory admitting somebody to mental treatment in an institution, against the persons will and at the same time in the best interest of the person, is paternalism. The informants' attitudes and beliefs of the effects and function of forced treatment will define their practices. In this way elite interviewing can contribute with new and specific information. Elite interviews can also give you detailed information about a specific process or a specific event (Tancey, 2007). In my case I seek to find details regarding the process behind compulsory admissions. The details will be used to answer the three research questions.

According to Andersen(2006) when working with expert informants it is important that the researcher is active, not only listening to the information the informants presents, but also take

initiative to control the interview asking additional questions when you need to get something clarified. Andersen (2006) also states that expert informants are usually good at presenting themselves and their case in a positive light (Andersen 2006). This leads us to a potential problem, the informants might feel that they should protect themselves and their hospital, therefore holding back information or not giving me the "entire picture". This would make the study unreliable and reduce its validity. This is something that I have been conscious of when preparing for, and during my interviews.

5.4 Reliability and Validity

Reliability says something about whether the research has been conducted in a confident and proper manner. To ensure reliability, the researcher has to account for how the data are developed during the research process. This involves distinguishing between the information gathered during the fieldwork, and the researcher's own evaluation of this information. The difference between field data, for instance reports from interview conversations, and the researcher's own comments and assessments, have to be stated clearly. Tape recordings of interview conversations are a more reliable source of independent data than only written field notes, where the interviewer has to reconstruct statements and citations. Reliability is also based on the researcher's account of his or her relations to the informants, and how this could influence the information that is being given (Thagaard, 2003). Given the fact that I have worked part time at a closed psychiatric institution for years, I have to take care not to let my preconceived ideas and believes influence my research, assuring objectivity.

To ensure reliability I am using a dicta-phone during the interviews. The interviews will be conducted in Norwegian so I have to take great care when translating them into English making sure that I do not make any mistakes.

Internal validity asks whether the study investigates what it is meant to investigate, whereas external validity asks in what contexts the findings can be applied. In the case of qualitative research the sample you choose is therefore very important. This is certainly the case regarding my study. What I am studying is the process behind compulsory admissions. That is

the individual healthcare professionals understanding and interpretation of the law, their attitudes regarding the use of force, and what they believe may be the reasons for the different practices. I think the validity of my study have been secured given the fact that all of my informants is in a position where they make decisions regarding compulsory admissions, thus they have first-hand experiences in the processes. I also believe that the fact that I am working at a psychiatric hospital may strengthen the validity. Since I am familiar with psychiatric patients, their conditions, the system and the professional terms related to the field, I will most likely avoid misunderstandings and misinterpretations.

5.5 Generalization

I have chosen my informants based on non-probability sampling; on top of that my sample is small. In other words it is not statistically generalizable. The findings can however be transferable to a relevant context, situation or group of people. In other words transferability is related to external validity. Like mentioned above, external validity is the context in which the findings from a study can be transferred. Internal validity is in this context dependent on the sample (Malterud, 2001). The findings from interviewing a small, but highly relevant group of key actors within a field can be transferable to other actors within that specific field, or to a similar process or context. Given the fact that I have chosen a highly relevant sample and studied a very specific process, securing internal and external validity, I believe that my findings can be transferable to other healthcare professionals working in the same specific context. I also think that it contributes to the already existing literature. Even though the findings of a qualitative study are not considered to be facts involving the population at large, it could have transference value in the form of theories, descriptions and notions regarding a specific setting or situation (Malterud, 2001).

6 Presentation of findings and discussion

To gain answer to my three main questions, I started my interviews by asking my informants about the "act of mental healthcare" and how they understood and interpreted the different criterions. I also wanted to get an impression of their attitudes towards the use of force, and which variables that influences their decisions. I continued by asking about whether or not they were influenced by signals from the Government, or if they were more influenced by their working environment. I followed up by asking my informants about what they believed to be the reasons behind the regional differences in the use of compulsory admissions.

I have chosen paternalism as my theory for my research because all kinds of force used upon people for their own benefit, but against their wishes is paternalism. I consider this appropriate given the fact that the law regulating the use of compulsory admissions involves making choices for others contrary to their will, but in their best interest.

6.1 "The act of mental healthcare" understanding and interpretation

When my informants were asked about whether or not they considered "the act of mental healthcare" to be difficult to interpret, almost all of them answered that it was challenging. One answered: "*Yes and no, it is difficult to interpret the law because the legislator is not himself sure about how to interpret it*". Everyone I interviewed was well aware of the contents of the law. However, the contents of the law are, like before mentioned, up so subjective, individual interpretation. This is also the case regarding the severity of the patient`s condition and his or her needs for compulsory treatment.

"Serious mental disorder"

Going into the criterions of the law I started by asking my informants about how they understood the term "serious mental disorder". Here I got somewhat similar answers. They considered a person that was having a psychosis to be suffering from a "serious mental disorder", but also other severe mental conditions where mentioned. Most of the answers were similar to the descriptions used in the before mentioned NOU when explaining how to interpret the term.

One informant stated; "*I would use the interpretation that is the background for it. A serious mental disorder, are defined and described as psychosis, and that is not further explained. A psychosis is a psychosis and in reality you do not need to have a specific diagnosis for it*". "*Then you have the other group, well the thought is that you will catch this group with very severe personality disorders. The description is that the functional failure should be so great that it is comparable to a psychosis"* she went on.

Another mentioned psychosis and severe depression as the main conditions. She then stated that: "*I look at it in this way, a serious mental disorder is a description of a person`s functioning more than a diagnosis, it revolves around the person`s ability to understand which reality they are in, and their understanding and ability to make choices regarding their own mental condition*".

One of my informants maintained that a person had to be psychotic to be suffering from a "serious mental disorder". He went on by saying that it could be difficult to determine whether a person he received was psychotic or not in cases where the patient was influenced by drugs.

One of my informants said that in certain cases of personality disorders, where the condition is very severe, greatly influencing the patient`s behaviour it could be compared to and treated in the same way as you would for a person suffering from psychosis. Thus, he would consider a person with these symptoms as suffering from a "serious mental disorder". He also stated that the main element was psychosis.

Another informant also held the opinion that certain cases of severe personality disorders could be characterized as a "serious mental disorder" if the functioning of the patient were severely influenced.

Treatment criteria – recovery/worsening option

I continued by asking the informants about the treatment criterion, how they understood it and when they would apply it.

One pointed out that when dealing with the recovery option they usually looked at the individual patient`s history and how they had reacted previously when they were committed. For instance if they receive a patient that is manic and they know of experience that this specific patient without treatment will get very psychotic one would consider the recovery option to be met. If the patient is new to them she continued, then they would compare him or her to similar patients to make their evaluation.

Another informant considered this criterion to be the hardest to evaluate. Especially in cases with patients with a long history of psychosis it could be very hard to evaluate whether or not the patient would profiteer from compulsory admission. "*These are patients that have symptoms of psychosis even when they are medicated, and when committed they gets restless and aggressive, making their condition worse*". He finished by saying that whether or not a patient would experience a "considerable improvement" in his or her condition could be very difficult to evaluate.

Yet another of my informants believed that it was almost never the case that anyone would have their condition considerably worsened or their possibility to get cured considerably reduced without treatment. He believed on the other hand that the patient could get his or her conditioned worsened by being involuntary committed to hospitalization.

Another of my informants said that the worsening option was the easiest to consider regarding the treatment criterion. The case was usually that a patient had stopped taking and/or refused to take his or her medication, making it necessary with compulsory mental healthcare to restart the treatment of the patient and thus avoiding a "considerable worsening" of the patient`s condition.

Another stated that the worsening option was often used to continue keeping the patient in the institution because one feared that the patient's condition would deteriorate if he or she was discharged. The worsening of the patient condition would often happen because the patient would start using "street drugs" when discharged. In addition a patient might stop taking his or her medications and that their security net, represented by the safety of the institution in the form of regular routines and the support of healthcare professionals, would disappear.

Regarding the treatment criterion we can clearly see that it is more challenging to interpret than the main criterion, this was confirmed by most of the informants. This is not difficult to understand, the treatment criterion has a demand for a degree of recovery/worsening, and it also has a time limit for the effects to appear. We can also see that the attitudes towards using the treatment criterion as a reason for compulsory admissions differ. One states that this is a criterion that she uses a lot and that it is easy to decide whether or not the criterion is met. Others have doubts about the effects and benefits in individual cases where this criterion may be applied. One even believed that it is almost never the case that anyone would have their possibility of cure considerably reduced, or their condition considerably worsened without treatment. To commit someone on this basis he considered to be totally wrong, he believed that this would most likely worsen the condition of most patients. It is not hard to see from these statements that the individual attitudes and beliefs regarding the effects of treatment differ. This will again influence the practicing of compulsory admissions.

Danger criterion

When dealing with the danger criterion in regards to danger to oneself, the possibility of the patient committing suicide in the near future is considered. If one come to the conclusion that suicide is a considerable risk, then all of the informants felt that the additional criterion of danger were met.

When considering the danger to others one informant said that she again looked at the previous history when they received a patient. If for instance the patient had committed murder in psychosis earlier she would almost always feel that this part of the danger criteria was met.

Another of my informants felt that the danger criteria were harder to evaluate than the treatment criteria. ”*The danger criterion is pretty challenging, it is a pretty challenging text to interpret, danger criterion is not given a time limit in the same way as the treatment criteria,*” she said. She went on to say that she would look into the previous history of the patient when making her assessment.

An additional informant also felt that this criterion was difficult to evaluate and in cases where he used it, the case was obvious. He also found, like the previous mentioned informant, that the time aspect was difficult to evaluate.

This was also the opinion of others. The question of just how “dangerous” the patient should be was also something that the majority found difficult to consider.

Total evaluation

The last part of the law says that even though the criterions in the law is met no one should get committed to compulsory mental healthcare unless a total evaluation says that this is obviously the best alternative for the patient. I asked my informants about how they proceeded when considering whether compulsory admission was the obviously best alternative for a patient. One informant answered that she would consider how negative a patient would experience the measure, in other words the degree of resistance on the part of the patient. Based on this consideration she would ask herself if the patient would profiteer on the measure or not. She would also compare the patient`s possible experience of being at home versus being in an institution, looking at whether the patient is alone or if he or she have resources, like friends and family to help him or her.

Another one claimed that: “*If we know the patient from earlier in the system, our former experiences will influence the total evaluation*”. She would also evaluate the family and living conditions of the patient on the outside. She stated; “*If for instance it is children in the home, one would maybe to a larger extent be holding the patient back longer than one would if the patient did not have children in their home*”. She also said that she would evaluate the resistance of the patient, how bad the patient feels about being compulsory admitted and compare it to the consequences the patient would experience without treatment. In addition she would consider the level of functioning on the part of the patient. Is the patient eating,

sleeping etc.? The functioning of the patient outside of an institution was also something that other informants said they considered.

Another of my informants said that; "*I would consider to which degree a patient is defined by his or her illness*". Looking at the patient's history he would evaluate the effects of the medications. The possibility of the patient extracting serious damage to him or herself by extensive drug abuse and the ability of the patient to control his or her impulses is also something that he would consider. He went on by stating that also practical matters will influence this total evaluation, for instance, if the patient have a place to live or not?

When asked this question one of my informants answered that he would look more into the practical sides than on the condition of the patient. Are the services the patient need available? Does the patient have a place to live? These are questions that he would ask himself. But, of course: "*I would also consider the condition of the patient*" he concluded.

My informants generally did not have any specific answer on how they would go about to consider this part. The answers were for the most part general. The condition of the patient, would the patient benefit from staying at the hospital and how severe is the symptoms of the patient. All these questions are up to subjective evaluation. One doctor may consider a patient to be well enough to be discharged, while another may consider the same patient to be too sick to be discharged. If the patient will profit from treatment in the institution or not and the severity of the symptoms of the patient is likewise a matter of individual interpretation on behalf of different healthcare professionals. Since it is no clear lines here it is inevitable that patients will be treated somewhat different by different decision makers. I also got the impression that practical aspects like if the patient has a place to stay or not may influence the decisions. Some of my informants said that they would be very reluctant to discharge a patient if the patient in question does not have a place to live; others said that they would discharge them anyway if the criterions for keeping them compulsory admitted are not present.

Voluntary solutions

The law also states that voluntary options shall be tried before anyone can be hospitalized against their will.

The law states that: "*nobody shall be compulsory committed to treatment in a mental hospital without trying voluntary solutions first*". However, the law also states that this can be avoided in cases where "*trying voluntary solutions is obviously pointless*". I asked my informants how they proceeded to meet this paragraph.

One of my informants found this part of the law difficult to interpret, she stated that the only case where this would be obviously pointless to try would be in cases where the patient where dead. However, she did not have any answer on how to proceed to meet this criterion.

Another felt the same way, that this criteria could be difficult to interpret, because when is it obviously pointless?

Yet another said that; "*if the patient is considered to be suffering from a serious mental disorder, then the patient is obviously not autonomous and thus not in a position to make rational decisions. So why should I then try to convince the patient of receiving voluntary treatment?*" He went on by saying that in certain cases, for instance when a person is brought in by the police and is hostile and threatening, he believed that most healthcare workers would consider voluntary solutions to be obviously pointless, and avoid trying to get consent from the person.

Another one, became quite for a moment, and then answered that: "*You will very soon get an impression of whether the person will volunteer or not*". My impression was that this was something that he rarely tried.

Most of my informants did not have any clear answer to this question. One informant however, believed that many patients got committed because healthcare workers are not good enough when promoting voluntary options. Another one answered that the patient must be given information about different options and one should listen to the patient`s thoughts and expressed needs and try to find a solution together. He believed that this was something that was rarely tried by the responsible healthcare professionals.

It is my feeling that there is no specific way of meeting this criterion. "*Trying voluntary solutions first, unless it is obviously pointless*" could be a variety of different things. You could ask the patient if he or she want treatment and argue that you have tried to get the patient to volunteer, or you can use some time talking to the patient and presenting the patient with, if possible, different options of treatment. One of my informants gave me a piece of

interesting information regarding this matter. He claimed that; "*the conversion prohibition makes it more convenient for healthcare professionals to use compulsory mental healthcare, rather than making the patient volunteer*". The "conversion prohibition" says that you can`t transfer anyone from voluntary treatment to forced treatment (Lovdata). The reason that he says it is more "convenient" is that if a person that the healthcare professional feels is in need of treatment is volunteering, that person can at any time demand to be discharged from the hospital and/or end their relationship with the mental healthcare services. The healthcare services is then, due to the conversion prohibition, prohibited from transferring that person to forced treatment. In that case, the patient that has accepted treatment will be discharged from the treating institution and the healthcare professional responsible must let the patient leave the facilities before "they" go and pick up the patient again. The same physician went on by saying that the patient would in many cases be picked up again and readmitted, using compulsory admission, usually the same day that he or she is discharged. I do not know how big this problem is, but I can clearly see why it can be more convenient for the mental healthcare professionals to practice in this way, even though it contradicts the act of mental healthcare.

I got the impression that only two of my informants made any significant effort to meet this paragraph. The attitude of the majority seemed to be that it was "obviously pointless" in most cases. Here we also see a considerable difference in the beliefs and attitudes towards the value of trying to come to a voluntary solution.

Understanding and interpretation

Everyone I have talked to, knows the contents of the law well, many of them has also looked into court rulings, and is continually updating themselves about new literature and information on the topic. Even though my informants knew the contents of the law, their interpretation of it differs to some degree. Regarding the main criterion "serious mental disorder" all of them understood it in a similar way. However, when interpreting the treatment and danger criterions one can identify differences both in the interpretation and in the attitudes regarding when it is appropriate to use. Making a "total evaluation" seems to be

challenging. Like we have seen from the answers regarding the "total evaluation", many and diverse aspects is considered in the evaluation. The total evaluation may include most aspects of a person's life, not only the condition and the severity of the symptoms present, but also the psychiatric history of the patient, the possible effects and consequences of the treatment compared to no treatment and practical sides like housing, family situation etc. Since it is no clear lines here, it seems inevitable that patients will be treated somewhat different, by different decision makers.

Every informant knew that voluntary options should be tried before anyone can be compulsory admitted, unless this is "obviously pointless". In this case, with the exception of two informants, I got the clear impression that this was something that most of them seldom tried; their attitudes towards this point seemed to be that they believed up front that committing the patient to mental treatment is the best option.

Given the fact that every criterion, like we have seen, is the subject of individual interpretation of details regarding the patient's condition and the effects and consequences of treatment inside a timeframe, makes these decisions very complex. The informants know the contents of the law well, but their attitudes towards when to use compulsory admissions differs. Here we can see paternalism in different forms. If someone will be compulsory admitted or not is obviously influenced and connected to the healthcare professional in charge. His or her understanding of the law and the beliefs and attitudes he or she holds regarding the effects and consequences of compulsory admission to treatment in a mental hospital will determine the outcome for the patient. This obviously leads to different practices, which again may explain the regional differences in the use of compulsory admissions.

6.2 Do you believe that other healthcare professionals could interpret the law in a different manner?

Expanding on the first question I continued by asking my informants if they believed that the law could be interpreted differently by other healthcare professionals.

The opinions regarding this point differed. One informant answered; "*I think that is unlikely, that big a difference between professionals, no I don't think so*".

Another one answered that he was uncertain, but in contexts where he had discussed the matter with colleagues working in other regions, he had the impression that they interpreted the contents of the law for the most part in the same way.

One informant believed on the other hand that many of the healthcare professionals making decisions regarding compulsory admissions do not even know the contents of the law. For instance, he claimed; "*many do not even know that suicidal tendencies are connected to one of the additional criteria`s, but believes that this alone is enough to commit someone*". He went on by saying that he himself refused 90 per cent of the requests he received for compulsory admissions. This shows clearly that the responsible people working in the municipalities interpret the law different than the persons working in the Health enterprises he said. He believed that it also were the same kind of differences between the health enterprises.

Another physician believed that many healthcare professionals, that has responsibilities regarding compulsory admission, uses §3-2 forced observation in "the act of mental healthcare" when they are dealing with suicidal persons. Often these people do not meet the main criteria of "serious mental disorder", but only the additional danger criteria, in other words they are breaking the law when committing someone on that basis. The reason for this practice is that healthcare professionals are afraid that the person in question will take their own life. Here I would like to make a reference to paternalism, acting in the best interest of the patient the healthcare professional chooses to break the law. According to several of my informants the county doctors are sending signals that no one shall take their lives, and that they are encouraging the healthcare workers in charge to use force on persons in risk groups even in cases where there is no legal basis for it. "*The hospital emergency centres and the DPSs have received strong signals that when it comes to suicidal patients they should always send requests for forced observation using § 3-2*" one physician informed me. "*It is several years since the mental healthcare services have practiced this in the proper legal manner,*" he continued. This was also the belief of another, who claimed; "*the use of forced observation on people with suicidal tendencies who are not believed to be suffering from a serious mental disorder is totally wrong, but is something that happens a lot*". Another informant confirmed this indirectly by stating that: "*we would be very restrictive when using the danger criterion, more restrictive than many others would in regards to danger to oneself. When it is claimed*

by a patient that I have plans to commit suicide, most healthcare professionals is not that concerned about whether or not the main criterion of serious mental disorder is present. That is at least my impression after talking to colleagues". She followed by saying that:" *I think this is wrong, it is actually legal to commit suicide*".

Two of my informants have confirmed that they have held people against their will on this basis, others, like the one sited above, have told me that they know that colleagues of them have done the same thing. These are obvious cases of paternalism; one even chooses to neglect "the act of mental healthcare". In cases like these paternalism goes before the law.

This practice, in my opinion, contradicts the legal basis for committing someone to hospitalization at a mental institution. The law states that for someone to be committed to mental healthcare he has to be evaluated by two independent doctors, where one of them shall be independent of the treating institution. When you have a practice where the healthcare professional working in the municipalities, in cases where they suspect suicidal thoughts (which in itself do not meet the criterions of the law), routinely sends requests for forced observation, you deprive the person of his legal rights according to the "act of mental healthcare". The thought is that the person in question shall be fully examined by two independent doctors, with this practice however, you leave it up to the responsible healthcare professional at the health enterprises alone to make the decision. In my opinion this reduces the authority of the law.

It seems, from the answers here, that healthcare professionals may have different understandings of the law, and that their attitudes regarding the use of force and the beliefs in paternalism differ. This can be confirmed by the actions of the healthcare professionals working in the municipalities, when they are sending anyone that may be suicidal to forced observation. Some of these healthcare professionals might not even know the contents of the law; others may send requests for forced observation even when they know that the main criterion is not present. The differences in the practices of sending requests for forced observation and compulsory admissions on behalf of healthcare professionals working in the municipalities can be confirmed by the statistics. The statistics shows that certain regions sends five times as many requests for compulsory admissions then does the areas with the lowest numbers. Two of my informants have confirmed that they have compulsory admitted people that they consider to be suicidal even in cases where they know the main criterion of "serious mental disorder" is not present. This they do in the best interest of the patient, even

when they know they are breaking the law. This strengthens what is already assumed. The understanding of the law and the attitudes towards the use of force held by the individual healthcare professional will influence their practices. Healthcare professionals will also, with encouragement from the county doctors, consciously break the law when they believe that it is in the best interest of the patient. In other words paternalism is placed above the law. This practicing may influence the regional differences we see in the use of compulsory admissions.

6.3 Mixed signals from the government

One informant added that he felt that: "*the government wants it both ways; they want the use of force to be reduced, at the same time they want to make sure that no one takes their own life*". Here we see clearly a case of mixed signals from the government which to me is one of the most striking elements revealed during my investigation. This may confuse the healthcare professional and contribute to the different practices we see in the sector. First off, the government states that the Norwegian mental healthcare services uses to much enforcement and that they want the use of force to be reduced. Secondly, they do not want anyone to take their life.

6.4 Pressure/signals from the Government

I asked my informants if they would be influenced by pressure from the government. One of my informants answered that she herself would not be influenced. She went on to say that she felt that in many cases where she heard politicians and others in the media say that; "*voluntary solutions are always best bla, bla, bla*." She got the thought and the feeling that: "*you have no idea what you are talking about*". She went on to say that in many cases, even when the patient is not a danger to anyone, it is obvious that the person is so sick that he or

she needs help, even if the person refuses. That Governmental official`s and others does not understand this makes her at times very frustrated.

A similar attitude were held by another he said that: *"it depends on the individual physicians competence and feeling of mastery, I will not be influenced by the signals from for instance the minister of health, I would consider him as an authority yes, but he do not have thirty years of experience, he is a person that have received information from others, maybe more inexperienced physicians would listen*".

Another one answered that he believed that this could influence some physicians to a certain degree, but that it were stated from the clinical leadership of the hospital he was working, that the important thing is "the right use of force". So he would make his decisions based on his interpretation of the criterions in the law and not based on the signals from the Government. He emphasized that in certain cases where the main criterion of "serious mental disorder" is not present it could be tempting to use compulsory admissions, but then the numbers would be wrong and the law broken.

Others confirmed this view and answered that this was most likely not the case. One informant stated that; "*physicians and other healthcare professionals taking decisions in the matter are usually very independent and confident in their own evaluation, and will not let non-professionals influence their decisions*".

It appears that some responsible healthcare professionals will be influenced by pressure and signals from the Government that the use of force should be reduced. Health enterprises may also feel the pressure and instruct their employees to change their practices. However, it seems, based on statements from the informants, that most healthcare professionals will not be influenced by Governmental pressure. Especially experienced physicians believe that they know what is best for the patients, and not the Government. Again, in the name of paternalism, they will do what they believe is best for the patients, and not follow the lead of the Government.

6.5 Professional environment and attitudes

I asked my informants if they believed that the professional environment and the traditions of an institution could influence the healthcare professional in their decisions regarding the use of compulsory admissions. I also put in the fact that regions with traditional asylum is shown to have higher numbers of compulsory admissions than regions without. All of my informants thought to some degree that healthcare professionals would be influences by their working environment when making their decisions.

One of the informants believed that the factors; internal culture of an institution, their routines and the person(s) responsible for instructing new doctors and psychologists greatly influences the attitudes and practices in an institution. In addition to this she said, "*The colleagues you have will influence your decisions*". He went on by saying, quote; "*you are socialized into a certain way of thinking*". Here I would add that during my interviews it has been revealed to me that the people taking decisions regarding compulsory admissions do not have courses in law during their education. In my opinion this would make them more likely to conform to the practices and routines of an institution when starting to work there, than they would if they had some schooling in the act of mental healthcare.

All of my informants believed that the professional environment one worked in, and the established routines in the healthcare professionals working environment would influence the individual healthcare professional's behaviour. This is not surprising and is confirmed by numerous studies in social psychology regarding group behaviour in a workplace. The ones who do not conform to the established norms will be isolated and frozen out (Hogg & Vaughan 2005). There is no reason to believe that this should be any different for physicians working at a mental hospital then workers in different areas. This means that if you as a new healthcare professional are beginning to work in a medical institution you would adopt the practices and routines of the institution. The ones that train you will socialise you into a certain way of thinking and acting which again will shape your behaviour. This can explain that the regions/places that have long traditions of having mental asylums have higher enforcement rates than the ones who does not. It could also explain why the same areas keep having high figures while others consistently have low numbers. Given the fact that the healthcare workers in question do not receive any training regarding the "act of mental healthcare" and how to interpret it during their education, and given the complexity connected with interpretation of the criterions in the law it is not hard to imagine that they will be "shaped" in a certain way by their superiors and colleagues when starting their work in an

institution. Perhaps coursing in “the act of mental healthcare“, and how to interpret it, should be mandatory for anyone that is applying for positions where you are to take decisions regarding compulsory admissions and the use of other kinds of force upon patients?

6.6 Opinions on the reasons for the differences

I asked my informants about what they thought could be the reasons for the regional differences in the use of compulsory admissions. Here I got a variety of different answers and possible reasons. One element that one of my informants brought fort was the opinion that the numbers themselves were unreliable. He claimed that: “*First and foremost the numbers themselves are suspect*”. A similar element that was brought fort was underreporting, some hospitals may not report all the cases. A third informant said that:” *I discuss this from time to time in more structured forums. That you are honest in the way you report is one factor*”. This is a problem that came to my attention during my survey into the literature prior to my interviews. Some of the literature has covered this, it is claimed that differences in reporting and registration routines can influence the numbers, it is however uncertain to what degree, but it is not considered to be a main reason for the differences, but a contributing factor. This was also the belief of the formerly referred to informants.

Distance to a mental hospital was also something that was mentioned as a possible contributing factor, even though the physician mentioning this was uncertain about the impact of the factor. He believed that it could turn both ways depending on different patient groups. My immediate thoughts regarding the statement are that this may be a contributing factor explaining the high enforcement figures of the Hospital of Northern Norway. One could imagine that the huge areas of Finnmark and Troms which have many rural areas with small population represent a special challenge for the mental healthcare services. If a patient is sent hundreds of kilometres to a mental hospital with a request for compulsory admission one could be lead to believe that the healthcare professionals at the receiving hospital would be more likely to put that person under forced observation then in areas with shorter distances between the population and the hospitals. It takes vast resources to transport a person over huge distances and therefore chances are that the barriers to be put under forced observation

are weaker, making the hospital more certain that they will not receive that same person again shortly. However, the hospital of Nordland who also is a limited populated area has a small number of compulsory admissions. One could contrary to the hypothesis I presented above imagine that distance to the hospital could make the healthcare professionals working in the municipalities more hesitant to refer persons to compulsory admission, knowing that this will take large resources in the form of travelling cost, perhaps even with the assistance of the police if the patient do not comply to the measure. This, however, are my thoughts on the matter.

Another informant felt that it was big differences in the quality of the supervisory commissions. This is the commission that is supposed to watch what happens and make sure that the law is followed. It is the commission that patients forward their complaints to when they feel that the law is broken and/or that their rights have been violated. He added that most of the legal practices are based on the rulings of the control commissions, in addition to the rulings of the Supreme Court. In other word, how the control commissions interpret the law and how they act influences the behaviour of the responsible healthcare professionals. Differences in the way in which the supervisory commissions at the different hospitals interprets the contents of the law, and how they interprets a patient`s mental condition will obviously influence the practices and routines at the hospital in which they are employed. This is due to the fact that they have the power to overrule the healthcare professionals who makes decisions regarding the use of force.

Yet another believed that services provided by the municipalities have a major impact on the "enforcement rates". She told me:" *I think that it revolves much around the services provided by the municipalities. If you provide a sufficient number of well suited, adequate apartments, with services then I could imagine that the use of compulsory admissions would be reduced*". She also emphasizes that late intervention could be a reason. If you intervene at an early point, many compulsory admissions could have been avoided she says. The point about intervening at an early point is supported by authorities on the field and is written about in the literature, for instance in NOU (2011:9). One could easily imagine that if you intervene at an early stage with someone who is developing a mental disorder you can prevent it from flowering. If the mental disorder is allowed to develop the patient may get so sick that he or she will no longer know what is best for themselves, and the use of force may be necessary to prevent the mental disease from developing additionally (treatment criteria), or the

development of the disease may cause the patient to become a danger to him or herself thus making the use of force necessary.

Other reasons that are mentioned are, like most writings suggest, socio-demographic reasons. Especially the number of drug abusers and the access to illegal drugs is believed to greatly influence the numbers. One informant working in the Hospital of Sørlandet told me that they had a project going where they worked with the Hospital of Innlandet to see how they can reduce the use of force. He went on by saying that their region had a higher number of drug induced psychosis than did the Hospital of Innlandet, this is due to a higher number of drug addicts. He said that:" some of the differences we experience are that we have a higher number of drug induced condition at our place". Then he added that they also received more requests for compulsory admissions than most other regions (430 per 100 000, hospital of Innlandet about 110-130). The high number of requests for compulsory admissions is often due to people being drugged there and then and not because the person is suffering from a "serious mental disorder". Many of these requests are denied.

The socio-demographic explanation is most likely part of the reasons for the differences. It is evident, that health is influenced by social factors, the so called "social determinants of health" (Daniels 2008). In other words social factors will influence your health. Like I have previously touched upon in the paper; drug addicts, immigrants, homeless people, people with low education and income are more likely to have mental problems than other groups. This is a fact. However, this element is only part of the reason for the differences. Like I explained earlier in detail, Oslo has the most drug abusers, immigrants and homeless people, but they score about average on the national statistics regarding the number of compulsory admissions when compared to the population. In addition we can see from the statistics that the hospital of Northern Norway is at the top of the statistics. This maybe the least urbanised area of Norway.

Inadequate follow-up system was mentioned. Many patients often return and is readmitted after they have been discharged, the majority of my informants believes that drug abuse is a big part of the problem. Many psychiatric patients has a so called "drug induced psychosis" which happens when substance abuse makes a person become mentally sick. Often when patients who has been treated and becomes asymptomatic or at least better after a psychosis induced by drugs, they are discharged and when they get out they start using drugs again. The drug abuse leads to a new psychosis and the patient is readmitted again. Several of my

informants believed that many of their patients get well, not necessarily due to medication and therapy, but due to the absence of "street drugs". "*This negative spiral is making their mental illness more severe as time goes by and the circle repeats itself*", to quote one of my informants. Another element is that many patients are suffering from a chronic schizophrenia. When these patients gets treatment and experience the safety of an institution with daily routines, regular meals and physicians and healthcare workers that takes care of them and watches over them the patients often gets better and are relieved of symptoms. When they get out the safety net often disappears and gradually the patient often sees their condition worsening again. Creating adequate and effective follow-up systems may help prevent the discharged patient form returning.

An additional element that was brought forward was that pressure from the police could lead to compulsory admission. For instance in cases were the police have brought someone in who might be disoriented; the police often claim and "demand" that the person be committed because they consider him or her to be mentally ill. Often healthcare professionals in charge will commit people because of pressure, even if the person in question is not considered to be suffering from a "serious mental disorder". There is no support for this statement in the literature, but one could imagine that some persons will fall between two shares. Someone may be violent and irrational, which the police consider to be mentally ill, while the mental healthcare services consider the person to not meet the criteria`s in the law. In a situation like, or similar, to the ones described one can imagine that pressure from dominant police officers may influence the decisions of the healthcare professionals.

7 Summary and conclusion

Understanding and interpreting the process behind compulsory admissions

The main focus of my thesis has been on the process behind the use of compulsory admissions to psychiatric hospitals inside Norway. The background for compulsory admissions and other uses of force in the psychiatric sector is the "act of mental healthcare" which describes the criterions and conditions that have to be present if somebody is to be compulsory admitted. Whether or not a person's condition corresponds with the criterions of the law is up to subjective evaluation. It is therefore given that the way the independent healthcare professional understands and interprets the criterions in the law will influence his or her decision. Compulsory admissions, after the "act of mental healthcare", are mainly justified by being in the best interest of the person concerned. I have therefore chosen paternalism as my theoretical background. "Paternalism can be defined as an action which restricts a person`s liberty justified exclusively by consideration of that persons best interest and carried out against his present will" (Garriston and Davis 1983).

With that background I have conducted semi-structured interviews with 10 healthcare professionals who have the responsibilities of making decisions regarding compulsory admissions. The sample was carefully chosen using purposive sampling, in other words, the sample was strategic, based on the goal of the research. I found out that my informants knew the contents of the law well, but that their interpretation of it differed. This is easily spotted in their attitudes regarding the use of force. Some think that the use of force is often necessary others think that it is seldom necessary. Some believes it usually benefits the patients, others believe it usually harms the patient. Some will use force on suicidal patients that is not considered to be suffering from a "serious mental disorder", others will not. Here the parallel to paternalism can be made, what is believed to be in the best interest of the patient and at the end what becomes the situation for the patient, is the product of the responsible healthcare professional`s attitude towards the use of force which varies from person to person.

The place the healthcare professional works, with their practices and routines, the attitudes of their superiors and their colleagues seems to shape the behaviour of the healthcare professionals more than the contents of the law or signals from the Government. In many cases, healthcare professional will break the law intentionally, if they believe that it is in the best interest of the patient. The criterion of the law that says that voluntary solutions should be tried before anyone can be committed, unless it is obviously pointless, seems to be overlooked in most cases.

My informants believe that it is multiple factors that influence the differences in the practicing of compulsory admissions. All these different factors and variables make it difficult to point to one or two concrete reasons. Reasons that were mentioned were unreliable numbers, distance to hospital, different routines, socio-economic factors, differences is the interpretation of the law, not knowing the law, conflicting signals from government and county doctors, that insecure healthcare professionals uses force more often than the more experienced ones and that the different professional environments creates different attitudes. The most striking element to me is that many healthcare professionals choose to use forced observation on suicidal patients even if the main criterion of the law is not present. The responsibility for this practice however, is shared by the healthcare professionals with the County doctors who send signals that anyone with suicidal thoughts shall be sent on to forced observation, even if the patient is not considered to be suffering from a "serious mental disorder".

To reduce the differences and make the practicing of compulsory admission more in accordance with the law I would suggest that anyone that will be working as a decision maker regarding compulsory admissions and other kinds of practices involving the use of force in the mental healthcare services should be educated in the "act of mental healthcare". Being thought how to interpret the different criterions and also more concrete how to proceed when trying to make a patient accept voluntary treatment. The Government cannot continue sending mixed signals where they want the use of force to be reduced on one hand, and on the other expecting no one that is mentally unbalanced to take their lives. The same problem arises when the county doctors are instructing the municipalities to send every person which is expected to be suicidal to forced observation, even if the main criterion of the law is not present. This needs to be sorted out. Perhaps the Government should present some new

legislation to deal with suicidal persons that are not considered to be suffering from a “serious mental disorder”.

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9 Appendix

9.1 Appendix # 1: Interview structure

I will conduct semi-structured interviews when talking to my informants.

A qualitative investigation into the reasons for the regional differences, in proportion to inhabitants, in the number of persons committed to treatment in mental hospitals against their will.

Informants: 10-14 doctors and/or psychiatrists that are responsible for committing people or sends requests for compulsory hospitalizations in the region in the country with the lowest number of compulsory admissions, and in the region with the highest numbers.

Duration 60-90 min

Place: The workplace of the informants

Time: April/May 2013

Devices: Dictaphone

Person conduction interviews: Project leader

Contents and questions:

Short introduction about the project and the giving of guaranties regarding anonymity.

First question:

Your region is having the highest/lowest number of people committed to compulsory admission in proportion to the number of inhabitants. Do you have any idea of what could be the reasons for this?

Do you believe that the law could be interpreted differently in other regions?

Do you know how long the average period for compulsory admission is in your region?

Are there any patient`s here, that is suffering from other kinds of mental illnesses, like dementia, that may be registered as a psychiatric patient when they are really not?

Second question:

The act of mental healthcare describes the criteria`s that have to be present before anyone can be committed to hospitalization. However, the law is obviously product for interpretation. Do you find it hard to determine whether a person meets the criteria`s in the act of mental healthcare or not?

Do you think the law is difficult to interpret?

How would you determine if a person is suffering from a “serious mental disorder”, which is the main criteria in the law? What kind of conditions would you say meets that criterion?

Going on to the additional criteria’s. How do you consider the treatment criteria? How do you evaluate whether a person with mental problems would get their possibility of cure significantly reduced if they do not receive treatment, and how do you evaluate whether someone will get their condition considerable worsened or not without treatment?

Under what conditions do you consider someone to be a danger to him/herself, or to be a danger to others?

Looking away from the «danger criteria», we get to the last point in the law. How do you determine whether compulsory admission to a psychiatric hospital is the overall best option for the patient?

Do you find making decisions about whether someone fulfills the criteria’s or not difficult?

If so, do you seek council from colleagues?

When discussing with colleagues is it often that there is a disagreement between you regarding if a patient meets the criteria`s in the law or not?

Third question:

The law also states that voluntary options should be tried, before anyone can be hospitalized against their will.

How do you proceed to meet this paragraph?

Do you try to persuade the patient to receive treatment? If so how?

Do you present the patient with different options for treatment?

Forth question:

Do you think that the number of available places could influence the fact that someone gets committed or not?

Fifth question:

How do you determine when a patient is “well enough” to be discharged from the hospital?

What will happen to the patient when he or she is discharged?

Do the same patients often return after being discharged from the hospital?

If so, what do you think is the reason for this?

If not, what do you think is the reason for this?

9.2 Appendix #2 Request for participation in study

Forespørsel om å delta i intervju i forbindelse med en masteroppgave

Jeg er masterstudent ved institutt for helseledelse og helseøkonomi ved Universitetet i Oslo. Mastergraden jeg tar går på engelsk og heter:" Health leadership, policy and management". Jeg holder nå på med den avsluttende masteroppgaven. Masteroppgaven omhandler bakgrunnen for tvangsinnleggelser til psykiatrien. Jeg er interessert i hvordan personer med ansvar for tvangsinnleggelser oppfatter og tolker loven om psykisk helsevern, og om hvordan de opplever sin rolle som beslutningstaker. I tillegg til det er jeg interessert i rutiner og praksis rundt tvangsinnleggelser.

For å finne ut av dette ønsker jeg å intervjue 10-14 personer (intervjuene vil bli gjennomført på norsk) som har som ansvarsområde og ta avgjørelser i forhold til tvangsinnleggelser.

Intervjuene vil være semi-strukturert og vil vare ca 60 min. Tidspunkt bestemmer vi sammen. Jeg vil under intervjuet benytte en båndopptaker og ta notater.

Det er frivillig å delta i prosjektet og du har full anledning til å trekke deg på et hvilket som helst tidspunkt. Alle deltakere vil være anonyme og alle opplysninger vil bli behandlet

konfidensielt. Dersom du trekker deg vil alle innsamlede data om deg bli slettet. Når oppgaven er ferdig, innen 15. November 2013 vil alle person opplysninger slettes.

Dersom du ønsker å delta på intervjuet, er det fint om du skriver under på den vedlagte samtykkeerklæringen og sender den til meg, eller eventuelt gir meg den når vi møtes.

Hvis du ønsker ytterligere opplysning rundt prosjektet kan du kontakte meg på tlf 48 26 10 91 eller send en e-post til k.n.ugstad@studmed.uio.no. Du kan også kontakte min veileder Eli Feiring på tlf 22850528, eller på e-post eli.feiring@medisin.uio.no

Studien er meldt til Norsk samfunnsvitenskapelig datatjeneste(NDS)

Med vennlig hilsen

Kristian Ugstad

Durudveien 16C

1344 HASLUM

Samtykkeerklæring:

Jeg har mottatt skriftlig informasjon og er villig til å delta i studien.

Dato **Signatur**