Why community compulsion became the solution — Reforming mental health law in Sweden

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**ABSTRACT**

The aim of this article is to understand how compulsory community care (CCC) has become a solution in mental health policy in so many different legal and social contexts during the last 20 years. The recent introduction of CCC in Sweden is used as a case in point, which is then contrasted against the processes in Norway, England/Wales and New York State.

In Sweden, the issue of CCC was initiated following high-profile acts of violence. Contrary to several other states, there was agreement about the (lack of) evidence about its effectiveness. Rather than focusing on dangerousness, the government proposal about CCC was framed within an ideology of integrating the disabled. The new legislation allowed for a broad range of measures to control patients at the same time as it was presented as a means to protect positive rights for patients. Compared to previous legislation in Sweden, the scope of social control has remained largely the same, although the rationale has changed — from medical treatment via community treatment and rehabilitation, to reducing the risk of violence, and then shifting back to rehabilitation in the community.

The Swedish approach to CCC is similar to Norway, while New York and England/Wales have followed different routes. Differences in ideology, social control and rights orientations can be understood with reference to the general welfare and care regimes that characterize the four states.

1. Introduction: a controversial trend

During the last 20 years or so, a distinct trend has occurred in mental health law in industrialized democracies. States have increasingly introduced legislation facilitating compulsory care outside of hospital settings. This development, which we will refer to as compulsory community care (CCC), has been controversial in most Western countries. Supporters of CCC have argued that it might reduce the risk of relapse leading to re-hospitalization of patients who have been discharged from hospital care and encourage the provision of adequate treatment and care in the community (Appelbaum, 2001; Churchill, Owen, Singh, & Hotopf, 2007). In addition, CCC has been portrayed as a less restrictive alternative to in-hospital compulsory care (Hiday, 2003). A further rationale for CCC has been to protect the public from potentially dangerous people who have been diagnosed with severe mental disorders (Churchill et al., 2007). On the negative side, it has been pointed out that CCC could lead to net-widening, i.e. that a larger number of citizens might be subjected to compulsory care (Geller, Fisher, Grudzinskas, Clayfield, & Lawlor, 2006), or increase the risk of human rights abuses. Also, if the use of CCC expands, treatment methods that motivate patients to engage more actively in treatment might be neglected (Brophy & McDermott, 2003). Furthermore, some argue that relocating coercive intervention to home settings interferes with the integrity and autonomy of patients in new and potentially more problematic ways (Sjöström, 1997). Churchill et al. (2007) have conducted what is perhaps the most comprehensive research review about the efficacy of CCC. Drawing on the few existing randomized controlled studies as well as naturalistic, descriptive ones, they conclude that “it is not possible to state whether community treatment orders (CTOs) are beneficial or harmful to patients.” An earlier Cochrane report came to a similar conclusion (Kisely, Campbell, & Preston, 2007). Since then, some positive outcomes for patients have been identified in an evaluation of the Assisted Outpatient Treatment Program in New York (Swartz, Swanson, Steadman, Robbins, & Monahan, 2009). However, the authors argue that the results are difficult to generalize because there was a substantial infusion of new service dollars when CCC was introduced.

Given the scarcity of empirical evidence and heated opposition to CCC, it is surprising that this form of compulsory intervention has been adopted quite consistently throughout the Western world. It is even more surprising given the variety of social welfare systems...
that have adopted CCC over a relatively short span of time. With few exceptions, CCC has not been the subject of empirical social policy studies. Those studies that have been conducted focus primarily on national contexts in Anglo-Saxon countries. Drawing mainly on developments in Australia, but also the US and England/Wales, Brophy and McDermott (2003) analyzed the social, economic, policy, legal and ethical contexts in which CCC has been introduced. Using a “force field analysis” they identify the driving and restraining forces at work. They suggest that a “domino effect” is part of the reason why CCC legislation has spread so rapidly both within nations and internationally. Homicides committed by people who suffer from mental illness and the prospect of cost reductions are among the factors that have encouraged the spread of CCC. Kahan, Braman, Monahan, Callahan, and Peters (2010) identify two main characteristics of the debate in the US: its intensity and a lack of definitive empirical data about CCC’s effectiveness. They also note that ideological arguments are seldom invoked. Drawing on Douglas's theory of cultural cognition (DiMaggio, 1997; Douglas, 1970), they try to explain why there is controversy over outpatient commitment laws in the US. They find that individuals who are “hierarchical” and “communitarian” tend to be more positive to CCC than are “egalitarian” and “individualistic” individuals. They also argue that such values affect individuals’ perceptions of policy relevant facts, which, in turn, has consequences for opinions about CCC. Churchill et al. (2007: 18–19) notes that empirical data can be interpreted differently depending on the ethical position one takes as regards CCC, while Swanson (2010) suggests that arguments against CCC have sometimes appealed to the same values as those in favor.

Our ambition is to expand the discussion about how CCC has conquered the world, both by suggesting additional theoretical perspectives that can advance our understanding and by contributing to empirical knowledge by focusing on another case. Our aim in the article is to understand how compulsory community care has become a solution in mental health policy in so many different legal and social contexts. To do so we use the case of Sweden, a country that recently added CCC to its social policy legislation after many years of controversy. In order to discuss the matter on a general level, we will contrast Swedish developments with similar processes in Norway, England/Wales and New York State. In particular, we are interested in understanding this development in terms of risk-oriented policies in the context of a specific welfare regime.

Questions that we address in analyzing our data are:

- What approaches do proponents and opponents of CCC use to promote their views?
- How are perceptions about the dangerousness of individuals invoked?
- How are issues about patient rights invoked?
- What knowledge claims are made about CCC?
- How are arguments used in the debate linked to different kinds of treatment and political ideologies?

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2. Theory: social policy in the risk society

Cross-national research that compares welfare systems often uses the term welfare regime. Esping-Andersen (1990) has described differences among these regimes in terms of decommodification, i.e. the degree to which wage earners are dependent on the market. He describes three ideal types of welfare regimes in industrialized democracies: ‘liberal’, ‘conservative’ and ‘social democratic’. Gender oriented researchers have drawn attention to how concepts such as care regime and defamilization create a broader perspective on social policy and social rights. They have argued that education, housing, health care and personal social services are equally important in contemporary social policy. These researchers also tend to put personal autonomy at the center of analysis (O’Connor, 1999; Orloff, 1993; Sainsbury, 1999). This strand of research appears more relevant for our purpose, which is to improve our understanding of mental health policy. One of the very few attempts to develop specific theories about mental health policy is Goodwin’s (1997). He finds that states that share traits in Esping-Andersen’s typology also tend to be similar as regards the deinstitutionalization process. According to Goodwin, liberal welfare regimes put emphasis on rehabilitation, and their long-term support services suffer from quality problems. Conservative regimes minimize state invention, while social democratic regimes stress social rights and tend to have better services.

During the last 20 years, social science has shifted its attention to what has been referred to as the risk society (Beck, 1992). A fundamental trait of the risk society is a refocusing of attention away from the distribution of wealth to an emphasis on the distribution of risk. Society becomes increasingly preoccupied and defensive about risk. This development has also been discussed in relation to social policy. Kemshall (2002: 90) points out that “mental health provision is one arena in which needs, rights, and risks have long competed.” Historically, risk management strategies have evolved from the incarceration of the mentally ill to their integration. Simultaneously, the site of risk management has moved from institutions to the community (cf. Ryan, 1996). Kemshall’s description is based on the situation in the United Kingdom, but the argument can be applied to many other countries. Deinstitutionalization and the shift to community care have led to increased attention to risk. As a result, risk reduction has become a policy concern. Of particular interest is how to protect the public from what has been perceived as dangerous individuals suffering from mental illness. Focus and resources have been concentrated to a small, residual group of high-risk individuals who are presented as a danger. Professionals have increasingly been blamed for incidents of violent crime involving offenders with mental illness. Kemshall maintains that such incidents have been interpreted as symptoms of flaws in the community care system.

A shift in the media’s representation of the mentally ill also reflects society’s preoccupation with risk: from a focus on the institutional abuse of patients to a focus on the mentally ill who assault innocent citizens. Deinstitutionalization could be portrayed as a project in which risk-taking is encouraged — that by taking positive risks, people with mental health problems become empowered. In fact, however, the main thrust of discussions and representations has undoubtedly been on risk management rather than on the positive aspects of risk and/or the rights and needs of those suffering from mental health problems.

Wolff (2002) discusses how social policy makers take political risk into account. She studies the creation of new mental health policy in the United Kingdom in the late 1990s in order to explore how policy makers seek to minimize risk. She identifies three types of risk: inactivity risk, errors—judgment risk and ineffectiveness risk. As regards strategies to manage political risk, Wolff distinguishes between single-bullet approaches and shotgun approaches. The latter involve using a wide range of measures to address a problem. Another distinction Wolff makes is between signature risk and operation risk. The first refers to situations in which individual decision makers are given responsibility for potential mishaps that might occur in the future. Operation risks arise when a group, for example a health or local authority, shares general responsibility for executing a policy and achieving the intentions behind it. General responsibility can also be spread across different levels of government. With regard to mental health policy in the UK, Wolff discusses how the then new Labor government managed errors—in—judgment risk by adapting to the public’s perception of violence and by including experts in the policy-making process. To address ineffectiveness and inactivity risks, the government adopted a shotgun approach including, for example, new services, new
controlling powers, better detection of needs and improved interagency cooperation. By assigning the responsibility for executing policy to local agencies, the national government deferred both signature and operation risks. Wolff argues that strategies adopted for reducing policy risk might be counterproductive, e.g. creating a short-sighted chaos of new policies, giving service providers incentives to avoid high-priority clients and creating a cycle in which security concerns will continue to grow. All this leads to a growing community-care backlash according to Wolff. She shows that her analysis is applicable to the US and, quite possibly, to most other industrialized democracies as well.

As a consequence of the risk society, our view of the state has changed. Rather than asking for protection from the state, we increasingly expect protection by the state. This leads us to another theoretical perspective that has been applied to mental health provision, namely, social control. The shift in risk management strategies from incarceration to integration can also be interpreted in terms of a shift in controlling strategies: from external and physical control of individuals to internal and mental control (cf. Foucault, 1995). New knowledge and technologies emanating from the so-called psy-disciplines have become important controlling features (Innes, 2003: 32–49). For our purposes, we note how controlling strategies undergo a juridification, i.e. law and legal reasoning is increasingly relied upon to shape and constrain behavior. Compulsory community care can be seen as a quintessential example of the internalization of control that Foucault described.

3. Background: the Swedish welfare system

Policy and reforms in the mental health field do not occur in a closed system. They have to be understood in the context of wider concerns such as the general structure of the welfare system (Drake, 1999; Huber & Stephens, 2001). Scholars of social policy often describe Sweden as an ideal type of the social democratic welfare regime. Since World War II, the model that evolved in Sweden has been characterized by generous and general welfare programs. Social insurance, extensive social services and medical care are all key areas of the Swedish welfare system. General programs, typically operated by the public sector, have been combined with selective measures targeting vulnerable or underprivileged groups. These latter efforts have been legitimized in terms of normalization and inclusion in the labor market. The emphasis on community based strategies as a means of promoting normalization and inclusion constitutes the Swedish context of the de-hospitalization of mental health policy. In recent years, the central concepts of this policy have been full participation, equality and a distinct focus on positive rights. This is reflected in disability legislation. A large proportion of former mental health patients have been redefined as persons with mental disabilities, and they have increasingly been included in programs and strategies that are part of disability policy (Markström, Sandlund, & Lindqvist, 2004). Reforms enacted since the 1990s which target the elderly, disabled and those with severe mental disorders have typically shifted responsibilities from the health care sector to social services, reflecting the increased focus on the normalization of everyday life. As a result of these reforms, the community mental health sector has expanded in the sense that there is more social support for people with psychiatric disabilities.

Thus, mental health policy in Sweden reflects Goodwin’s (1997) depiction of mental health policy in social democratic regimes. It is also an example of the defamiliarization of care. However, the government’s application of ‘soft’ steering instruments (Howlett, 2009) like information, general guidelines and temporary funding has created a situation in which access to and quality of service differs among local providers. Despite the government’s emphasis on rehabilitation and recovery, Lindqvist, Markström, and Rosenberg (2010) characterize everyday practice in Sweden as dominated by a caring perspective. Sheltered housing and day centers are given priority, at the expense of more rehabilitation-oriented strategies.

4. Methods

Documents from the parliamentary process are the main source of data in this study about developments in Sweden. These include committee reports, government bills, proposals to the parliament and transcripts of parliamentary debates. In addition to this material, we have interviewed two persons with unique insight into the process. We have also drawn upon mass media debates and professional journals such as the Swedish Medical Journal.

To develop a contrast to the Swedish case, we have gathered information about Norway, England/Wales and New York State. For each of these cases we conducted formal interviews with experts4 and had informal discussions with other experts. The interviews, which we taped, lasted about 60 min on average. We also collected newspaper articles and scholarly articles from professional and academic journals and gathered material from the parliamentary process.

The analysis followed a hermeneutic interpretive process, which we structured by a close reading of the key parliamentary documents in Sweden, primarily the government bill, because it is here that the official justification for CCC is developed in detail. Other data sources were then used to trace how features in the bill came to be included, what meanings have been attached to key notions and what positions various stakeholders have taken. The analytical process has been organized by an initial set of five themes: key stakeholders, knowledge claims, ideology, risk/control and patients’ rights. Examples and citations from the data that we have included in the article are typical of the entirety of the material.

5. Analysis: how CCC was introduced

Before turning to our analysis of the Swedish case, we provide a short description of developments in Norway, England/Wales and New York.

5.1. Outpatient coercion in Norway, England/Wales and New York

Norway, England/Wales and New York represent different routes to introducing compulsory community care as well as different approaches to social policy. Similar to Sweden, Norway has a social democratic, Scandinavian welfare regime. New York and Britain are examples of liberal regimes (Esping-Andersen, 1990). Carpenter (2000) claims that British mental health policy incorporates elements of both liberal and social democratic regimes. The legal systems in Sweden and Norway are generally referred to as civil law (or Scandinavian civil law), in contrast to the common law tradition in England/Wales and the US. Focusing on Sweden allows this study to transcend the common-law context that has thus far dominated socio-legal research about CCC and mental health law in general. New York was chosen because it has been formative for the debate about CCC in the US. The process in England/Wales has occurred more or less simultaneously with Sweden’s, while Norway has a longer tradition of CCC. All of the states had arrangements for various sorts of provisional discharge prior to the enacting of CCC legislation.

Norway has had legislation permitting CCC since 1961. In 1998, a comprehensive national mental health program was launched. Over a 10-year period, extensive revisions were made in the mental health

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3. Anders Milton, former national coordinator of psychiatric services and Kjell Broström, secretary of policy at the National Association for Social and Mental Health.
4. We are grateful for the generous contributions of Professor Georg Høyer and research director Trond Hatling in Norway, professors Peter Bartlett and George Szumukler in the UK and professor John Monahan in the US. Any remaining factual errors are the responsibility of the authors.
system and funding for the sector increased substantially. One part of the program was to review legislation, and it was in that context that the parliament accepted a new mental health act in 1999. It came into effect in 2001. Prior to this, CCC could only be initiated following compulsory treatment in a hospital. Under the new regulations patients can be committed to CCC without a prior hospital stay. Generally, CCC has not been controversial in Norway. The revisions made in 2001 did not lead to much heated debate. Controversies that did arise concerned other issues within the larger national mental health program. There seems to be a consensus that CCC is “a least restrictive form” of coercive care. Service-user organizations were not opposed to CCC on principle, but raised concerns about forced treatment in patients’ homes. Forced treatment is not legal under the new regulations, and medication provisions must be approved in a separate procedure.

Although New York was not the first US state to introduce CCC, the enactment of “Kendra’s law” in New York in 1999 led to debates and the subsequent introduction of similar legislation all over the country (Kahan et al., 2010). That year, a young woman was killed after being pushed in front of a train in the New York subway. The perpetrator suffered from mental illness, and the incident led to a debate about dangers posed by people with mental illness and flaws in the mental health system. Immediately after the subway incident, the independent organization the Treatment Advocacy Center took a strong position in favor of the introduction of CCC legislation. Despite opposition from several service-user and advocacy organizations, legislation was introduced within a year of the incident. Partly to address concerns from critics, the law was only authorized for a period of 5 years, with renewal contingent on an internal evaluation of the program. The Act was subsequently renewed in 2005 and 2009.

The debate in England/Wales was fuelled by high-profile new stories in the early 1990s about a few spectacular, violent incidents involving people with mental disorders. During the 1990s several policy initiatives were taken to increase control over the mentally ill in the community, and particularly with regard to offenders with mental illnesses. The government took initiatives to incorporate Community Treatment Orders (CTOs) into the existing Mental Health Act 1983. Facing strong opposition from almost all stakeholders, government bills were delayed or withdrawn until CTOs were finally included in the 2007 revision of the act. During this extended process, new measures to control patients were introduced. Until CTOs were finally incorporated into legislation, community patients could be controlled through conditional leave from hospital, guardianship and supervised discharge (Churchill et al., 2007).

In their cross-national comparison, Churchill et al. (2007) identify two major forms of compulsory community care (or CTO) design. The “least restrictive” CCCs are characterized by having the same admission criteria as compulsory care in-hospital. The objective is to treat deterioration that has already occurred, and CCC is potentially applicable to any involuntary patient. The other form of CCC is “preventative”. Characteristic of this form is that there are different criteria for applying it as compared to compulsory hospital care. It makes it possible to treat patients for the purpose of preventing deterioration resulting in dangerousness, and it targets a specific group of (dangerous) patients. New York is a clear-cut example of the preventative form, while Norway is an example of the rare, least restrictive form. England/Wales includes both alternatives in its legislation.

5.2. Debate and legislation in Sweden

To understand the current rules governing outpatient coercion in Sweden and the social processes leading up to it, a historical background is necessary. The introduction of the Compulsory Mental Care (certain cases) Act in 1966 is a natural starting point. In fact, this was the first time that a clear legal distinction was made between involuntary and voluntary care in Sweden. The act included regulations about provisional discharge which made it possible to require patients discharged from compulsory care to accept certain treatments/conditions. Typical provisions included injections with neuroleptics at an outpatient clinic and supervision by an appropriate person. Provisional discharges were granted for up to 6 months, after which a discharge board could extend them for additional six-month periods. In the bill which became the Compulsory Mental Care Act, the government stated that provisional discharge rules were primarily aimed at forensic patients (Proposition, 1966: 197).

The de-hospitalization of psychiatric services began in the 1970s. An ideological shift occurred, which led to increased concern about the oppressive aspects of psychiatric services and the rights of patients. It was in this climate that the current legislation was ratified in 1992. It was intended to strengthen the legal rights of patients and to reduce the extent of coercive intervention in psychiatric care. Among other things, the government had found that provisional discharge was being applied too liberally (Proposition, 1990: 155). The Compulsory Psychiatric Care Act regulates civil commitment, while the Forensic Psychiatric Care Act regulates forensic commitment of offenders with severe mental disorder. Under the new laws, administrative courts review patients within 4 weeks of admission, and then again at least every 6 months after that. Despite opposition from important referral bodies such as the Swedish Medical Association, the Swedish Association for Psychiatrists and the National Board of Health and Welfare, provisional discharge was abolished in the 1991 legislation. Nevertheless, the new laws included regulations that made it possible to grant patients temporary leave with provisions that are similar to those of provisional discharge. The purpose behind temporary leave was to facilitate a patient’s transfer from hospital to community care.

In an evaluation of the new legislation, a parliamentary committee observed that a practice had developed that deviate from the intentions of legislators when they passed the law (Tvångspsykiatrikommittén, 1998: 318). The number of patients subject to long-term temporary leave was higher than expected and had increased over time. Some regions appeared to apply the rules more loosely than others, and the Committee concluded that some practices might violate both the Swedish constitution and the European Convention on Human Rights. Contrary to what legislators had intended, temporary leave was used liberally and in the same fashion as provisional discharge under the former legislation. The Committee argued that temporary leave had been introduced at a time when community services were not yet properly developed. Given the comprehensive reform of psychiatric services in 1995 (Markström, 2003), the commission argued that the time was ripe to introduce something it described as a “new form of care” — Community Care with Special Provisions. This proposal made the case for a preventative type of CCC which required finely tuned coordination between medical and community care providers. The proposal contained the same provisions for patients that were applied for temporary leave. The committee noted that they were relevant in a context of rehabilitation and normalization of the daily life of the patient. The committee further specified two main target groups for Community Care with Special Provisions. One group was patients with a combination of both severe mental disorder and drug/alcohol abuse. The other was patients with long-term mental disorders, a history of repeated involuntary admissions and a record of failure to comply with treatment. Violent and dangerous patients were not specifically mentioned at this stage.

Due to reactions against the CCC proposal from for example the major service-user group the National Association for Social and Mental Health, the government never introduced it in parliament. Instead, the government secured parliamentary support to impose additional restrictions on the use of temporary leave. A subsequent evaluation concluded that despite stricter rules, the use of long-term temporary leave continued to increase (Socialstyrelsen, 2002). In 2005, the proportion of patients with long-term temporary leave had risen again. In 10 years, the proportion of all patients subject to it had more
than doubled; for forensic patients it had almost tripled. In addition, of those patients on temporary leave, 45% of forensic and 21% of civilly committed patients had been on it for longer than 6 months.

Over a period of a few months in 2003, the Swedish news media reported extensively on four fatal incidents in which men suffering from mental illness attacked people in public settings. Notably, one of the victims was the Swedish minister of foreign affairs, Anna Lindh. These incidents led to an intensive public debate about mental health services. The political parties’ leaders and other high-profile party representatives were active participants. The perception that the mentally ill are dangerous was a theme in the debate, but the main thrust of it was that the de-hospitalization and psychiatry reform of the 1990s had failed to properly address the needs of the mentally ill in the community. Insufficient coordination among various medical and social services was seen as a major part of the problem, as was a lack of resources. The government appointed a national coordinator of psychiatric services to investigate how to improve services and distribute additional fiscal resources. The directives to the national coordinator included a minor instruction to consider the rules governing long-term temporary leave. In contrast to the government in New York and England/Wales, the Swedish government did not commit itself to enacting CCC legislation. Such caution avoids errors-in-judgment risk, but at the price of an increased inactivity risk. We believe this difference might reflect differences in political cultures among the countries.

In 2006, the national coordinator of psychiatric services broke a tradition of continuous criticism of the liberal use of temporary leave when he presented a memorandum proposing the introduction of CCC — or “Community Care with Special Provisions”. The memorandum was very similar to the proposal that had been rejected only 7 years earlier. However, the arguments behind the new initiative were different. The national coordinator argued that it was necessary to adapt legislation to current practice, which was to use temporary leave more frequently than legislators had originally intended. The typical problem identified in the memorandum was the patient who did not take medication as prescribed. The national coordinator argued that forensic patients in particular needed longer transition periods, thus marking a shift in emphasis as regards target groups for compulsory community care.

As in New York, the legislative process was extremely swift, and the parliament passed the legislative revisions in March 2008. They came into effect a few months later, on 1 September. The statutes that eventually became the new CCC regulation were based on the proposal from the national coordinator. CCC was introduced to replace long-term temporary leave (Proposition, 2007). The parliament defined the purpose of the new regulations as being to facilitate transition to community care and rehabilitation and to decrease the need for repeated readmissions to compulsory hospital care. There is a strong emphasis on the need for coordinated care plans that specify the responsibilities of medical and community service providers as well as other social welfare authorities. Similar rules apply in the legislation for both forensic and civil patients. Under the new acts, CCC can only be initiated following in-hospital compulsory care, and only after an application from a chief psychiatrist to an administrative court. The court can initially approve CCC for 4 months, and then extend it for 6 months at a time. The court reviews the coordinated care plan, and authority to impose special provisions rests with it. The legislators envisioned the following special provisions to be relevant (Proposition, 2007: 84):

- Obligation to accept medication or other care/treatment
- Obligation to stay in touch with a designated person
- Obligation to stay at a specific home or other institution, visit primary health care or engage social services
- Obligations regarding residence, place of residence, education or work
- Prohibition on drugs and alcohol
- Prohibition on visiting particular places or contacting specific persons
- Other provisions that are necessary or that follow from the coordinated care plan.

The recall powers – i.e. the power to revoke CCC – are relatively weak. Failure to adhere to the special provisions cannot in itself lead to readmission to hospital. An indispensable need for hospital treatment is a requirement of readmission under CCC. Thus, the readmission criteria are virtually the same as those for any other citizen. The Swedish CCC rules are therefore vulnerable to criticism that has been directed against Kendra’s law in New York, namely, that they lack teeth (cf. Swartz et al., 2009: 7).

Looking at the development in Sweden over the past 50 years, it is striking how similar today’s CCC rules are to the provisional discharge rules of 1966. Lawton-Smith, Dawson, and Burns (2008) make a similar observation about developments in England and Wales with regard to the 2007 shift to a comprehensive supervised community treatment regime. It seems that, in reality, the scope of social control has remained largely the same, although the rationale behind social control has changed — from medical treatment via community treatment and rehabilitation, to reducing the risk of violence, and then – perhaps – a shift back to rehabilitation in the community. We can also observe that clinical practice has remained beyond the control of legislators. Even if coercive interventions in the community have consistently been described asacceptable only in exceptional situations, their use has varied substantially across regions and over time. Also, new proposals have seldom included any formal measures that actually limit a clinician’s authority to apply such measures. The various formal instruments – “provisional discharge”, “temporary leave” and today’s “compulsory community care” – are strikingly similar as regards the practical means that they give psychiatrists to control the lives of discharged patients. However, despite this stability in both the design of regulations and clinical practice, the issue has been intensely debated. We now turn to an examination of some main themes in the debate leading up to CCC.

5.3. Key stakeholders

The role of stakeholders in policy formation is crucial to the management of errors-in-judgment risks, and it is important for the government that stakeholders feel that they are included and listened to. Although there are differences among Swedish stakeholders, there are distinct patterns that appear relatively stable over time. Starting with service-user organizations, the dominant National Association for Social and Mental Health is not opposed to compulsory care as a matter of principle. However, it has been consistently negative to community-based compulsion for non-forensic patients. Regarding forensic patients, the standpoint of service-user organizations has been that CCC would actually be a least restrictive alternative without conceivable drawbacks. The National Association for Supporting Drug Addicts – an organization with perhaps less influence in this area – has also expressed concerns about CCC. The main organization for family members (“the Swedish Schizophrenia Fellowship”) has a more positive approach to compulsory care in general, and this attitude extends to community compulsion. Generally speaking, the opinions of and input from both service-user and family groups have considerable weight in the mental health policy process in Sweden (Markström, 2003). The views of service-user and family organizations appear to be similar in each of the four cases that we looked at.

Among professional groups, psychiatrists and their professional bodies have mainly been in favor of CCC. In part this can be understood in terms of the influence of the pharmaceutical industry (cf. Carpenter, 2000). The few psychiatrists who are critical tend to have an approach to psychiatry that is more oriented towards community
care and psychodynamic therapies and less medication-oriented than their mainstream counterparts. In New York, the organization New York Lawyers for the Public Interest strongly and actively opposed Kendra’s law. There has been no such involvement by lawyers or civil rights groups in Sweden. Lawyers with experience representing clients are virtually invisible in the Swedish debate. We are not aware of a single article written by an attorney.

In both England/Wales and the US, independent and charity organizations with strongly held beliefs about mental health care actively articulate and argue for them in public debate. It is striking that this is virtually non-existent in Sweden. No independent organizations have come even close to the role played by the Zito trust in England. In the American context and in the wide range of stakeholders, this kind of experience is found in the following excerpt from a parliamentary debate:

Today, we are presenting a new proposal /.../ There has also been a powerful demand from the profession — those who work in the real world. Let’s not forget that this proposal was initiated by the coordinator of psychiatric services Anders Milton. A clear – I would say massive – majority of the opinions expressed in written comments on the proposal during the consultation process support it.

(MP Tobias Krantz, Liberal People’s Party, May 7 2008)

At the end of this statement, the speaker makes a general reference to the experiences of a wide variety of actors who commented on the government bill in writing. Significantly, he highlights one kind of experience — that of “the profession”, i.e. the medical profession. He further extends the authority that is associated with this group to the coordinator of psychiatric services, who is a publicly known physician (although not a psychiatrist). The status attributed to doctors might provide an air of scientific support without the need to refer to specific scientific reports. From an errors-in-judgment point of view, it would be risky to counter arguments that rely on medical knowledge, whether scientifically based or not.

The following excerpt from the parliamentary debate illustrates the rhetorical strategy of referring to a case that went wrong:

How much harm can you inflict on another human or yourself before someone intervenes? As for me, I will never forget meeting the mother of a boy who didn’t want help, who didn’t realize that he needed it. He committed a serious crime while he was ill, and he hurt and distressed many people, including himself. Some sort of intermediary form of compulsory care would have been good for him.

(MP Magdalena Andersson, Moderate Party, May 7 2008)

Referring to an individual case is also a way to claim experience. Individual cases are suitable for dramatizing events and useful for appealing to emotions. It is difficult for others to counter such arguments because they are based upon individual experience. The speaker also appeals to common sense, another rhetorical strategy which is used to present knowledge claims about the efficacy of CCC.

Common sense is also called upon in the following excerpt from the parliamentary debate:

I have no difficulty saying that I am certain that this form of care will provide those individuals who really don’t want to do wrong with help, so that they don’t do what they don’t want to. I mean, if you demand that a person stay drug-free because you know that using drugs is the trigger when things go really wrong, regardless of whether that person is violent to other people or to things that belong to society, well, that helps the person.

(MP Chatrin Pålsson Ahlgren, Christian Democrat Party, May 7 2008)

One way of making something appear to be common sense is to present facts as self-evident. In the quote above, this is accomplished with statements like “I have no difficulty saying that I am certain...” and “you know that using drugs is the trigger”. By siding with the patients...
“who really don't want to do wrong”) this MP manages to express ethos with a benevolent attitude, while at the same time reproducing the image of the mentally ill as potentially violent (“when things go really wrong”). Her factual statements are presented as self-evident without reference to external sources. Referring to common sense serves a purpose similar to what Garland has observed in studies of crime policy: “The importance of research /…/ is downgraded and in its place is a new deference to the voice of ‘experience’, of ‘common sense’ of ‘what everyone knows’.” (Garland, 2001: 13).

5.5. Risk and control

In light of the new emphasis on risk in social policy, we are interested in how risk has framed the discourse about CCC. Unlike Norway, the introduction of CCC in New York and England/Wales — was prompted by violent events involving people who were mentally ill. In England/Wales there was a time lapse of at least 15 years between the cases that the early discussions revolved around and the enactment of CCC (CTOs). Similar to developments in New York, it seems quite clear that the timing of the Swedish introduction of CCC was heavily influenced by a few violent incidents. The sudden attention to violence and the characterization of community mental health as a failure created an inactivity risk for the government. That risk was partly managed by the government's announcement that it was appointing a national coordinator of psychiatric services and also by a parliamentary debate about mental health care within a month of Anna Lindh’s death.

In what follows, we try to trace themes in the discourse that led to the enactment of CCC. The opening statement in the parliamentary debate captures several elements that were typical of the discussions:

Mister speaker! Sweden has been stricken by a series of horrible and incomprehensible acts of violence. We share the grief and despair of the parents who lost their little daughter, with the children who lost their mother, with the husband who lost his wife and with the relatives who lost a dear member of their family.

When we learned that several of these crimes, perhaps all, were committed by severely ill and confused people we also asked questions: Have these people tried to get help? What kind of help have they received? Why are individuals who are so obviously dangerous allowed to move around freely?

(Minister of Social Affairs, Lars Engqvist, Social Democratic Party, October 6, 2003)

Note the emotional appeal and dramatic repetitions of “the parents who lost”... “the husband who lost...”, etc. A typical feature in this passage is how the minister positions the broad topic of the debate - mental health care - within the specific framework of a few violent incidents. This is similar to what Rasmussen and Höijer (2005) found in their analysis of images in the Swedish media following the violent incidents in 2003. They point to two major themes: the mental health system is portrayed as being in a state of crisis and mental illness is associated with danger. However, we have also found that there is considerable ambivalence in the debate. Participants have been careful not to reproduce the association between danger and persons who are mentally ill. The following contribution from the opposition leader illustrates this more cautious approach:

Mister Speaker! A series of horrendous acts of violence is the reason for the debate we are having today. This, by the way, is also why we were somewhat hesitant about having a discussion like this. When acts of violence are the starting point for a discussion about mental health, it might lead our thinking in the wrong direction.

(Fredrik Reinfeldt, Moderate Party, October 6, 2003)

To some extent, a reluctance to portray the mentally ill as dangerous can be detected in the media. Although dangerousness is part of the picture, it did not become the key issue in media discussions about policy. The appointment of the national coordinator was the only political initiative that was taken during this period, when the dangerousness of the mentally ill was featured in the media. In contrast to the UK, Swedish authorities did not respond by instigating anything similar to the homicide inquiries that became part of mental health policy in the UK in the mid 1990s (cf. Wolff, 2002). In the government bill, where the official rationale for the policy was eventually spelled out, it is striking to observe how reducing risk was pushed to the background by an agenda oriented towards treatment and rehabilitation.

Despite this, at the critical point in time when the new proposal about CCC was put forth, it seems that dangerousness resurfaced as the primary concern. The most influential decision-maker was the national coordinator of psychiatric services. In our interview, while expanding on his rationale for favoring CCC, he started talking about the similarities between forensic and civilly committed patients:

Sometimes there is only a very small difference if you're sentenced to this place or that one. For some people who are locked up, /…/ someone jabs a fork in someone's leg in a psych ward and it gets reported to the police. The police say “well that one is already doing time, so why should we get involved?” So, the person in question would have been sentenced, they meet all the criteria — committed a crime and severely mentally ill. Well, the prosecutors, they can't do anything about it, so they just let it go. So you know, there is a thin line, an overlap between forensic and civil commitment. That's why we thought we might as well have it for both [groups].

In this conversation, the national coordinator stresses the fact that patients in ordinary, non-forensic care may in fact be violent. This then becomes the motivation for including the group in his CCC proposal. The subtext is that risk of violence is the key rationale for introducing CCC. Note also his use of language that comes from correctional treatment contexts (e.g. “sentenced” and “doing time” in the context of civil commitment), which further illustrates a strong orientation towards risk.

The excerpt also illustrates another noteworthy feature in the discourse about CCC, namely the lack of distinction between civil and forensic patients. The focus of the discussion is on offenders and forensic patients. With regard to this group there is consensus that CCC helps reduce the risk of violence, while at the same time providing a least restrictive treatment alternative. There are no stakeholders who oppose CCC for forensic patients. However, in the debate, arguments relating to the forensic context are implicitly extended to patients who have been civilly committed. Swanson (2010) has pointed out that CCC was not originally understood as an instrument to control dangerous patients. Rather, the motivation for CCC was to address problems of lack of compliance with regard to medication and revolving-door patients in mental health services. Something similar can be said about Sweden. The first proposals about CCC legislation were motivated by therapeutic concerns and subsequently rejected. When a concern about dangerousness surfaced, a window of opportunity arose to bring the issue back onto the political agenda. The intermingling of forensic and civil patients made it possible to propose a form of coercion that had not been accepted before.

5.6. Patients’ rights

In ethical discussions about compulsory care, the positive goals achieved by coercive intervention (securing treatment, protecting self/others etc.) are balanced against infringement of the patient's integrity and autonomy (Richardson, 2007). Arguments about autonomy and patients’ rights have been persistently raised by critics of the CCC proposals in England/Wales and the US (Lawton-Smith et al., 2008;
The new form of care requires careful consideration with respect to how the special provisions [that patients would be subjected to] constitute an infringement on the freedom and rights guaranteed by the constitution. With this in mind, the question of whether to commit [a patient] to the new form of care should be a matter for the court to decide.

(Government bill, p 77).

It is characteristic that statements like the one above are not followed by any further discussion of specifics or efforts to analyze nuances in notions such as autonomy, integrity or rights. The quote also illustrates a peculiar trait in how integrity and rights are talked about in Sweden — i.e. the essential concept is the “rule of law”. The ethical conflict is primarily discussed as a matter of legal procedure. Although the rights of the patient are acknowledged, they do not appear absolute or inviolable. To the extent that arguments about autonomy are made, we have identified three that are used to justify the violation of rights. One is that to restrict autonomy in the short run leads to increased autonomy in the long-term. Another is that restrictions in autonomy outside the hospital setting are better than restrictions in the hospital. Finally, restrictions in everyday life create a potential for comprehensive improvements in quality of life.

The design of the provisions to which patients under CCC can be subjected cast additional light on the issue of patients’ rights. The provisions mentioned in the government bill were listed above (see “Debate and Legislation in Sweden”). They are quite extensive in scope, affecting almost every aspect of an individual’s everyday life — housing, social contacts, medication, use of drugs, employment, education, etc. In addition, the government adds the possibility of imposing “Other provisions that are necessary or follow from the coordinated care plan.” In addition, the bill also gives the courts the authority to delegate decision-making power over provisions to the psychiatrist treating the patient. We argue that this way of designing the provisions is evidence that concerns about the rights of patients have not been at the heart of deliberations about CCC. Overall it seems that there has been little political risk invested in patients’ rights.

5.7. Ideology

Instead, new regulations must be aimed at achieving a permanent transfer out of compulsory care. This can be accomplished by requiring coordinated planning and follow up of services provided by the health and social care authorities. A coordinated care plan is to be drawn up for this purpose.

(Government bill, p. 71)

For someone reading the government bill without prior knowledge of the historical circumstances, it would not be possible to detect that the proposal about CCC actually originated from a debate about the dangerousness of people suffering from mental illness. Rather, the dominant discourse in the bill revolves around the best way to provide treatment and support in the community setting. The government discusses how different service providers can better coordinate their efforts and emphasizes the value of various aspects of community care such as housing, employment and social activities. The guiding principles are the rehabilitation and participation of the patient and the adaptation of services to the patient’s unique situation and needs. This reflects the dominant ideology in Swedish disability policy, which was reinforced in the work of the national coordinator of psychiatric services 2003–2006. It can also be seen as a shotgun approach to the concerns that surfaced in 2003 following well-publicized violent incidents.

The strong emphasis on treatment and care is also expressed in language use. There is a tendency to word things in a way that implies the coercive features in CCC are something else. The government chose to rephrase the terminology in the original proposal, from “community care with special provisions” to “Compulsory community care” in order to clarify the coercive nature of the proposal. Yet in the bill itself as well as in the subsequent debate, CCC is constantly referred to as “a new form of care” rather than a new form of coercive intervention. This is similar to the euphemism used for CCC in New York: “Assisted outpatient treatment”. That legal term itself does not provide any information about the fact that the foundation of the regulation is coercive intervention (cf. Kahan et al., 2010).

The approach to medicine in the bill reflects the overall emphasis on psycho-social forms of support and treatment. In the bill, medication is rarely mentioned in discussions of treatment and care. The government specifically states that CCC is not intended to be used as a convenient tool for distributing forced medication. However, when the government lists the special provisions it expects caregivers to apply for in court, forced medication is at the top.

Sjöström (1997) maintains that Swedish psychiatry leans in the direction of a paternalistic approach, in which needs identified by professionals tend to prevail over the wishes of the patient. He has also shown that such paternalistic values appear to extend to decision-making by courts about coercive intervention. It has also been argued that a similar tendency is found in court proceedings regarding compulsory care for drug and alcohol abusers and in child protection cases (Holland, Jacobsson, & Sjöström, 2007). In official documents that discuss CCC, old systems might be criticized for endangering patients’ rights. Despite this, such problems are not addressed when concrete proposals are presented. For instance, the government observed that rules for temporary leave from hospital have been applied too liberally and frequently, yet it proposes new rules that have no effect at all on the extent of community compulsion. Another example is that the benevolent ambitions described in the government proposal for CCC are seldom connected to the need to coerce the patient. There is also no explanation as to why coordination between service providers, improved housing facilities or appropriate training of staff requires that the patient be subjected to coercion. Such expressions of paternalism are in keeping with the overall welfare regime in Sweden, with its high level of state responsibility and extensive support systems for clients and patients, particularly in disability policy.

With regard to political ideology, it is difficult to find any political differences regarding compulsory psychiatric care. The Green and the Left parties, representing 12% of the votes in parliament, rejected the proposal. The political left (socialists) in Sweden has a tradition of being more critical of mental health services that are based on medical treatment in hospitals, and also of being more critical of coercive interventions. Liberals and conservatives have tended to be more active on particular issues within forensic care. It was the Liberal Party that brought CCC into the debate following the death of Foreign Minister Anna Lindh. The leader of the party argued that it had been a mistake to withdraw the CCC proposal put forward a few years earlier, and the party subsequently submitted a bill supporting CCC. Kahan et al. (2010) have observed that neither liberal–conservative ideology nor party affiliation had a significant influence on support for outpatient commitment laws in the US. Similarly, critics of CCC in Sweden have not argued their positions with reference to socialist or environmentalist
values, nor have proponents explicitly referred to liberal ones. In cultural cognition terms, Kahan et al. have found that people with hierarchical rather than egalitarian values are more inclined to embrace CCC. The Swedish case corroborates this, since the Left and Green parties can be portrayed as the most non-hierarchical. However, in international comparison Swedish political culture in general tends towards egalitarian and communitarian values. This raises the question as to how CCC can be reconciled with such values. Possibly, the specific ideology described above means that in Sweden, CCC can be conceptualized as a health-promoting reform and not as the intervention of a less benign state.

6. Concluding discussion: the primacy of psychiatric and popular perceptions

There are numerous assumptions and statements in the literature about how violent incidents involving offenders with mental illness have led to the enactment of CCC legislation. Nevertheless, to our knowledge, this is the first attempt to closely investigate this matter empirically and to analyze the mechanisms involved. In our investigation of the Swedish case we have identified several problematic features in the discourse surrounding the introduction of compulsory community care:

• CCC was adopted despite consensus that there was no body of evidence supporting its effectiveness.
• Although the government links CCC to an ideology of rehabilitation, it does not clarify how coercive is relevant to realizing such ambitions.
• Although the new legislation allows for an expansion of coercive powers, CCC is construed as less coercive and the coercive elements are downplayed.
• Although psychiatrists have been criticized for liberally applying coercive practices, the new regulations are adapted to those practices.
• Although the introduction of CCC came about in the aftermath of high-profile crimes, the revised law allows for preventative restrictions on non-violent civilly committed patients.
• Although the introduction of CCC came about in the aftermath of high-profile crimes, the stated intention was to limit coercive powers.

Looking at this list of fundamental disagreements and contradictions, it is surprising that CCC was eventually enacted with relative consensus. Disagreements and contradictions can also be found in discussions about CCC in other states. Returning to the question of how discussions about CCC unfold in different socio-political settings, Fig. 1 summarizes differences and similarities between Sweden and the states we have chosen for comparative purposes.

Briefly summarizing the Swedish case, there was some controversy about the introduction of CCC. The issue was initiated following high-profile acts of violence. There was agreement about the (lack of) evidence about its effectiveness. The government proposal about CCC was framed within an ideology of integrating the disabled and it allowed for a broad range of measures to control patients. Finally, it was framed in terms of securing positive rights for patients.

The figure clearly shows that England/Wales and New York form a distinct group. Norway and Sweden are not only different from these two Anglo-Saxon states, but also from each other, despite the similarities of their welfare regimes. We would argue that differences in ideology, control and rights orientations can be understood with reference to the general welfare and care regimes that characterize the four states. Although we have identified a difference in ideology between Norway and Sweden, those ideologies appear similar when contrasted with the protection orientation in England/Wales and the US.

The differences in Controversy, Violence and Evidence appear to be related to circumstantial factors. A possible explanation as to why there was relatively little controversy in both Sweden and Norway is that the CCC proposals were part of a shot-gun approach to addressing the entire mental health system in order to control risks of inactivity and ineffectiveness. In that context, CCC could be depicted as one of many improvements in the system. Moreover, specific issues related to CCC were overshadowed by other debates related to the reforms. Regarding differences in the role played by scientific evidence, the lack of interest in Norway can partly be explained by the fact that the process took place in the 1990s, when less research was available. The lack of controversy and orientation towards positive rights are further explanations as to why evidence has been less important in Norway. The relative lack of controversy about CCC in general and the positive rights orientation also shed light on why there was agreement in Sweden about how research evidence was to be interpreted. It seems that in England/Wales and the US, where the debate was more polarized, proponents of the opposing sides selectively used research findings to support their own arguments (Churchill et al., 2007).

This article began with the assumption that differences in social welfare regimes would lead to different approaches to compulsory community care. Although we have identified nuances in discourses about CCC, one strong impression remains. CCC has become the all-encompassing solution virtually everywhere. How is that possible given considerable variation in socio-political traditions?

We believe that one important factor is the role that the medical profession has played in policy formation. To a large extent, the field of mental health is seen as a medical domain. In this article, we have shown that when research does not provide clear support for any side, clinical experience and the opinions of psychiatrists (“the profession”) become the primary knowledge sources for evaluating the prospects for CCC. In practice, ensuring that the patient takes her medicine is the chief component of CCC. One might argue that the development in England/Wales, where the Royal College of Psychiatrists actually opposed the government initiatives, contradicts our argument. However, the opposition from psychiatrists in England/Wales was not primarily based on principle, but rather was a reaction against the way in which the government handled the process and some particular features in the proposal, e.g. the focus on dangerousness and the inclusion of patients with personality disorders. A government would be taking a substantial errors-in-judgment risk if it were to promote policy contrary to the preferences of such a high-status professional group.

The other possible explanation for the consistency in which different welfare states have adopted the same policy is a widely shared cultural conception about mental illness. Reviewing research in predominantly Western countries about public beliefs and attitudes towards people with mental illness, Angermeyer and Dietrich (2006) find that a majority of the public believe that people with mental disorders are in need of help, but also that they are unpredictable and
dangerous. Such attitudes are also reproduced in media representations of mental illness ([Klin & Lemish, 2008; Magnusson, 2010; Nairn, 2007; Rasmussen & Höijer, 2005; Stout, Villegas, & Jennings, 2004]). Such attitudes are consistent with the two main types of arguments raised in relation to CCC, either that the coercive intervention is needed to help the patient or to protect the public from violence. Particularly in the parliamentary debate in Sweden, we have observed how the arguments rest on taken-for-granted assumptions and reliance on common sense. In sum then, the motivation for accepting CCC appears to rest upon a paradoxical mix of accepting medical expertise and relying on gut feeling.

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