The compliant court – Procedural fairness and social control in compulsory community care

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Abstract

Compulsory community care (CCC) was introduced in Sweden in 2008. This article investigates all written court decisions regarding CCC over a 6 month period in 2009 (N = 541). The purpose is to examine how the legal rights of patients are protected and what forms of social control patients are subjected to. 51% of CCC patients are women and 84% are being treated for a psychosis-related disorder. In the court decisions, only 9% of patients are described as dangerous to themselves, while 18% are regarded a danger to others. The most common special provisions that patients are subjected to are medication (79%) and a requirement that they must maintain contact with either community mental health services (51%) or social services (27%).

In the decisions, both the courts and court-appointed psychiatrists agree with treating psychiatrists in 99% of cases. Decisions lack transparency and clarity, and it is often impossible to understand the conclusions of the courts. There is considerable variation between regional courts as regards the provisions to which patients are subjected and the delegation of decision-making to psychiatrists. This means that decisions fail to demonstrate clarity, transparency, consistency and impartiality, and thus fail to meet established standards of procedural fairness.

Surveillance techniques of social control are more common than techniques based on therapy or sanctions. Because of the unique role of medication, social control is primarily imposed on a physical dimension, as opposed to temporal and spatial forms. The article concludes that patients are at risk of being subjected to new forms of social control of an unclear nature without proper legal protection.

1. Introduction

This article attempts to discuss a relatively new phenomenon within international mental health law – compulsory community care (CCC) – within the framework of two different discourses that have been paramount to socio-legal research about mental health during the past 50 years: (1) the legal rights of patients and (2) mental health care as “social control.”

Internationally, the legal rights of patients have been particularly important in discussions of compulsory psychiatric care. Many legal reforms have been justified primarily on the grounds that they are intended to protect patients’ rights. The legal regulation of coercive interventions is circumscribed by various international conventions covering human and legal rights as well as ethics in psychiatric and health care (Carney, Tait, Perry, Vernon, & Beaupert, 2011). A crucial concern in legal conventions is procedural safeguards, particularly in the context of court proceedings. Like any other situation in which a state applies coercive measures on its citizens, the standards for procedural safeguards must be high. The legitimacy of compulsory psychiatric care – which also impacts on mental health care in general – rests on well-founded clinical decision making and careful legal monitoring.

Within sociology, mental health care has often been analyzed in terms of a society’s means to control deviant citizens. Compulsory care has been characterized as a particularly pertinent example of social control within psychiatry. Social control theory has helped put the issue of mental health into a broader context of deviance, tolerance, and – increasingly in recent years – risk (Kemshall, 2002).

Compulsory community care emerged in the 1980s and has been widely introduced in industrialized democracies during the last 15 years. It seems uncontroversial to claim that it is fruitful to apply classic concepts such as legal rights and social control to this relatively new phenomenon. However, CCC also generates new challenges to these traditional perspectives. Starting with legal rights, one can observe that although psychiatrists retain decision-making power, the actual delivery of care is distributed over a wider variety of personnel, and there is greater diversity of treatment delivered in a multitude of different types of settings. Confident decisions about CCC are hard to
make since there is considerable debate on the effectiveness of CCC in the research community (Burns & Dawson, 2009; Churchill, Owen, Singh, & Hotopf, 2007; Kisley, Campbell & Preston, 2006; Phelan, Sinkewcz, Castille, Huz, & Link, 2010; Swartz, Swanson, Steadman, Robbins & Monahan, 2009). As a result, the legal bodies that monitor coercive practices face particularly demanding challenges. How do mental health courts, tribunals and similar legal bodies monitor decision-making and the application of coercive measures in the community?

From a social control perspective, CCC might represent a shift from physical control practices to “softer” means that do not openly force individuals to comply. To the extent that CCC fosters individuals to behave according to caregivers’ wishes, it can be seen as an illustration of the thesis of the “internalization of control” (cf. Foucault, 1991). Control is no longer exercised by externally enforcing medication and incarcerating patients. CCC offers a softer regime that not only promotes compliance on a behavioral level. It might also affect patients to cognitively adopt caregivers’ views on how they should lead their lives and manage their illness. The shift from controlling criminals in prison to control through probation and electronic ankle bracelets might be a parallel to the transfer of mental health care from the asylum to compulsory community care. We are interested in whether CCC comprises a shift in forms of social control and, if so, what it means.

Given this background, the aim of the article is to investigate court decisions regarding compulsory psychiatric care in Sweden. Our focus is legal rights and social control, and we ask the following questions:

1. Who is subjected to compulsory community care and on what grounds?
2. What coercive measures (“special provisions”) do courts apply on patients?
3. To what extent is procedural fairness achieved?
4. What forms of social control are present?

Questions 1 and 2 are primarily empirical whereas questions 3 and 4 are primarily analytical.

The data reported here are part of a larger project – Coercion in freedom: Genesis, implementation and rule of law in psychiatric outpatient coercion in Sweden – which also includes a study of the socio-political origin of CCC (Sjöström, Zetterberg, & Markström, 2011) and the implementation of the new legislation on the municipal level.2

1.1. Compulsory community care in Sweden

Compulsory community care was introduced in Sweden in 2008 following a public discussion of the failures of community care occasioned by media coverage of a few incidents in which persons suffering from mental illness attacked others in public settings (Sjöström et al., 2011). Proponents of the new legislation argued that CCC would be a less restrictive alternative, while also addressing concerns about public safety. Critics argued instead that new groups would be subjected to coercive measures – so-called net widening (Geller, Fisher, Grudzinskas, Clayfield, & Lawlor, 2006) – and that there would be a shift in focus from collaborative support to social control. In the final draft of the legislation that was passed by the parliament, risk concerns gave way to issues about disability rights and the need for care. One explicit purpose of the new legislation was to improve the legal safeguards for patients who were subjected to long-term temporary leave under the previous system. Although some patients were treated under temporary leave for several years, the intention was that such leave should only be applied for shorter periods of time. One means for improving legal safeguards was the introduction of mandatory court hearings for every patient who is transferred to CCC (Sjöström et al., 2011). Similar regulations were introduced for both forensic and “civil” patients. In Sweden, compulsory care for these two groups is regulated in two different laws that share many traits: the Compulsory Psychiatric Care Act and the Forensic Psychiatric Care Act. Through mandatory court approval, patients would be protected against unwarranted use of this new form of coercive intervention (Proposition, 2007, pp. 77, 94). The stated purpose of CCC is to enable the patient to accept treatment voluntarily. Churchill et al. (2007) distinguish between two forms of CCC: “least restrictive” and “preventative”. The latter has different admission criteria for in-patient and out-patient commitment and typically aims to prevent deterioration. According to this classification, the Swedish form of CCC qualifies as preventative.

Only in-patients under compulsory care are eligible for CCC. The coercive element of CCC consists of “special provisions” to which the patient is subjected. These are individual orders for treatment and behavioral mandates and are to be designed to meet each patient’s individual needs. The legislation has been criticized as “toothless” because under the law, patients cannot be forced to comply with special provisions. Legislators have stated that patients should not be recalled to hospital simply because they fail to comply with special provisions. Nor does the law allow for recall to assess and evaluate the patient. Accordingly, the legal criteria to re-admit patients under CCC are the same as for non-patients. These criteria include (1) suffering from severe mental disorder; (2) opposing treatment or treatment cannot be provided without consent; and (3), exhibiting an indispensable need for hospital care.

Decisions to initiate a period of CCC are made by administrative courts after an application has been filed by a chief psychiatrist. The court also decides about special provisions, although it may delegate this responsibility to the treating psychiatrist. Although a psychiatrist is responsible for the application to the court, the actual delivery of services may be provided by different providers, typically both community mental health services and social services. The court can approve CCC for a maximum of six months, after which a new court decision is necessary to prolong it. If the court rejects an application to transfer an in-patient to CCC, the patient is automatically discharged from compulsory care. By applying for CCC, the treating psychiatrist is effectively acknowledging that there is no longer an indispensable need for hospital care.

Court hearings are held at the hospital and typically take about 30 min. They are headed by a judge, who makes a decision together with three lay judges. Formally, there are two opposing parties – the chief psychiatrist and the patient – although the hearings are usually held in a non-adversarial style. The chief psychiatrist is typically represented by the patient’s treating psychiatrist, who performs a quasi-prosecutorial role. To protect their legal rights, patients have the right to an attorney, and most of them make use of it. The court is assisted by an independent psychiatrist who asks questions of the parties and delivers an expert opinion towards the end of the hearing (Proposition, 2007). Questions from the attorney and the court-appointed psychiatrist are directed to the parties. It is rare that any other witnesses are heard. Apart from the mandatory hearings for extensions of care every six months, patients can request hearings at any time by filing an appeal with the court.

2. Theory and previous research

Drawing from their international review of CCC, Churchill et al. (2007) conclude that the typical patient is a male of about 40 years old who has an extensive history of illness and previous experience of in-patient care. He has a history of low compliance to medical treatment and is in need of post-hospital care. He has been diagnosed with schizophrenia or affective disorder and has a potential for violence. These characteristics are strikingly similar across different types of jurisdictions, as well as geographical and cultural borders. Burns and Dawson (2009) take this as evidence that there is increasing agreement about the patients for whom CCC is appropriate.
2.1. Legal rights

The legal rights of patients under CCC can be studied along three dimensions. One of these concerns legal rules: e.g. admission criteria, time limits, specification of coercive measures, standards for practitioners’ qualifications and procedural arrangements. Another dimension focuses on clinical practice, i.e. the extent to which those who work closest to patients actually take note of legal rights and abide by the rules that limit their power over the patient. On this dimension, it is also relevant to consider what resources are available and the organization of services. The primary focus on legal rights in this article concerns a third dimension: the legal monitoring of clinical work. In recent years, the academic community has shown less interest in this issue. At the heart of this dimension are the hearings at which courts, tribunals or similar legal bodies make decisions about coercive interventions directed at individual patients.

According to empirical studies, there is little evidence that court hearings, tribunals and similar procedures are successful in actually protecting the legal rights of patients under compulsory care (Bursztajn, Guthell, Mills, Hamm, & Brodsky, 1986; Carney et al., 2011; Donnelly, 2010; Kirk & Bersoff, 1996; Perkins, 2003; Sjöström, 1997). Such legal procedures often seem to be biased towards accepting the recommendations of treating psychiatrists rather than serving as an impartial mediator between the interests of treatment and public protection on the one hand, and protecting the integrity and human rights of the individual patient/citizen on the other. Several different kinds of practices and mechanisms appear to contribute to this phenomenon. Apparently, legal bodies tend to interpret evidence from a treatment-oriented perspective, putting a strong emphasis on public protection and what appears to be “in the interest of the patient.” Consequently, monitoring bodies tend to take a less “legalistic” approach in cases about mental health. That is, they are less vigilant in following strict legal rules and are less insistent about upholding general legal principles like the protection of the liberty of the individual. Moreover, attorneys representing patients do not appear to give priority to “defending” their clients against deprivations of liberty. To the extent that psychiatric experts are involved, they do not seem to play a major role in challenging the recommendations of treating psychiatrists. In some legal systems, they are part of the tribunal. One possible consequence of this might be that a medical perspective dominates the thinking of the agent whose role in the process is supposed to be to protect individuals against the possible side effects of that very perspective. In other jurisdictions, expert psychiatrists have a more independent role vis-à-vis the legal body. Empirical findings indicate that they do not assist the court in independently scrutinizing the arguments of the treating psychiatrist. Thus, empirical research indicates that the balance between medical/public protection interests and patient/legal rights interests tends to favor of the former.

Evaluations of the role of legal monitoring of psychiatric coercion are influenced by the theoretical perspectives that are used. One perspective that is currently influential in the Anglo-Saxon world is that of therapeutic jurisprudence (TJ). This is an “interdisciplinary approach to legal scholarship and law reform that sees law itself as a therapeutic agent” (Winick, 2008, p. 25). This means that legal professionals and legislators should strive to avoid imposing antitherapeutic consequences, as well as promote therapeutic consequences, as long as such ambitions do not collide with legal rules (Winick 2003: 110). When TJ proponents apply this perspective to court proceedings relating to compulsory psychiatric care, they emphasize the sense of trust, dignity and participation that patients experience. They further argue that such values increase the willingness of patients to accept both the courts’ approval of coercive interventions and the treatment itself (Freckelton, 2003; Winick, 1999). Thus, research inspired by therapeutic jurisprudence tends to focus on patients’ perceptions and the therapeutic outcomes of cases rather than the legal rights of patients. Despite its influence, the TJ perspective has not yet been subjected to much critical analysis. However, some authors have raised concerns that the emphasis on the welfare of the client/patient may jeopardize the protection of their legal rights (cf. Arrigo, 2004; Freckelton, 2008).

Regardless of where one refers to strike a balance between therapeutic considerations and protection of legal rights, it is necessary to specify the meaning of legal rights in a mental health context. We have chosen to focus on the notion of procedural fairness (fair trial).

To specify the concept we have drawn on article 6 of the European Convention on Human Rights (ECHR) and principles highlighted in the parliamentary documents related to the Swedish Compulsory Psychiatric Care Act. For the purpose of analyzing whether procedural fairness is accomplished in Swedish practice, we will look at the following indicators: impartiality, transparency, clarity and consistency. First, a court must be independent and impartial. In written decisions, this would be reflected in how courts give equal considerations to both parties’ claims. As a broad notion of procedural fairness, transparency means that there needs to be sufficient public information about the process, for example by making decisions publicly available and allowing access to hearings. In our data, transparency would be demonstrated in the amount of relevant information provided by the court. The notion of clarity concerns the possibility to retrospectively assess the rationale behind a court decisions. In CCC hearings, this would be demonstrated in how courts apply the criteria in the compulsory psychiatric care act to the circumstances of each citizen. Consistency means that equal cases must be treated equally. In written decisions, consistency could be studied by looking for variations in groups of patients (e.g. gender, age) and regional variations between courts.

Although one can argue that other characteristics could be included or that there are other ways to categorize them, we contend that all these characteristics would be widely accepted as fundamental to procedural fairness in a democratic society, regardless of legal system. Some relevant characteristics, for example the adequacy of legal assistance, have been left out because they are not possible to study with our data.

2.2. Social control

Social control is a social mechanism involving a social reaction or sanction to behavior that is regarded as deviant. As a sociological concept, social control is neither intrinsically good nor bad. The literature contains a multiplicity of ways to analyze various aspects of social control, such as proactive-reactive, hard-soft edge, formal-informal and internal-external (cf. Cohen, 2002; Innes, 2003). Compulsory psychiatric care is a phenomenon that lends itself to analysis in terms of social control, i.e. a societal response to deviant behavior (Dennis & Monahan, 1996; Innes, 2003, p. 15; Sjöström, 1997). Historically, control has been exercised through the physical restraints of asylums, but today it is increasingly maintained through “softer” deinstitutionalized means (Geller et al., 2006). Kemshall (2002) argues that the introduction of community compulsory care signifies a shift within the mental health field that began in the 1980s, from a focus on treatment and rehabilitation to one of control and surveillance. Scheid-Cook (1991) describes the introduction of CCC in the US as a political compromise to meet a number of social and organizational demands. Increasing demands to control the mentally ill in the community could be combined with the principle of least restrictive alternative, which became established during the deinstitutionalization years. For our purpose, we will apply a model of social control to the CCC decisions in our material. On the one hand, this model makes distinctions between the functions of different techniques of coercion as described in the rulings: surveillance, therapy and sanctions. Surveillance can be a means to protect the public, but also to protect the individual (patient). Therapeutic techniques serve the aim of changing the individual and are typically regarded as something unequivocally productive and benign for the person. In contrast, sanction techniques are viewed as negative for the individual and consist of implicit or explicit threats.
of the consequences of unwanted behavior. On the other hand, the model also distinguishes between different dimensions of how the above techniques operate. Temporal control interferes with how the individual can use and structure her time, spatial control restrains the individual's right to move around freely and physical control interferes with the individual's body regardless of where it is (Fig. 1).

Control can take a number of different concrete forms. In our data it is primarily discernible in how the court issues special provisions for patients. In what follows we will discuss the application of these special provisions, which means that our analysis will be limited to formal domains of control. When interpreting the data, it has occasionally been difficult to establish which dimensions or techniques particular provisions should be attributed to. To some extent this is a methodological problem, but it also reflects the complexity of the concept of social control — different aspects of it overlap to some extent.

3. Methods and material

The empirical data for this article consists of all CCC court hearings in Sweden over a six-month period (March 1st to August 31st 2009), starting six months after the introduction of the new form of care. This period was chosen to enable us to collect data on the early practice of CCC while avoiding the vagaries that might have occurred during the very first months. Because we wanted our data to include cases of rare occurrences, such as refusals of treating psychiatrists' applications, we estimated that we needed a fairly large number of rulings and thus a relatively long period of time. Because extension hearings must be held every six months, our decision to examine a six-month time period allowed us to avoid the same patient appearing twice in the material.

Several documents are produced in connection with each CCC hearing. These typically include an application with a coordinated care plan from the treating psychiatrist, a protocol written by the court clerk and the court's decision. The latter is the only document that is publicly available. The written decisions are typically between 2 and 8 pages long. The format, as well as the richness of information, varies among the courts. The decisions themselves, including the identity of patients, are public documents. As a result, to some extent the courts write the decisions in a way that protects the privacy of patients. An unfortunate consequence of this is that crucial information about why a particular decision was made is often left out or unclear. For example, courts are reluctant to provide information about diagnoses.

The 21 regional administrative courts\(^3\) that existed during the period we studied were required to notify the National Board of Health and Welfare about all CCC hearings. We were thus able to retrieve a complete list of these decisions from the National Board of Health and Welfare. The decisions themselves were then obtained from the courts. We are therefore confident that our data represent virtually all cases that were actually heard during the target period. Our material consists of a total of 541 decisions regarding 516 non-forensic patients.\(^5\)

All of the article's authors have been involved in coding the data in terms of 13 variables. The variables cover the regional court hearing the case, the court's decision, patient characteristics, special provisions, the recommendations of court-appointed psychiatrists and the patient's position regarding the treating psychiatrist's application. Inter-coder reliability has been achieved first by comparing the coding of a smaller subsample followed by discussions to refine our concepts, and then by statistically checking for possible differences between coders. As regards the latter, no significant differences were found.

For the purpose of analysis, the written rulings should not be seen as a means to fully understand the actual reasoning of the courts. However, we expect them to reflect some aspects of the courts' rationale for their decisions. More importantly, the written decisions can be analyzed in terms of how they demonstrate that the legal rights of patients have been protected. The unit of analysis varies depending on the variable. For example, the outcome variable is calculated based on the number of decisions, while gender is based on the number of patients.

We began the analysis by computing frequency tables for the central variables. More sophisticated analysis of correlations was ruled out due to low variance in outcome (virtually all decisions accept the treating psychiatrist's application), which means that we cannot present any findings about differences between groups of patients. The concepts of procedural safeguards and social control have been analyzed using different methods. The analysis of the former is based on a normative foundation. Data have been contrasted with a theoretical definition of what is reasonably required to protect patients' legal rights. In the latter case, we have created a theoretical model of the techniques and dimensions of control and then discussed the extent to which these notions are discernible in the special provisions found in the decisions. By and large the model has captured the actual special provisions found in the decisions. Two types of provisions have proved to be difficult to incorporate into our model: on the one hand, provisions about following routines and rules within the patients' housing facility and on the other provisions about counseling. Overall, the interpretive dilemmas we have occasionally encountered are due to the fact that the rulings include very little information about the rationale behind the approval of special provisions.

Since the data are publicly available and our analytical focus transcends the circumstances of individual patients, we have refrained from contacting participants in the hearings. The project has been approved by the Regional Ethical Review Board in Umeå.

4. Results and analysis

4.1. Patients

Before analyzing the data in terms of social control and legal rights, this section provides a statistical description of some basic features, including patient characteristics and the special provisions approved by the courts. It is difficult to describe the proportion of in-patient compulsory care and CCC among psychiatric patients in Sweden based on official statistics. However, the following numbers will provide a rough picture. In 2010, about 50 000 patients were treated in psychiatric in-patient facilities (5.3/10 000 inhabitants). Among in-patients, about 20% were under compulsory care, with forensic and civil patients each accounting for about half (Socialstyrelsen, 2012).
In our Swedish CCC data, 31% of patients actually accept being subject to CCC. The age of patients in our cases ranges from 14 to 86, with a mean of 47 (49 for women and 45 for men). Thus, Swedish CCC patients are somewhat older than what is reported by Churchill et al. (2007). 51% of the patients in our study are women, which means that the proportion of women in CCC in Sweden is larger than what is common in other countries. However, this proportion is the same as for psychiatric inpatients in Sweden (Socialstyrelsen, 2008). A conceivable explanation for this difference between Sweden and other countries is the small proportion of patients who are described as dangerous to others in combination with a relatively limited emphasis in Swedish legislation on protecting the public (see Table 1). This interpretation lends support to international findings that countries that use need for treatment as an admission criteria (as opposed to dangerousness) tend to have a larger proportion of women under compulsory care (Salize & Dressing, 2004).

Information about diagnosis is not mentioned systematically in the decisions. Specific diagnoses are only sometimes mentioned, but when coding we have also drawn conclusions about diagnosis based on other information, for example medication and other treatment. Information about diagnosis is completely left out in about one-third of decisions. Possibly, this reflects a concern about protecting the privacy of patients since the decisions are public documents. There is no legal requirement to include such information, although the parliamentary ombudsman has pointed out that the courts must provide sufficient information explaining the basis for their decisions (Lavin, 1999). Aside from the uncertainties in the data, it appears that Swedish CCC patients suffer from similar psychiatric conditions as those found in international studies (Table 2).

4.2. Special provisions

Most rulings contain more than one special provision — two or three is most common. Even though the Government emphasized in its bill to the parliament that CCC was not primarily intended to secure the continuation of pharmaceutical treatment outside of the hospital, it is not surprising that medication is by far the most common special provision. We have not been able to identify any clear or meaningful correlations either within special provisions or between them and other variables, such as diagnosis or gender. Interestingly, there is no correlation between diagnosis of drug or alcohol abuse and special provisions controlling drugs and alcohol. This can be explained by the practice of several courts to routinely issue such special provisions to all patients. Another interesting finding is that decision power over special provisions is delegated to the treating psychiatrist in 41% of all hearings, either as a general delegation or as an addendum to a specified list of provisions. In these cases, psychiatrists are provided wide discretion to decide about provisions at any time (Table 3).

4.3. Procedural fairness

4.3.1. Courts virtually always approve psychiatrists’ claims

First, we would like to call attention to the fact that 99% of applications from treating psychiatrists are approved. Even in light of findings that courts rarely rule against the claims of psychiatrists and the fact that research that has described these types of hearings as rubber stamp procedures (Winick, 1999), this figure is strikingly high. How can it be interpreted? One possible explanation is that Swedish psychiatrists are exceptionally skilled at interpreting and applying the law. Alternatively, psychiatrists might be reluctant to apply CCC except for the most urgent and obvious cases, meaning that CCC is not applied as much as it should be. One possible reason for such reluctance to apply CCC is the risk that an in-patient will be automatically discharged from compulsory care if the court denies an application to transfer her to CCC. In our view, however, it is difficult to ignore the interpretation that courts fail to critically assess the arguments made by psychiatrists, and thus fail to meet standards of impartiality. Even though the patient’s position on the treating psychiatrist’s claim is usually reported in the ruling, courts almost never explain why they accept the arguments of psychiatrists in cases in which the parties have opposing views and descriptions of events.

4.3.2. Court-appointed and treating psychiatrists virtually always agree

The rationale for the requirement that a court-appointed psychiatrist is mandatory in all hearings is to facilitate the court to critically examine the arguments of the treating psychiatrist. However, as it turns out, despite their different roles in the hearings, these two psychiatrists agree in 99% of the cases. This is surprising given the difficulties of making reliable predictions about individual psychiatric patients. The agreement between the psychiatrists might help explain the high success rate of treating psychiatrist’s applications, which was mentioned above. This finding also raises concerns that it reflects a failure to meet standards of impartiality. The finding is consistent with previous qualitative analyses by Sjöström, Jacobsson, and Hollander (2002) about the contribution of court-appointed psychiatrists in Sweden. Drawing on tape-recordings and field observations from hearings, they find that court-appointed psychiatrists apply a “collegiate repertoire” when interacting with treating psychiatrists and that they fail to ask any questions that substantially challenge the assessments of treating psychiatrists. These results gain additional credibility from the fact that many courts have difficulty finding appointed psychiatrists who are independent from the treating psychiatrists whose assessments they are assigned to investigate.

4.3.3. Decisions lack transparency and clarity

It is quite common that rulings lack transparency with regard to formal legal issues. For example, in many cases courts do not specify whether a hearing concerns a transfer from in-patient care to CCC or whether it is about extending an on-going instance of CCC. A recurring problem in the decisions has been identifying the concrete circumstances that motivate court decisions.

The rationale for decisions is also frequently unclear. Typically, the court justifies its decisions with a short description of the circumstances of the patient, followed by a citation of the relevant legal criteria, and

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Table 1

<table>
<thead>
<tr>
<th>Gender</th>
<th>Danger to self</th>
<th>Danger to others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>9%</td>
<td>18%</td>
</tr>
<tr>
<td>Women</td>
<td>11%</td>
<td>7%</td>
</tr>
<tr>
<td>Men</td>
<td>8%</td>
<td>30%</td>
</tr>
</tbody>
</table>

Information about danger to self/others is not provided in any standard format in the decisions. Coding we have also drawn conclusions about diagnosis based on other information, for example medication and other treatment.

Table 2

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>When mentioned (n = 368)</th>
<th>All hearings (N = 541)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not mentioned</td>
<td>-</td>
<td>32%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>84%</td>
<td>58%</td>
</tr>
<tr>
<td>Abuse of alcohol/drugs</td>
<td>14%</td>
<td>12%</td>
</tr>
<tr>
<td>Bipolar</td>
<td>10%</td>
<td>6%</td>
</tr>
<tr>
<td>Neuropsychiatric</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Depression/anxiety/OCD</td>
<td>4%</td>
<td>2%</td>
</tr>
</tbody>
</table>

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6 Given this lack of impartiality in the decisions, one might wonder about the role of attorneys. It is possible that some attorneys have vigilantly challenged the claims of psychiatrists and insisted on clarification. However, that would not be visible in our data. Previous research about court hearings relating to compulsory care in Sweden indicates that attorneys are very passive in this respect (Hollander et al., 2007). Defender, spokesperson, therapist — Representing the true interest of the client in therapeutic law. International Journal of Social Welfare, 16, 373–381.)

finally a statement that the criteria are met. In most cases, there is no discussion or explanation that connects the two. This is true both for the decisions to agree to CCC and decisions regarding special provisions. The following excerpt from one ruling (Administrative Court of Norrbotten County, case 1017-09) illustrates this mode of writing. The court approved the treating psychiatrist’s application to extend CCC. In the written decision, which is three pages long, the court explains its reasoning under the heading “The court’s assessment”.

The investigation in this case shows that Lars Johansson suffers from a severe mental disorder. The documents provided show that it is of critical importance that Lars Johansson takes the prescribed medication and maintains the supportive contacts suggested by the treating psychiatrist. The court finds that, due to his mental health condition and personal situation, he must adhere to particular special provisions in order to enable him to receive necessary psychiatric care. Due to his mental condition, there are strong reasons to assume that treatment cannot be provided with his consent. The court finds that the suggested provisions are well-balanced and should be applied.

Direct quotations from the law are highlighted in italics. The only factual circumstances mentioned in the case are: “Lars Johansson opposes coercion. He opposes all medication and regards himself as completely healthy.” From this information, it is impossible to discern the concrete factual circumstances that led the court to find that the criteria for continuing CCC had been met and to determine that the special provisions suggested by the treating psychiatrist were appropriate. The documents that the court refers to in the decision are not available for examination. Thus, as is the case in numerous other decisions, one fails to meet standards of clarity and transparency.

4.4. Social control

After inventorying the special provisions, we assessed the ways in which the different provisions exercise social control. The figure below represents our overall interpretation (Fig. 2).

4.4.1. Surveillance

Special provisions aimed at surveillance are common in the decisions. This technique operates on all dimensions through provisions about medication, staying in contact with particular service providers, specifying the town and type of housing in which the person must live and monitoring drug/alcohol use. On a temporal dimension, surveillance techniques may specify how often patients must be in contact with service providers. The spatial dimension primarily operates through surveillance techniques, e.g. provisions about where a person may live, prohibitions against leaving town, requirements to visit a particular facility and prohibitions against being in the company of specific persons. A physical dimension of surveillance may be exercised through requirements about medication, e.g. requirements that it must be given by injection or that it must be distributed by staff. In addition, rules that prohibit the use of drugs and alcohol are common. When such rules contain requirements for patients to give urine or blood samples, they also represent physical surveillance. Another example is the relatively rare case of patients with eating disorders who are required to have their weight monitored.

4.4.2. Therapy

Except for medication, special provisions that have therapeutic aims are rare. Among those that do exist, there is a temporal dimension when patients are required to follow sleeping patterns that are seen as normal. The therapeutic side of this lies in the view that sleeping patterns are important to maintaining a stable mental condition. Moreover, some therapeutic interventions are structured time-wise, e.g. when to take medicine and attendance at a day center. On a spatial dimension, therapy is controlled when medication and daily activities are connected to specific locations. Additionally, provisions about housing can have therapeutic goals. The most important component of CCC, by far, is medication, which concerns treatment on a physical dimension. Occasionally, patients are obliged to medicate for diabetes or follow a particular diet. There is another group of provisions – although rare – that do not fit in to our model: counseling, family therapy or attending AA meetings. In a very general sense these may operate on temporal and spatial dimensions but primarily they are designed to affect something within the mind of patients. To the extent that these techniques actually aim at changing how patients think about their behavior, they can possibly represent an internalized dimension of control.

4.4.3. Sanctions

The law does not provide a possibility to impose sanctions against CCC patients who fail to comply with special provisions. The only sanctioning technique that is available occurs on a spatial dimension. In the rare cases when patients are readmitted to the hospital, they have not necessarily violated their provisions. A decision to readmit can be justified exclusively with reference to mental status and need of treatment.

5. Concluding discussion

5.1. Methodological considerations

Since our data include all written decisions in Sweden during a given period of time, this study does not have any problems of representativeness. Obviously, the court decisions do not provide us with a complete picture of either procedural fairness or social control. For example, additional data from coordinated care plans would probably have given us more information about the reasons for particular decisions. Regarding social control, data other than those on special provisions might have

Table 3

<table>
<thead>
<tr>
<th>Special provisions</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
<td>79%</td>
</tr>
<tr>
<td>Contact with community mental health services</td>
<td>51%</td>
</tr>
<tr>
<td>Contact with social services</td>
<td>27%</td>
</tr>
<tr>
<td>Supervised or sheltered housing</td>
<td>25%</td>
</tr>
<tr>
<td>Prohibition on the use of alcohol/drugs</td>
<td>15%</td>
</tr>
<tr>
<td>Counseling</td>
<td>5%</td>
</tr>
<tr>
<td>Occupation, studies, etc.</td>
<td>4%</td>
</tr>
<tr>
<td>Living in a specified city</td>
<td>3%</td>
</tr>
<tr>
<td>Not mentioned</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>15%</td>
</tr>
</tbody>
</table>

The name of the patient has been altered in this article.
allowed us to identify other techniques and the dimensions on which they operate. Such data can be obtained in different domains: e.g., the design of legislation, court hearing conversations, interaction between and perceptions of caregivers and patients.

The most difficult methodological problem in this study has been the lack of transparency, clarity, and consistency in the written decisions. Taken as objective measures, the reliability of information about diagnoses and dangerousness is questionable. Moreover, the deficiencies in transparency and clarity have prevented us from comparing how different groups of patients have been assessed. It is somewhat ironic that deficiencies in procedural fairness become a major obstacle in researching this very topic.

However, information about our key interest—the special provisions—is reliable and always reported by the courts. Regardless of the methodological limitations of this study, the shortcomings in procedural fairness that we have identified by examining decisions are real problems in themselves. Information from other sources cannot change this conclusion to the better. On the other hand, it is quite possible that there are additional problems in procedural fairness that cannot be detected by studying written court decisions only.

5.2. The legal rights of patients

Overall, our findings about procedural fairness in the decisions are disconcerting. We have identified deficiencies in all four areas that we defined as fundamental components of a fair trial: transparency, clarity, consistency, and impartiality.

The methodological problem of transparency and clarity that we discussed earlier is also a problem in terms of procedural fairness. The decisions lack information about the circumstances of patients, and they fail to explain the reasons behind the conclusions drawn by the courts in individual cases. Hence, it cannot be determined whether or not the patients subjected to CCC actually satisfy the criteria as stated in the law. Patients and others are not privy to information about the actual considerations used by courts to reach their decisions. As a consequence, it is difficult for patients to raise counterarguments for appeals, which hinders the development of a rich body of case law. In terms of consistency, we have identified substantial regional variation in decisions as regards how CCC decisions are designed, which special provisions are applied and the extent to which decisions are delegated to treating psychiatrists. This indicates that the rights of patients are not protected in a consistent manner throughout Sweden. Finally, the decisions reveal a lack of impartiality vis-à-vis the parties in the hearings—i.e., psychiatrists and patients. More than 99% of decisions are made in favor of the claims of treating psychiatrists, court-appointed psychiatrists agree with treating psychiatrists in 99% of cases, and a substantial minority of courts routinely delegates decision-making authority to treating psychiatrists. Moreover, the reasons for this decision are not explained by the courts.

Taken together, our findings indicate that, to some degree, Swedish courts fail to protect patients from being unduly subjected to CCC. It can be noted in passing that previous research based on observations and audio-recordings from similar proceedings in Sweden came to similar conclusions (Hollander, Jacobsson, & Sjöström, 2007; Sjöström, 1997).

5.3. Social control

The distinction between dimensions and techniques of social control is an analytical one. A particular special condition imposed on a patient can involve different controlling techniques and dimensions simultaneously. The virtue of these conceptualizations is that they allow us to discuss the coercive measures applied in CCC more generally. Among the dimensions of control, the physical form stands out as the most critical simply because of the unique role of medication. Even though this form of control is fundamentally physical, it also affects how subjects are able to move in time and space, and even how they think about their treatment and way of life. The physical dimension is furthermore manifest in surveillance and therapeutic techniques. Along with the physical dimension, the spatial dimension is prominent in decisions about CCC, particularly through provisions about housing and which town a patient shall live in. The spatial dimension is the only one in which sanction techniques can be applied, something which happens in the rare cases when patients are readmitted to hospital care.

Our model does not take into account the distinction between hard–soft edge and internal–external forms of control. Our data do not allow us to draw any certain conclusion about these forms of control. At one level, the assumption that CCC is primarily a form of “soft” control is supported by the lack of teeth in the legislation. Possibly, the dominant techniques found here—therapy and surveillance—could be regarded as soft and hard forms respectively. However, little is known about the workings of CCC in everyday practice.

The fact that a surprisingly large proportion of CCC patients actually consent to treatment might indicate that patients have internalized behaviors promoted by their caregivers. Similarly, the presupposition in the law that each instance of CCC should involve a high degree of cooperation, suggests that patients might internalize moral expectations when complying with their special provisions. To some degree, provisions about daily activities, following rules, maintaining normal sleeping patterns and restrictions on alcohol and drug use can be regarded as therapeutic techniques that make patients internalize health-promoting everyday routines.
5.4. What does all this mean?

Taking a broader perspective on the Swedish application of CCC, we observe that coercive elements are somewhat elusive. Legislators have stated that CCC requires cooperation between patients and service providers, and a substantial proportion of patients actually accept the treatment proposed by their treating psychiatrist. Furthermore, the law itself lacks the teeth to force CCC patients to comply with treatments offered by service providers, and the grounds for issuing particular provisions are often unclear. This means that it is difficult to define and analyze the essence of this form of coercion — what are the vital components of compulsory community care? As a consequence, it is problematic to talk about its effects. How can we be sure that it works? To the extent that things go well, how do we know that this is due to the coercive components rather than the effects of a wider treatment regime?

In the international discourse about mental health law, interest in the ideas of “therapeutic jurisprudence” has increased in recent years. TJ has informed the practice of mental health law in a wide array of jurisdictions. Although this paradigm is seldom explicitly referred to in Sweden, we would argue that perhaps more than anywhere else in the world, the Swedish ideology of mental health law embraces the fundamental values of TJ. This is reflected in how the Swedish Government, in the bill proposing the introduction of CCC, labeled it as “a new form of care,” thus downplaying the fact that it was actually a bill about a new form of coercion. In addition, the bill has a strong emphasis on the inclusion and cooperation of the patient and the quality of care rather than the coercive elements (Sjöström et al., 2011). Moreover, court hearings are held in the less adversarial administrative courts and characterized by a tone and setting that are highly informal. How, then, does this quintessential case of TJ function? Our results point to substantial failures in the protection of legal rights. It seems that the preoccupation with therapeutic perspectives in designing and practicing CCC has led legislators as well as practitioners to forget about pertinent aspects of patients’ rights.

Finally, bringing together the perspectives of social control and patient rights, we conclude that the failures in procedural fairness make patients vulnerable to being exposed to new forms of social control of an unclear nature.

References